WellCare
NJ FamilyCare (NJFC)

Provider Reference Guide

LIBERTY DENTAL PLAN®

Making members shine, one smile at a time™

TABLE OF CONTENTS

SECTION 1. LIBERTY DENTAL PLAN INFORMATION

INTRODUCTION

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

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

In order to provide the most current information, updates to the Provider Reference Guide will be available on the LIBERTY website at https://www.libertydentalplan.com/Resources/Documents/ma_Office_Portal_User_Guide.pdf.

OUR MISSION

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

LIBERTY DENTAL PLAN PROVIDER CONTACT & INFORMATION GUIDE

IMPORTANT PHONE NUMBERS & GENERAL INFORMATION

Toll Free
888.352.7924

Eligibility & Benefits: Option 1
Claims: Option 2
Prior Authorizations: Option 3
Referrals: Option 4
Request Materials: Option 5
General Information: Option 6

HOURS

An adequate number of LIVE representatives are available

Monday – Friday

8 a.m. EST – 8 p.m. EST

PROVIDER RELATIONS DEPARTMENT

888.352.7924

800.268.0154 (fax)

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

EMAIL

PRinquiries@libertydentalplan.com

ELIGIBILITY & BENEFITS VERIFICATION

Provider Portal
www.libertydentalplan.com
(i-Transact)
or
Telephone
888.352.7924, option 1

PRIOR APPROVAL SUBMISSION & INQUIRIES

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

Telephone
888.352.7924, option 3

EMAIL
referrals@libertydentalplan.com

Regular Referrals by Mail:

LIBERTY Dental Plan
ATTN: Referral Department
PO Box 401086
Las Vegas, NV 89140

Emergency Referrals

All requests for emergency specialty care should be made by calling: 888.352.7924, option 4

CLAIMS INQUIRIES

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

or

Telephone
888.352.7924, option 2

CLAIMS SUBMISSIONS

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

EDI
Payer ID #: CX083

EMAIL
claims@libertydentalplan.com

Paper Claims by Mail
or
Corrected Claims by Mail

LIBERTY Dental Plan
ATTN: Claims Department
PO Box 401086
Las Vegas, NV 89140

PROVIDER WEB PORTAL (i-TRANSACT)

www.libertydentalplan.com

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

- Electronic Claims
- Prior Authorization Submission
- Claims Inquiries
- Real-time Eligibility Verification
- Member Benefit Information
- Referral Submission
- Referral Status

Please visit:
Provider Portal
to register as a new user and/or login.

Your "Access Code" can be found on your LIBERTY Welcome Letter. If you cannot locate your access code, or need help with the login process, please call: 888.352.7924 for assistance or email: portalsupport@libertydentalplan.com

CLICK TO ACCESS THE FOLLOWING:

WellCare Provider Handbook

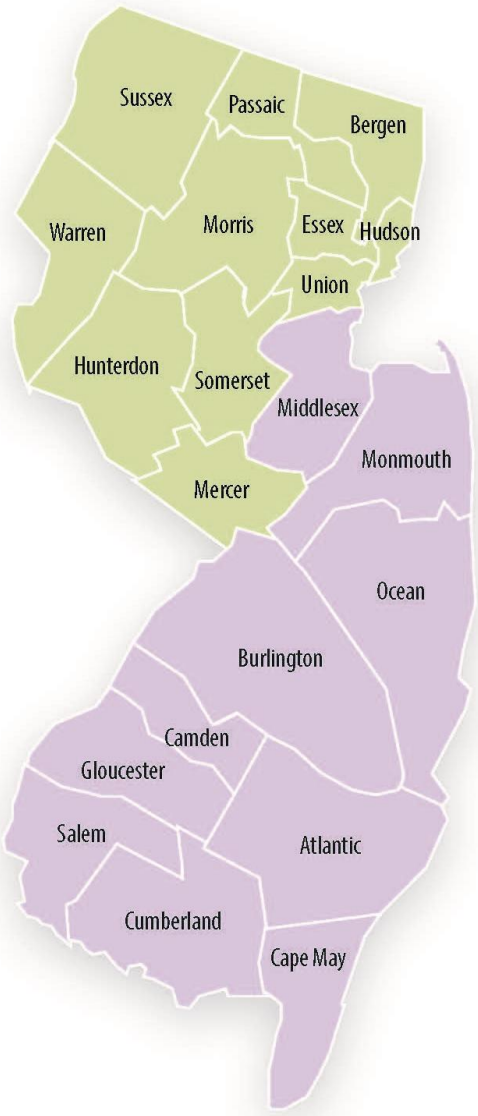
WellCare Member Handbook

Find a Dentist

NEW JERSEY PROVIDER RELATIONS TERRITORY ASSIGNMENT

Network Manager Territory Map

Assigned Network Manager	Counties:
Shazmin Rodriguez *Network Manager* **201.410.5190** shazming@libertydentalplan.com	Bergen Essex Hudson Hunterdon Mercer Morris Passaic Somerset Sussex Union Warren
Caroline Saienni *Network Manager* **917.231.6858** csaienni@libertydentalplan.com	Atlantic Burlington Camden Cape May Cumberland Gloucester Middlesex Monmouth Ocean Salem
Nicole Mosca *AVP Provider Relations* nmosca@libertydentalplan.com	
Alexis Arguello *Director, Provider Relations* aarguello@libertydentalplan.com	



www.libertydentalplan.com

Making members shine, one smile at a time™

SECTION 2. PROVIDER RELATIONS AND PROVIDER TRAINING

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

- Plan Contracting
- Escalated Claim Payment Issues
- New and existing provider training and education
- Education on WellCare Members and Benefits
- Opening, Changing, Selling or Closing a Location
- Adding or Terminating Associates
- Credentialing and recredentialing of owner and associate dentist Inquiries
- Change in Name or Ownership
- Taxpayer Identification Number (TIN) Change
- Changes in office hours

To ensure that your information is displayed accurately, and claims are processed efficiently, please submit all changes 30 days in advance to PRinquiries@libertydentalplan.com or in writing. Provider Relations will address your inquiry within three (3) business days of receipt.

	LIBERTY Dental Plan **ATTN: Provider Relations** P.O. Box 26110 Santa Ana, CA 92799-6110		**Provider Relations Team** M-F from 8 am – 8pm (Eastern Time) 888.352.7924
	Email at PRinquiries@libertydentalplan.com		

PROVIDER COMPLIANCE AND TRAINING

LIBERTY supplies required compliance training online for providers supporting government business. Participating providers are required to complete training annually and/or attest to completion of compliant training.

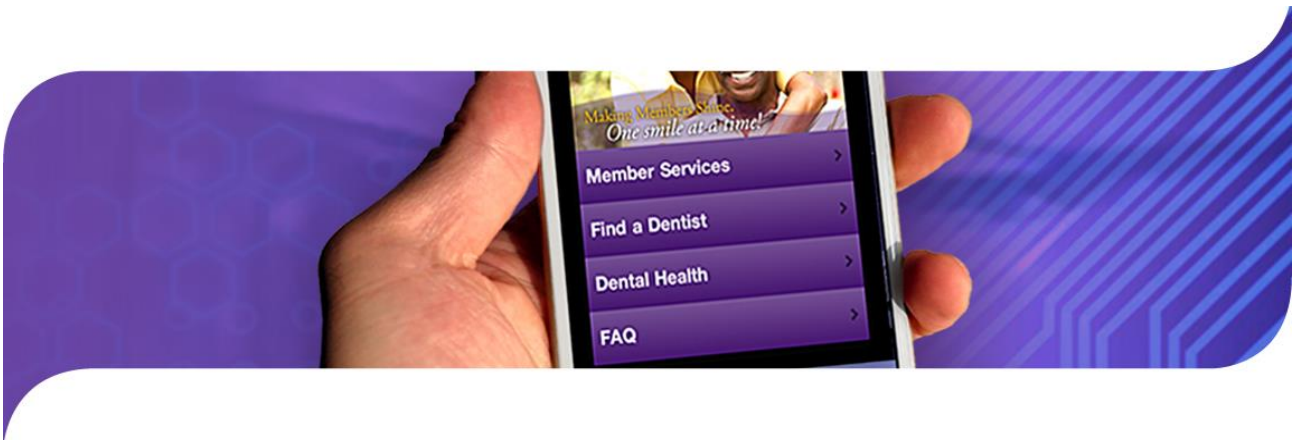
Provider Training can be accessed at www.libertydentalplan.com/Providers/Provider-Training-1.aspx

Trainings include but are not limited to:

- Critical Incident Training
- Code of Business Ethics & Conduct
- Cultural Competency Provider Training
- Fraud, Waste & Abuse Training
- General Compliance Training
- HIPAA

Providers must maintain supporting documentation of training for a period of 10 years for all office staff supporting LIBERTY's government business and can furnish the document upon request.

SECTION 3. ONLINE SELF-SERVICE TOOLS



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

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

- Submit Electronic Claims and requests for Prior Authorization
- Verify Member Eligibility and Benefits
- View Office and Contact Information
- Submit Referrals and Check Status
- Access Benefit Plans
- Print Monthly Eligibility Rosters
- Perform a Provider Search

ON-LINE ACCOUNT ACCESS

To register and obtain immediate access to your office's account, visit: https://www.libertydentalplan.com/Providers/Provider-Self-Service-Tools/ITransact.aspx.

All contracted network dental offices are issued a unique **Office Number** and **Access Code**. These numbers can be found on your LIBERTY Welcome Letter and are required to register your office on LIBERTY's Online Provider Portal.

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

If you are unable to locate your **Office Number** and/or **Access Code** , please contact our Provider Relations Department or email PRinquiries@libertydentalplan.com for assistance.

Detailed instructions on how to utilize our online services can be found in the https://www.libertydentalplan.com/Resources/Documents/ma_Office_Portal_User_Guide.pdf.

DIRECTORY INFORMATION VERIFICATION (DIV) ONLINE

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

There is an easier way to update your information through our Provider Directory Information Verification (DIV) website at http://www.libertydentalplan.com/ProviderDIV.

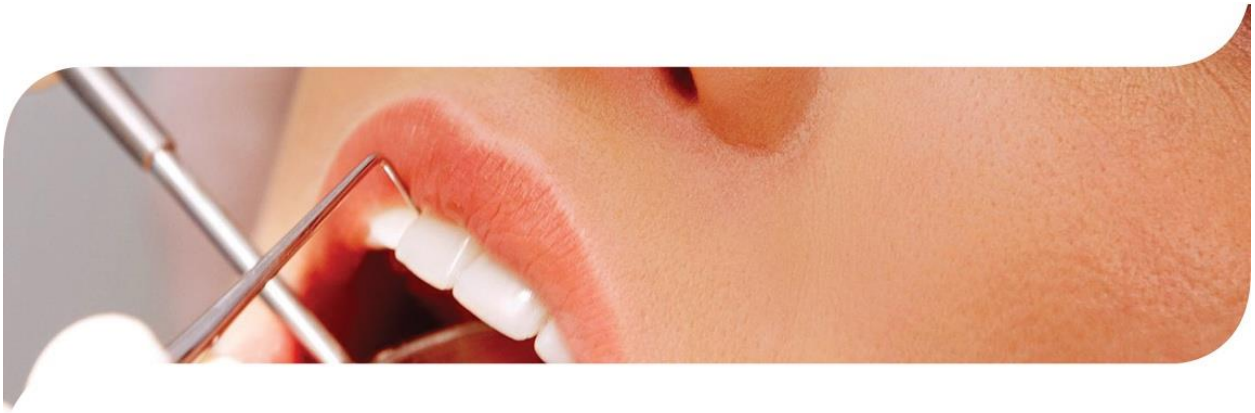
Anytime you have changes, including, but not limited to appointment times, office hours, address, phone number, fax number, associate dentist, etc. you'll be able to update or **attest** that no changes were made no less than **every 85 days** by going online.

Why do I need to update my provider information?

- Prevent and minimize costly claims payment delays
- Stop time consuming calls to validate your directory information
- Fix what's wrong with the click of a button
- No filling out paper forms and faxing or emailing
- Provide the most up-to-date information to existing and new members so they can make educational decisions about their provider office choices

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

SECTION 4. ELIGIBILITY



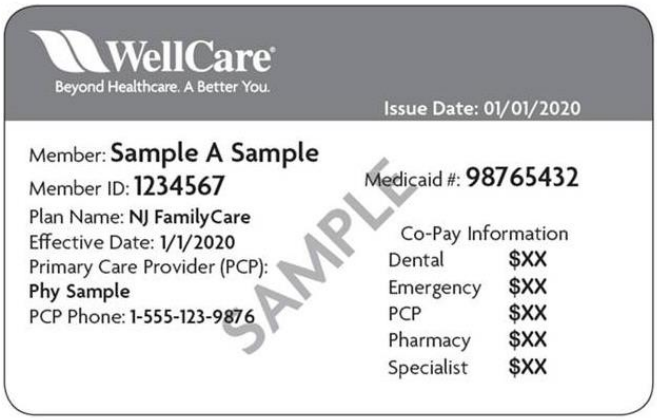
HOW TO VERIFY ELIGIBILITY

There are several options available to verify eligibility:

1. **Provider Portal**: https://www.libertydentalplan.com/Providers/Provider-Self-Service-Tools/ITransact.aspx (We recommend using Member's Last Name, First Name and Date of Birth *for best results)*
2. **Telephone:** Speak with a live Representative from 8 a.m. to 8 p.m. EST contacting our Member Services Department.

MEMBER IDENTIFICATION CARDS

WellCare members should present their ID card at each appointment. Providers are encouraged to validate the identity of the person presenting an ID card by requesting some form of photo identification. The presentation of an ID card does not guarantee eligibility and/or payment of benefits. In such cases, providers should check a photo ID and check against an eligibility list or contact Member Services or the online web portal for verification of eligibility.



PRIMARY CARE DENTAL ASSIGNMENT

Dental home is the ongoing relationship between the dentist and the patient, inclusive of all aspects of oral health care delivered in a comprehensive, continuously accessible, coordinated, and family-centered way. The dental home should be established no later than 12 months of age to help children and their families institute a lifetime of good oral health. A dental home addresses anticipatory guidance and preventive, acute, and comprehensive oral health care and includes referral to dental specialists when appropriate.

WellCare members can choose a Primary Care Dentist (PCD) at any time. Upon initial enrollment, LIBERTY will assign WellCare members to the nearest Primary Care Dentist based on such factors as language, cultural preference, previous history of the member or another family member, etc. WellCare members can change Primary Care Dentists at any time by either calling LIBERTY, going onto the LIBERTY website, or by being seen by an in-network Primary Care Dentist of their choice.

All NJ FamilyCare/WellCare Medicaid Adult and Child members must be assigned to their primary care dental home prior to treatment. Dental homes include general and pediatric offices also known as Primary Care Dentist (PCD).

Members can assign themselves to your office by one of the following ways:

- **Online:** http://www.libertydentalplan.com
- **Calling our Member Services Department at**: 888.352.7924

Primary Care Dentists ("PCD") may contact Provider Relations to request member reassignment or transfer.

WellCare is responsible for educating members on enrollment policies and procedures.

SECTION 5. MEDICAID PROGRAM GUIDELINES

DEFINITION OF MEDICAL NECESSITY

Medically Necessity Services as defined by State of New Jersey and WellCare contract, refers to services or supplies necessary to prevent, evaluate, diagnose, correct, prevent the worsening of, alleviate, ameliorate, or cure a physical or mental illness or condition; to maintain health; to prevent the onset of an illness, condition, or disability; to prevent or treat a condition that endangers life or causes suffering or pain or results in illness or infirmity; to prevent the deterioration of a condition; to promote the development or maintenance of maximal functioning capacity in performing daily activities, taking into account both the functional capacity of the individual and those functional capacities that are appropriate for individuals of the same age; to prevent or treat a condition that threatens to cause or aggravate a handicap or cause physical deformity or malfunction, and there is no other equally effective, more conservative or substantially less costly course of treatment available or suitable for the enrollee. The services provided, as well as the type of provider and setting, must be reflective of the level of services that can be safely provided, must be consistent with the diagnosis of the condition and appropriate to the specific medical needs of the enrollee and not solely for the convenience of the enrollee or provider of service and in accordance with standards of good medical practice and generally recognized by the medical scientific community as effective. Course of treatment may include mere observation or, where appropriate, no treatment at all.

We approve care that is "medically necessary" or "needed" including but not limited to:

- The treatment or supplies are needed to prevent, evaluate, diagnose, correct, prevent the worsening of, alleviate, ameliorate, or cure a physical or mental illness or condition and that meet accepted standards of dentistry;
- Treatment that meets EPSDT guidelines and regulations, following accepted medical and dental practices, provide services in an appropriate clinical setting, and as medically necessary.
- Will prevent the onset of an illness, condition, or disability;
- Will prevent the deterioration of a condition;
- Will prevent or treat a condition that endangers life or causes suffering, pain or results in illness or infirmity;
- Will follow accepted medical practices;

- Services are member-centered and take into account the individuals' needs, clinical and environmental factors, and personal values. These Criteria do not replace clinical judgment, and every treatment decision must allow for the consideration of the unique situation of the individual;
- Services are provided in a safe, proper and cost-effective place, reflective of the services that can be safely provided consistent with the diagnosis;
- Services are not performed for convenience only; and
- Services are provided as needed when there is no better or less costly covered care, service or place available.

EARLY AND PERIODIC SCREENING, DIAGNOSTIC AND TREATMENT SERVICES

Early and Periodic Screening, Diagnostic and Treatment (EPSDT)--a Title XIX mandated program that covers screening and diagnostic services to determine physical and mental defects in enrollees under the age of 21, and health care, treatment, and other measures to correct or ameliorate any defects and chronic conditions discovered, pursuant to Federal Regulations found in Title XIX of the Social Security Act.

1. Dental services may not be limited to emergency services.
    a. Dental screening by the primary care physician in this context means, at a minimum, observation of tooth eruption, occlusion patterns, presence of caries, and/or oral infection and include completion of the AAP caries risk assessment.
        i. The Primary Care Physician is required to refer a child to the dentist by one year of age or soon after the eruption of the first primary tooth, is mandatory, for a minimum of two (2) dental visits a year.
        ii. It is mandated that the PCP follow up during well child visits to ensure that all needed preventive and definitive dental services are provided thereafter through the age of twenty (20) to determine at a minimum dental visits twice a year for oral evaluation and preventive services occurred and that needed treatment services are being or were provided.
    b. A dental home should be established by two years of age through assignment of a PCD, dental referral or outreach.
        i. Comprehensive oral evaluation by a dentist should occur followed by periodic oral evaluations as needed.
        ii. A caries risk assessment should be provided on an annual basis for all children and be used to determine and develop a treatment plan.
        iii. Preventive services should occur at lease biannually and more frequently based on medical necessity.
        iv. All diagnosed disease should be documented, and all needed treatment should be provided in a timely manner.
        v. A referral to a dental specialist or dentist that provides dental treatment to patients with special needs shall be allowed when a PCD requires a consultation for services by that specialty provider as noted in section 4.2.6.1(f) of the MCO contract. You may access the Specialty Care Referral Form at https://www.libertydentalplan.com/Providers/Provider-Resource-Library.aspx.

2. There may be limitations or requirements associated with some of the Medicaid services (e.g., prior authorization, physician prescription or written order prior to rendering service; specific providers or facilities that must render care in order for services to qualify for reimbursement).

3. LIBERTY will not penalize a participating provider (by non-payment of claim) for treating an eligible member for a non-emergent visit because the member did not notify LIBERTY of their choice of a PCD.

Primary Care Physician (PCP)--a licensed medical doctor (MD) or doctor of osteopathy (DO) or certain other licensed medical practitioner who, within the scope of practice and in accordance with State certification/licensure requirements, standards, and practices, is responsible for providing all required primary care services to enrollees, including periodic examinations, preventive health care and counseling, immunizations, diagnosis and treatment of illness or injury, coordination of overall medical care, record maintenance, and initiation of referrals to specialty providers described in this contract and the Benefits Package, and for maintaining continuity of member care. A PCP shall include general/family practitioners, pediatricians, internists, and may include specialist physicians, physician assistants, CNMs or CNPs/CNSs, provided that the practitioner is able and willing to carry out all PCP responsibilities in accordance with these contract provisions and licensure requirements.

A referral to a dental specialist or dentist that provides dental treatment to members with special needs shall be allowed when a primary care dentist requires a consultation for services by that specialty provider.

New Jersey Dental Periodicity Table

Dental Service by Dental Professional	0-1 yr	2-6 yrs	7-20 yrs
A1. Oral Evaluation (Exam)	yes	yes	yes
2. Caries/Cavities Risk Assessment	yes	yes	yes
B. Fluoride Supplements	yes	yes	yes
C. Fluoride Varnish*	yes	yes	yes
D. Prophylaxis with Fluoride		yes	yes
E. Sealants (Permanent teeth to age 16 yrs)		yes	yes
F. Radiographs/x-rays (Non-emergency)	yes	yes	yes
G. Dental Treatment	yes	yes	yes

- **Oral Evaluations** (including oral hygiene instructions), **Fluoride varnish** and **Cleanings** with fluoride can be provided twice a year or more frequently based on medical necessity and for children with special health care needs.
- A prescription for **fluoride supplements** may be given by either your dentist or primary care provider (PCP) to help prevent cavities.
- *The application of **fluoride varnish** to protect teeth from cavities can also be done for children through the age of 5 by their PCP followed by a referral to the dentist for an oral evaluation, X-rays as needed, cleaning and dental treatment.
- A **Caries/Cavities Risk Assessment** – should be done once a year to determine your child's risk of developing cavities. The visit includes an oral evaluation, instructions on brushing, oral health, safety and nutritional counselling to parents/caregivers and children.
- **Sealants and repairs of sealants** should be provided to premolars and permanent molars of children between the ages of 6 through 16 to help prevent cavities
- **Dental treatment** services for primary "baby teeth" and permanent teeth include: **fillings, stainless steel crowns, treatment for toothache and extractions** and should be provided when recommended by your child's dentist.

NJ SMILES PROGRAM

Non-dental trained medical staff including, but not limited to PCPs, physician assistants and nurse practitioners may provide annual caries dental risk assessment, anticipatory guidance, fluoride varnish application and dental referral for children through the age of three (3) as part of a required well-child visit. Communication is required between PCP's and PCD's to facilitate the requirement of referral to a dentist for a dental visit by twelve (12) months of age.

1. Fluoride varnish may be applied by any trained medical staff who have proof of training for this service. Primary care physicians (pediatricians or physicians seeing pediatric enrollees), physician assistants and nurse practitioners can receive this training.
2. Fluoride varnish application will be combined with risk assessment, anticipatory guidance, and referral to a dentist that treats children under the age of six (6) and will be linked to well child visits for children through the age of three (3).
3. These three non-dental provider services will be reimbursed as an all-inclusive service billed as a CPT code and can be provided up to four (4) times a year. This frequency does not affect the frequency of this service by the dentist.
4. WellCare must provide training to all primary care physicians on the requirement of a bidirectional referral to a dentist for a dental visit by twelve (12) months of age.
5. WellCare must notify primary care physicians and primary care dentists on the NJFC bidirectional referral process and required communications between the primary care physician and primary care dentist provider groups. This will be monitored on a monthly basis to ensure compliance by PCPs and PCDs.
6. WellCare must provide training to all primary care dentists and primary care physicians on prescribing fluoride supplements (based on access and use to fluoridated public water) and their responsibility in counseling parents and guardians of young children on oral health and age appropriate oral habits and safety to include what dental emergencies are and use of the emergency room for dental services.
7. WellCare maintains a directory of dental providers for children on their website. It can be used as a resource to refer children under the age of six (6).
8. The caries risk assessment service shall also be allowed by the PCD and is billed using a CDT procedure code. The reimbursement will be the same regardless of the determined risk level. The risk assessment must be provided at least once per year in conjunction with an oral evaluation service by a PCD and is linked to the provider not the member. It may be provided a second time with prior authorization and documentation of medical necessity.

NJ FAMILYCARE PROGRAM

NJ FamilyCare programs provide medical and dental coverage to eligible children and adults based on income levels. LIBERTY provides dental services for eligible members in the FamilyCare A, ABP, B, C, D, MLTSS, FIDE-SNP, and DDD programs on behalf of WellCare. All NJ FamilyCare members in the aforementioned groups have comprehensive and identical dental benefits which include diagnostic, preventive, restorative, endodontic,

periodontal, prosthetic, oral surgical and other adjunctive general services. Some procedures require prior authorization with documentation of medical necessity.

Orthodontic services are age restricted and only approved with adequate documentation of a handicapping malocclusion or medical necessity. Participating providers are responsible for working with the Plan to ensure anticipated treatment is completed prior to the loss of benefit eligibility due to age.

Providers are required to obtain a signed Informed Consent Form and advise the member and parent or guardian of the following:

- The age limit for orthodontic coverage
- Length of treatment
- Consequences of excessive breakage of appliance(s) and/or other behavior that is not conducive to completing treatment in a timely manner
- Their financial responsibilities should coverage be lost

NJ FAMILYCARE INCOME CHART

NJFAMILYCARE
Affordable health coverage. Quality care.

Income Chart effective October 1, 2019

1-800-701-0710
TTY: 1-800-701-0720
www.njfamilycare.org

FAMILY SIZE *	Adult(s) (Age 19-64)	Plan First** (Family Planning)	Pregnant Women (Any Age)	Children (Under Age 19)					
	Federal Poverty Level % (FPL)								
	0 - 138%	> 138 - 205%	0 - 205%	0 - 147%	> 147 - 150%	> 150 - 200%	> 200 - 250%	> 250 - 300%	> 300 - 355%
	Maximum Monthly Income								
1	$1,437	$2,134	N/A	$1,531	$1,562	$2,082	$2,603	$3,123	$3,695
2	$1,945	$2,889	$2,889	$2,072	$2,114	$2,819	$3,523	$4,228	$5,003
3	$2,453	$3,644	$3,644	$2,613	$2,667	$3,555	$4,444	$5,333	$6,311
4	$2,962	$4,399	$4,399	$3,155	$3,219	$4,292	$5,365	$6,438	$7,618
5	$3,470	$5,155	$5,155	$3,696	$3,772	$5,029	$6,286	$7,543	$8,926
6	$3,978	$5,910	$5,910	$4,238	$4,324	$5,765	$7,207	$8,648	$10,233
Each Additional	$509	$756	$756	$542	$553	$737	$921	$1,105	$1,308
Monthly Premium	No premium	No premium	No premium	No premium	No premium	No premium	$44.50 per family	$90.00 per family	$151.50 per family
Copayments	No copay	No copay	No copay	No copay	No copay	$5 - $10	$5 - $35	$5 - $35	$5 - $35

* The size of your family may be determined by the **total number** of parent(s) or caretaker(s), and all blood-related children under the age of 21 **who are tax dependent, as well as any other tax dependent** residing in the home.

** Plan First does not meet the minimum essential health care coverage requirement.

CARE FOR MEMBERS WITH SPECIAL NEEDS

Children with Special Health Care Needs - those children who have or are at increased risk for chronic physical, developmental, behavioral, or emotional conditions and who also require health and related services of a type and amount beyond that required by children generally. This includes all children who are MLTSS Members.

Enrollee with Special Needs - for adults, special needs include complex/chronic medical conditions requiring specialized health care services and persons with physical, mental/substance abuse, and/or developmental disabilities, including persons who are eligible for the MLTSS program.

We offer care management services to children and adults with special health care needs, including referrals by the primary care dentist to a dental specialist when a consultation with a specialist is required. Our care management programs are offered to members who:

- Are developmentally disabled;
- Are home-bound;
- Are identified as needing assistance in accessing or using services; and
- Have long-term or complex health conditions, like asthma, diabetes, HIV/AIDS and high-risk pregnancy.

Our care managers are trained to help providers, children and adults to arrange services (including referrals to special care facilities for highly specialized care) that are needed to manage treatment. Our goal is to help members with special needs understand how to take care of themselves and maintain good oral health.

Our care management programs offer children and adults a care manager and other outreach workers. They'll work one-on-one to help coordinate oral health care needs. To do this, they:

- May ask questions to get more information about a member's health conditions;
- Will work with PCPs and PCDs to arrange services needed and to help members understand their illness; and
- Will provide information to help members understand how to care for themselves and how to access services, including local resources

Developmental Disabilities. While WellCare must assure that enrollees with special needs have access to all medically necessary care, the State considers dental services to be an area meriting particular attention. LIBERTY, therefore, shall accept for network participation dental providers with expertise in the dental management of enrollees with developmental disabilities. All current providers of dental services to enrollees with developmental disabilities shall be considered for participation in the LIBERTY's dental provider network. Credentialing and re-credentialing standards must be maintained. LIBERTY shall make provisions for providers of dental services to enrollees with developmental disabilities to allow for limiting their dental practices at their choice to only those members with developmental disabilities. LIBERTY and/or WellCare shall develop specific policies and procedures for the provision of dental services to enrollees with developmental disabilities in accordance with Section 4.5.1.F of the MCO contract. At a minimum, the policies and procedures shall address:

a. Special needs/issues of enrollees with developmental disabilities, including the importance of providing consultations and assistance to member caregivers.

b. Provisions in the dental reimbursement system for initial and follow-up dental visits which may require up to 60 minutes on average to allow for a comprehensive dental examination and other services to include, but not limited to: a visual examination of the enrollee; appropriate radiographs; dental prophylaxis, including extra scaling and topical applications, such as fluoride treatments; non-surgical periodontal treatment, including root planing and scaling; the application of dental sealants on permanent molars

and premolars; thorough inquiries regarding member medical histories; and most importantly, consultations with member caregivers to establish a thorough understanding of proper dental management during visits.

c. Standards for dental visits that recognize the additional time that may be required in treatment of members with developmental disabilities. Standards should allow for up to four (4) visits annually without prior authorization.

d. Provisions for home visits when medically necessary and where available.

e. Policies and procedures to ensure that providers specializing in the treatment of enrollees with developmental disabilities have adequate support staff to meet the needs of such members.

f. Provisions for use and replacement of fixed as well as removable prosthetic devices as medically necessary and appropriate.

g. Provisions in the dental reimbursement system to reimburse dentists for the costs of preoperative and postoperative evaluations associated with dental surgery performed on members with developmental disabilities. Prior authorization shall not be required for dental procedures performed during surgery on these members for dentally appropriate restorative care provided under general anesthesia. Informed consent, signed by the enrollee or authorized person, must be obtained prior to the surgical procedure. Provisions should be made to evaluate such procedures as part of a post payment review process.

h. Provisions in the dental reimbursement system for dentists to receive reimbursement for the cost of providing oral hygiene instructions to caregivers to maintain a member's overall oral health between dental visits. Such provisions shall include designing and implementing a "dental management" plan, coordinated by the Care Manager, for overseeing a member's oral health.

i. The Care Manager of an enrollee with a developmental disability shall coordinate authorizations for dentally required hospitalizations by consulting with the plan's dental and medical consultants in an efficient and time-sensitive manner.

NJ FAMILYCARE SCOPE OF BENEFITS

Dental Coverage	FamilyCare A	FamilyCare ABP, MLTSS, FIDE-SNP	FamilyCare B	FamilyCare C	FamilyCare D
Diagnostic Services** Preventive Services** Restorative Services Endodontic Services Periodontic Services** Prosthodontic Services Oral Maxillofacial Surgical Services Orthodontic Services Adjunctive Services Emergency Dental Services	Covered*			Covered* - $5 copay applies except for diagnostic and preventive visits	Covered* - $5 copay applies except for diagnostic and preventive visits

* NJFC covered services are listed on https://www.njmmis.com/, and are updated regularly.

** Additional benefits for diagnostic, preventive and some periodontal services shall be available (beyond the frequency limitations) as often as every three months to enrollees with special needs.

Services requiring prior authorization are orthodontics, periodontics, endodontics, occlusal guards, crowns, removable dentures, fixed bridge work and implants, oral surgery (except for D7111 and D7140), general anesthesia, and hospital certification surgical cases.

NJ FAMILYCARE (NJFC) REIMBURSEMENT

Contracted NJ FamilyCare (NJFC) network dentists are compensated on a fee for-service reimbursement model. Offices are required to submit claims for all services rendered. It is recommended that claims be submitted each month or each visit to ensure timely payment. As per Section B.4.1.22 of the MCO Contract, WellCare shall pay on a prorated basis for dental services that have a dental lab component, including cast crowns, fixed and removable prosthetics, retainers, and habit appliances based on stage of completion, if an enrollee dies or does not return to complete these services within three months from the last office visit for that service. For cast restorative and fixed prosthodontics, the prorate shall be 10 percent of the total payment for preparation of tooth with or without temporary, 85 percent of the total payment for impression and 95 percent of the total payment for completed not inserted. For removable prosthodontics, the prorate shall be 10 percent of the total payment for impression, 55 percent of the total payment for bite registration, 75 percent of the total payment for "try-in" stage and 85 percent of the total payment for completed not inserted. For appliances and retainers, the prorate shall be 10 percent of the total payment for impression and 85 percent of the total payment for completed and not inserted. For additional information regarding payment and eligibility, please visit the on-line Provider Portal, or contact the Member Services Department.

CONTINUITY OF CARE

Reimbursement for dental services in progress that require multiple visits to complete and are provided to eligible NJFC members who have a change in enrollment between NJFC Fee for Service non–managed care program (NJFC FFS) and a NJFC MCO or between NJFC MCOs. These dental services will include those services that require more than one visit to complete and will include, but are not limited to crowns (cast, porcelain fused to metal and ceramic), cast post and core, endodontic treatment and fixed and removable prosthetics. Payment is based on service being provided on or before 90 days of this change or beyond 90 days after this change. Information for orthodontic services begins in Section 10. Refer to Continuity of Continuation of Care Policy under the Provider Resource Library on LIBERTY's website.

a. **For services started while member is enrolled in NJFC FFS Program**

1. The NJFC FFS will provide reimbursement for those dental services approved to and initiated by a NJFC FFS dental provider prior to enrollment change and completed within 90 days of change to NJFC MCO enrollment.

2. The NJFC MCO of enrollment will provide reimbursement for those dental services approved to and initiated by a NJFC FFS dental provider prior to NJFC MCO enrollment change and completed more than 90 days after change to NJFC MCO enrollment.

b. **For services started while member is enrolled in a NJFC MCO**

1. The NJFC MCO of enrollment will provide reimbursement for those dental services approved to and initiated by a participating NJFC MCO dental provider prior to enrollment change and completed within 90 days of change to NJFC FFS enrollment. The NJFC MCO policy for prior authorization and reimbursement will be made available.

2. The NJFC FFS program will provide reimbursement for those dental services approved to and initiated by a participating NJFC MCO dental provider prior to enrollment change and completed more than 90 days after a change to NJFC FFS enrollment. The NJFC FFS policy for prior authorization and reimbursement will be made available.

3. The subsequent NJFC MCO will provide reimbursement for those dental services approved to and initiated by a participating NJFC MCO dental provider prior to enrollment change and completed more than 90 days after an enrollment change to the subsequent NJFC MCO. The policy for prior authorization and reimbursement of the subsequent NJFC MCO will be made available.

c. **Reimbursement will be made to the NJFC dental provider as long as they participate with either the NJFC MCO or NJFC FFS**. The provider shall be made aware of the NJFC FFS and NJFC MCO policies and requirements for obtaining a new prior authorization for the service(s) provided.

1. The dental provider shall be made aware of the NJFC FFS or NJFC MCO policies and requirements for obtaining a new prior authorization for the service provided during the period of change in enrollment and for those services not started but previously approved.

2. If the dental provider does not participate with the NJFC MCO or FFS program of enrollment, they shall be advised that they cannot provide or be reimbursed for any other services. The member must contact Member Services to locate a provider in their NJFC MCO or the MACC office to locate a provider in NJFC FFS.

d. **Continuity of care to case completion will apply with continued NJ FamilyCare/Medicaid eligibility in the event of change of Contractor enrollment or NJ FamilyCare program plan**. If a Member loses eligibility, the Contractor shall be responsible for continuity of care and reimbursement for the following dental services approved and started during a period of enrollment:

1. Endodontic, crown and prosthetic (both fixed and removable) services – the Contractor shall continue to provide coverage to completion of these services and any other associated services required for their successful completion after loss of eligibility when such endodontic, crown or prosthetic service(s) are approved and initiated under the Contractor's plan for 90 days following the loss of eligibility.

2. With loss of eligibility where endodontic treatment and associated restorative services have been approved and endodontic treatment was started, all other services required to restore the tooth to form and function shall be covered for completion.

3. Limited and interceptive orthodontics and treatment with habit appliances are reimbursed at the time of insertion and shall be covered for completion. This does not apply to comprehensive orthodontic treatment.

REFERRALS

WellCare shall not impose an arbitrary number of attempted dental treatment visits by a PCD as a condition prior to the PCD initiating any specialty referral requests. Neither WellCare nor LIBERTY shall obligate the referring dentist

to supply diagnostic documentation similar to that required for a prior authorization request for treatment services as part of a referral request. Neither the Contractor nor LIBERTY shall obligate the dentist receiving the referral to prepare and submit diagnostic materials in order to approve or reimburse for a referral. The Contractor shall authorize any reasonable referral request from a PCP/PCD without imposing any financial penalties to the same PCP/PCD. All final decisions regarding denials of referrals, PAs, treatment and treatment plans for non-emergency services shall be made by a physician and/or peer physician specialist or by a licensed New Jersey dentist/dental specialist in the case of dental services, or by a licensed mental health and/or behavioral health specialist in the case of behavioral health services. Prior authorization decisions for non-emergency services shall be made within fourteen (14) calendar days or sooner as required by the needs of the enrollee.

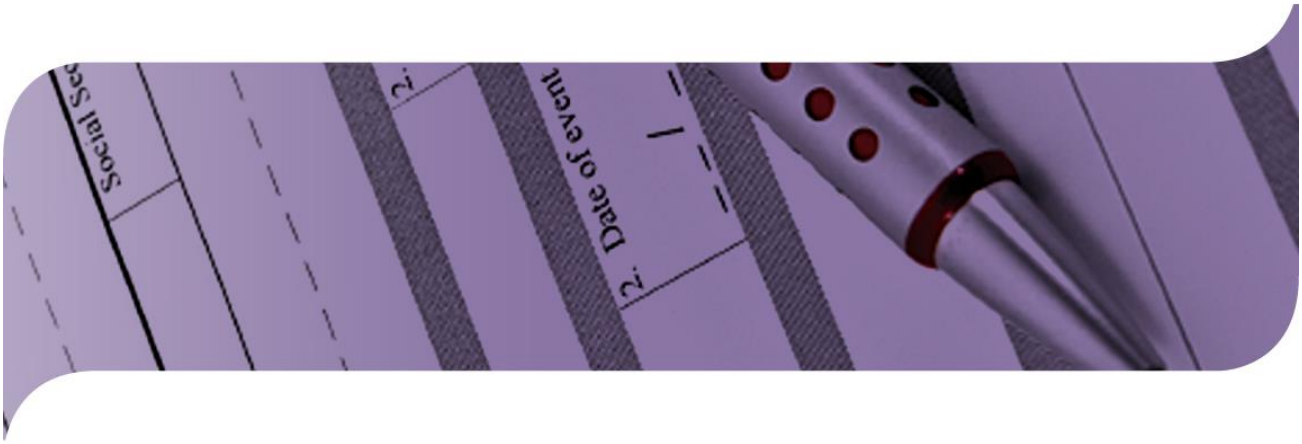
SECOND OPINIONS

WellCare shall have a Second Opinion program that can be utilized at the enrollee's option for diagnosis and treatment of serious medical conditions, for elective surgical procedures, when a physician recommends a treatment other than what the Member believes is necessary, or if the Member believes they have a condition that the physician failed to diagnose. The program can also be utilized at the enrollee's option for diagnosis and treatment of dental conditions that are treated within a dental specialty. In addition, the Member may receive the second opinion within the LIBERTY network or WellCare may arrange for the Member to obtain a second opinion outside the network at no cost to the Member. The Second Opinion program shall be incorporated into the WellCare medical and dental procedures and submitted to DMAHS for review and approval.

OWNERSHIP AND CONTROL DISCLOSURE

LIBERTY is required to obtain an ownership disclosure from all participating providers. Contracted Dental Offices must provide LIBERTY with complete and accurate information regarding ownership and control of the Dental Office on the Disclosure Form specified by LIBERTY. In addition, on or before the anniversary of the Effective Date of the Provider Agreement, Dental Office must provide to LIBERTY an updated Disclosure Form or written confirmation that there has been no change in the ownership and/or control of the Dental Office as disclosed on the Disclosure Form. Failure to provide ownership and control information annually may result in termination of the Provider Agreement.

SECTION 6. CLAIMS AND BILLING



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

ELECTRONIC SUBMISSION – CLAIMS, PRIOR AUTHORIZATIONS AND REFERRALS

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

1. **PROVIDER PORTAL** https://www.libertydentalplan.com/Providers/Provider-Self-Service-Tools/ITransact.aspx
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 the clearinghouse of your choice to begin electronic claims submission. The EDI vendors accepted by LIBERTY are:

LIBERTY EDI VENDOR	PHONE NUMBER	WEBSITE	PAYER ID
DentalXchange	**800.576.6412**	www.dentalxchange.com	CX083
Emdeon	**877.469.3263**	www.emdeon.com	CX083
Tesia	**800.724.7240 x6**	https://www.tesia.com/	CX083

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

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

PAPER CLAIMS

Paper claims must be submitted on the current ADA Dental Claim. Please mail all paper claim/encounter forms to:

ATTN: CLAIMS DEPARTMENT

LIBERTY Dental Plan
PO Box 401086
Las Vegas, NV 89140

CLAIMS SUBMISSION

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

1. All claims must be submitted to LIBERTY for payment for services no later than 180 days after the date of service.
2. Your National Provider Identifier (NPI) number and tax ID are required on all claims. Claims submitted without these numbers will be rejected. All health care providers, health plans and clearinghouses are required to use the National Provider Identifier number (NPI) as the ONLY identifier in electronic health care claims and other transactions.
3. All claims must include the name of the program under which the WellCare member is covered and all the information and documentation necessary to adjudicate the claim.

NOTE: ICD-10 codes may accompany procedures performed on claims for associated disease, illness, symptoms or disorders. Dentist may select a diagnosis code based on the present condition(s) of the member. Dentists should use their clinical education, experience and professional ethics while selecting the appropriate diagnostic code.

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

DATE OF INSERTION

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

NATIONAL PROVIDER IDENTIFIER

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

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

How to Apply for an NPI

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

- Web based application: https://nppes.cms.hhs.gov/NPPES/Welcome.do
- 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.

CLAIMS STATUS INQUIRY

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

	**888.352.7924**, press option 2		**Provider Portal:** www.libertydentalplan.com

CLAIMS STATUS EXPLANATIONS

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

CLAIMS RESUBMISSION

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

- Missing documentation
- Incorrect coding
- Processing errors

CLAIMS OVERPAYMENT

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

Notice of Overpayment of a Claim

If LIBERTY determines that it has overpaid a claim, LIBERTY will notify the provider in writing through a separate notice clearly identifying the claim; the name of the member, the date of service and a clear explanation of the basis upon which LIBERTY believes the amount paid on the claim was in excess of the amount due, including interest on the claim. LIBERTY will not seek reimbursement for an overpayment later than 18 months after the date of the first payment on the claim was made with the exception of those listed at N.J.S.A 26:2J-8.1. d(10).

Contested Notice

The provider may appeal LIBERTY's request for reimbursement of an overpayment within ninety (90) days, following the internal claims appeal process. LIBERTY shall conduct the appeal at no cost to the provider.

No Contest

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

OFFSET TO PAYMENTS

LIBERTY may offset the payment of a future claim or claims against a provider's current claim submission(s) when the provider fails to reimburse LIBERTY or a Member within an appropriate timeframe, as determined by LIBERTY, for the provider's failure to comply with LIBERTY's applicable administrative policies, procedures and/or determinations relating to dental plan administration issues, including, but not limited to those involving balance billing, incorrect charges, and grievance or treatment resolution decisions. LIBERTY will provide the provider with a detailed written explanation identifying the payments that have been offset against the specific current claim or claims.

Offset to Payments – Uncontested Notice of Overpayment

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

PROVIDER PAYMENTS THROUGH ECHO HEALTH, INC.

LIBERTY has partnered with ECHO Health, Inc. (ECHO®) to provide electronic funds transfer (EFT) and electronic remittance advice (ERA). Providers can enroll in EFT/ERA by logging into: https://enrollments.echohealthinc.com/EFTERAInvitation.aspx?tp=MDAxMzk=.

If you do not sign up for ECHO Health EFT/ACH, your office will be enrolled in Virtual Card Services. Virtual Cards allow your office to process payments as credit card transactions. Your office will receive fax notifications, each containing a virtual card number unique to that payment transaction. Once the number is received, you simply enter the code into your office's credit card terminal to process the payment as a regular card transaction. Normal transaction fees apply based on your merchant acquirer relationship.

There are no fees to enroll and receive EFT payments if you use this link and ONLY enroll with LIBERTY: https://enrollments.echohealthinc.com/EFTERAInvitation.aspx?tp=MDAxMzk=.

- If your office opts to enroll in EFT payments through the above link, you will need to wait for the first payment to be issued as virtual card and reference the draft number provided on the virtual card.

If you have any questions or need further information, please contact ECHO Health, Inc. at (833) 629-9725 or email EDI@ECHOHealthInc.com.

PEER-TO-PEER COMMUNICATION

If the provider has clinical questions or concerns about a referral, prior authorization and/or claim determination and would like to speak to a licensed clinical reviewer, you may contact:

	**LIBERTY Dental Plan** **ATTN: Provider Relations** PO Box 26110 Santa Ana, CA 92799-6110		**Quality Management Team** M-F from 8am – 8pm **(Eastern)** **888.442.3514**

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

SECTION 7. COORDINATION OF BENEFITS

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

MULTIPLE CARRIERS

NJ FamilyCare is a federal and state funded health insurance program created to help qualified New Jersey residents of any age access affordable health insurance

Members may be enrolled in a Managed Care Organization (MCO) or have benefits through the state Fee for Service Medicaid Program.

NJ FamilyCare (NJFC) provides coverage to each eligible beneficiary of the state assistance program. If a Member has another coverage it would always be primary. NJ FamilyCare (NJFC) is always the carrier of last resort. Thus, NJFC coverage is secondary to any other coverage a Member might have.

Providers should always bill other coverage first and provide an EOB from the primary carrier with their claim to LIBERTY for NJFC coverage. The Provider should submit Coordination of Benefits (COB) claims within 60 days from the date of primary insurer's Explanation of Benefits (EOB) or 180 days from the dates of service, whichever is later. LIBERTY will pay the difference up to the NJFC fee schedule.

SECTION 8. PROFESSIONAL GUIDELINES AND STANDARDS OF CARE

GENERAL DENTIST PROVIDER RESPONSIBILITIES

- Provide and/or coordinate all dental care for member;
- Perform an initial oral evaluation; Exceptions may be in the provision of diagnostic materials depending on the clinical presentation of the member;
- Provide a written treatment plan to members upon request that identifies covered services, non-covered services, and clearly identifies any costs associated of each treatment plan that is understandable by a prudent layperson with general knowledge of oral health issues;
- Provide supporting materials for dental services and procedures which document their medical necessity;
- Treatment plans and informed consent documents must be signed by the member or responsible party showing understanding of the treatment plan;
- Provide referrals with bidirectional communication between specialty care provider and PCD to ensure continuity of care;
- A financial agreement for any non-covered services shall be documented separate from any treatment plan or informed consent;
- Work closely with specialty care provider to promote continuity of care;
- Maintain adherence to LIBERTY's Quality Management and Improvement Program;
- Identify dependent children with special health care needs and notify LIBERTY of these needs;
- Notify LIBERTY of a member death;
- Arrange coverage by another provider when away from dental facility;
- Informing the enrollee that he/she must contact LIBERTY for assignment to a new office.
- Provide 48-hour access in case of emergencies, urgent dental treatment no later than 3 days of referral, or earlier as the condition warrants and urgent care appointments within 3 days of referral;
- Maintain scheduled office hours;

- Maintain dental records in accordance with New Jersey State Board of Dentistry regulations (NJAC 13:30-8.7);
- Provide updated credentialing information upon renewal dates;
- Provide requested information upon receipt of member grievance within the timeframe specified by LIBERTY on the written request;
- Notify LIBERTY of any changes regarding practice, including location name, telephone number, address, associate additions/terminations, change of ownership, plan terminations, etc. at least 30 days in advance;
- Provide dental services in accordance with peer reviewed clinical principles, criteria, guidelines and any evidence-based parameters of care;
- Provider will not discriminate or retaliate against an enrollee or attempt to dis-enroll an enrollee for filing a grievance or appeal;
- Provide dental services in accordance with the State of New Jersey Department of Human Services Division of Medical Assistance and Health Services and WellCare Contract.

SPECIALTY CARE PROVIDERS RESPONSIBILITIES

LIBERTY's specialty providers are Board eligible or Board Certified in accordance with NJ State Board of Dentistry Regulations. Providers who wish to advertise an area of dental specialty must meet the NJ Board requirements for that dental specialty and have a current "specialty permit."

- All the Responsibilities & Rights of the General Dentist listed above;
- Provide specialty care to members;
- Work closely with primary care dentists to ensure continuity of care;
- Bill LIBERTY Dental Plan for all dental services that were provided;
- A dentist with certification in the following specialties: Endodontics, Oral and Oral Maxillofacial Surgery, Periodontics and Prosthodontics must have or have confirmations of application submission, of valid DEA and CDS certificates. As required by the State of New Jersey, any provider that holds a valid DEA or CDS certificate must submit it per Appendix B.4.14 NJ QAPI Standard IX E.2
- Provide credentialing information upon renewal dates.

MEMBER RIGHTS AND RESPONSIBILITIES

LIBERTY complies with the Managed Care Organization Member Handbook Rights and Responsibilities and Evidence of Coverage. WellCare members have specific rights and responsibilities when it comes to their care. The member rights and responsibilities are provided to members in the member's Member Handbook and Evidence of Coverage.

VOLUNTARY PROVIDER CONTRACT TERMINATION

Providers must give LIBERTY at least 90 days advance notice of intent to terminate a contract. Provider must continue to treat members when medically necessary until the last day of the fourth month following the date of termination. Provider must continue to treat members for postoperative care when medically necessary until the last day of the sixth month following the date of termination. Affected members are given advance written notification informing them of their transitional rights. Certain contractual rights survive termination, such as the agreement to furnish records during a grievance or claims review. Please consult your provider contract for your responsibilities beyond termination.

MOBILE DENTAL PRACTICES AND MOBILE DENTAL VANS

LIBERTY is committed to offering provisions to a Member's place of residence, long-term care facility, skilled nursing facility or medical day care facility when medically necessary and where available. The contractor must monitor on an annual basis the standard of dental care rendered and ensure that needed referrals for dental treatment cannot be provided by a mobile dental practice occur. Dental services may be provided in these settings through the following modalities:

A. **Mobile Dental Practice** (utilizing portable equipment) is a dental provider traveling to various locations and utilizing portable dental equipment to provide dental services to members and members with special needs outside of a dental office/clinic in settings to include, but not limited to facilities, schools and residences.

   i. Facilities: These providers are expected to provide on-site comprehensive dental care (to include intra-oral radiographs), necessary dental referrals to general dentist or specialists and emergency dental care in accordance with all New Jersey State Board of Dentistry regulations and the NJ FamilyCare MCO Contract. The sites served by the Mobile Dental Practice must allow Member access to treatment and allow for continuity of care.

   ii. Schools: These locations are not considered a dental home and are limited to providing the following services: oral assessment/screening, prophylaxis, fluoride treatment, emergency care and referral to member's dental home when known or their MCO for assistance in locating a dentist.

   iii. Private Residencies and other residential settings: These providers are expected to provide on-site dental care for the homebound based on patient safety and ability to tolerate procedures outside of a clinical setting.

   iv. The MCO is responsible for assisting the member and facility in locating a dentist when referrals are issued. Patient records must be maintained at the facility when this is a long-term care facility, skilled nursing facility or school and duplicates may also be maintained in a central and secure area in accordance with State Board of Dentistry regulations. The MCO must submit documentation for all locations they visit and service and include the days and times for each location, except when a visit is to a residence.

B. **Mobile Dental Van** (utilizing a van) is a dental provider using a vehicle specifically equipped with stationary dental equipment used to provide dental services to members and members with special needs.

i. Providers using a mobile dental van to render dental services must also be associated with a dental practice that is located in a "brick and mortar" facility located in New Jersey, that serves as a dental home offering comprehensive care, emergency care and appropriate dental specialty referrals to the mobile dental van's patients of record (Members). They must demonstrate their ability to render dental treatment services and assist with dental referrals as needed.

ii. An exception to the "brick and mortar" requirements can be considered for providers using mobile dental vans that demonstrate they are only providing dental services to NJ FamilyCare members residing in a long-term care facility or are in a private residence/group home and unable to travel.

iii. The distance between the dental practice and the sites and locations served by the mobile dental van must not be a deterrent to the Member accessing treatment and allow for continuity of care by meeting the network standards for distance in miles as described in section 4.8.8 Provider Network Requirements.

iv. When a mobile dental van is used for school visits, health fairs or other one-time events, services will be limited to oral screenings, exams, fluoride varnish/topical fluoride treatment, prophylaxis and palliative care to treat an acute condition. State Board regulations must still be followed, and patient records are to be maintained in accordance with State Board of Dentistry regulations.

v. Providers utilizing Mobile Dental Vans must submit to the MCO documentation of all locations they will visit including the days and times (except when visit is to homebound members).

STANDARDS OF ACCESSIBILITY AND AVAILABILITY

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

Type of Appointment	LIBERTY Appointment Waiting Time Standards
Routine Care	**Within thirty (30) days**
Urgent Care	Appointments must be provided within three (3) days of referral
Emergency Dental Care	No later than forty-eight (48) hours, or earlier as the condition warrants
After-Hours/ Emergency Availability	**24 hours a day, 7 days a week**. All providers must have at least one of the following: • After hours calls must be answered by a person, not voicemail. • Answering service that is answered by a person, not voicemail, that will contact provider (or provider on call) on behalf of the member • Calls involving life threatening conditions or imminent loss of limb or functions conditions may be referred to the 9-1-1, emergency medical services, emergency

Type of Appointment	LIBERTY Appointment Waiting Time Standards
	room or urgent care facilities in the community (must be answered by a person, not voicemail), as per regionally available resources.
Scheduled Appointment In-Office Wait Time	**Not to exceed 45 minutes.** Offices must maintain records indicating member appointment arrival time and the actual time the member was seen by provider
Office Hours	**Minimum of 3 days/30 hours per week**
"Appointment Waiting Time" means the time from the initial request for health care services by a member or the member's treating provider to the earliest date offered for the appointment for services inclusive of time for obtaining authorization from the plan or completing any other condition or requirement of the plan or its contracting providers.	

AFTER HOURS AND EMERGENCY SERVICES AVAILABILITY

The provider's after-hours response system must enable members to reach an on-call dentist 24 hours a day, seven days a week. In the event the primary care dentist is not available to evaluate an emergency member of record within 24 hours, it is his/her responsibility to make arrangements to ensure that emergency services are available.

An emergency dental condition is an orofacial condition manifesting itself by acute symptoms of sufficient severity which impair oral functions including:

- Severe pain or infection of dental origin resulting in facial swelling and possible airway obstruction
- Uncontrolled bleeding due to tissue laceration
- Oral trauma to include fracture of the jaw or other facial bones and/or dislocation of the mandible

These serious conditions as well as other acute symptoms that occur outside of the normal office hours of a dental clinic or office require immediate medical attention to avoid placing the health of the individual in jeopardy. Most dental emergencies are best treated in a dental office and not a hospital emergency department.

A member must be scheduled to a time appropriate for the emergency or urgent condition, which could be within 24 hours, or the next business day in most cases. Only the emergency will be treated at an emergency or urgent care appointment. If the member is unable to access emergency care within our guidelines and must seek services outside of your facility, LIBERTY will be financially responsible for the payment of the covered emergency services.

APPOINTMENT RESCHEDULING

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

according to the same standards as initial appointments. Medicaid members cannot be charged for no show or missed appointment.

COMPLIANCE WITH THE STANDARDS OF ACCESSIBILITY AND AVAILABILITY

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

RECALL, FAILED OR CANCELLED APPOINTMENTS

Contracted dentists are expected to have an active recall system for established members. Recall systems should incorporate follow up on missed appointments and referrals, including referrals to address problems identified through EPSDT exams. Contact Member Services or the LIBERTY website for more information. Missed or cancelled appointments should be noted in the member's record. Please note that Medicaid beneficiaries cannot be charged for broken or missed appointments.

FACILITY PHYSICAL ACCESS FOR THE DISABLED – AMERICANS WITH DISABILITIES ACT

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

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

The Americans with Disabilities Act sets requirements for new construction of and alterations to buildings and facilities, including health care facilities. In addition, all buildings, including those built before the ADA went into effect, are subject to accessibility requirements for existing facilities. Detailed service and facility requirements for disabled individuals can be found by visiting www.ada.gov. You may access the Americans with Disabilities Act (ADA) Provider Survey Form from the Provider Resource Library at https://www.libertydentalplan.com/Resources/Documents/ma_Americans_with_Disabilities_Act_Provider_Survey_NJ.pdf

TREATMENT PLAN GUIDELINES

All members must be presented with an appropriate written treatment plan. If there is more than one treatment available, the treating dentist must also present those treatment plans, and any related costs for non-covered services.

Non-Covered Procedures and Treatment Plans: WellCare members cannot be denied their plan benefits if they choose "non-covered" procedures in combination with covered procedures. All accepted or declined treatment plans must be signed and dated by the member or his/her guardian and the treating dentist. Refer to the Members' benefit plans to determine covered and non-covered procedures.

NJFC Plan Non-Covered Services: Non-covered services can be discussed with the member. **Important Notice:** Any non-covered services selected by a member must be clearly presented on a separate treatment plan clearly stating that the service is **not covered,** and that the member has been informed of covered services and elects the non-covered service and understands and accepts the financial responsibility by signing a waiver.

Network dentists can refer members to the **Member Services Department**, Monday through Friday, 8 a.m. to 8 p.m. EST.

CONTINUITY AND COORDINATION OF CARE

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

A panel of network dentists shall be available in currently assigned counties from which members may select a provider to coordinate all of their dental care.

Continuity of care between the Primary Care Dentist (PCD) and any specialty care dentist must be available and properly documented. Communication between the PCD and dental specialist shall occur when members are referred for specialty dental care. LIBERTY expects PCDs to follow up with the Member and with the Specialist to ensure that referrals are occurring as per the best interest of the Member. Specialist providers are encouraged to send treatment reports back to the referring PCD to ensure that continuity of care occurs as per generally accepted clinical criteria.

The PCD is responsible for evaluating the need for specialty care, the need for any follow-up care after specialty care services have been rendered and should schedule the member for any appropriate follow-up care. LIBERTY expects the PCD to provide an array of services and reserve specialty referrals only for procedures beyond the scope or training of the PCD.

MEDICAL REFERRALS

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

INFECTION CONTROL

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

THE DENTAL RECORD

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

As required by the NJ State Board of Dentistry (N.JA.C. 13.30-8.7), dental records, including all radiographs, shall be maintained for at least seven years (or 10 as required by the NJ FamilyCare contract) from the date of the last entry, except that diagnostic and study models used for definitive treatment shall be maintained for at least three years from the date the model is made. Working models may be maintained.

Dental records must be comprehensive, organized and legible. All entries should be in ink, signed and dated by the treating dentist or other licensed health care professional who performed services. To the extent that the record is illegible or prepared in a language other than English, the licensee shall provide a typed or written transcription and/or translation at no additional cost to the member.

Services not recorded in the dental record in accordance with the requirements of this section shall be presumed not to have been performed. It shall be the responsibility of the licensee to produce evidence to establish that the non-recorded services were actually performed.

LIBERTY requires that Contracted dentists make available copies of all member records to the Plan upon request. Records may be requested for grievance resolutions, second opinions or for state/federal compliance. Non-compliance may result in disciplinary actions, up to and including transfer of enrollment or closure to new enrollment. Continued non-compliance may result in termination.

DENTAL RECORDS AVAILABILITY

Member dental records must be kept and maintained in compliance with and as required by the NJ State Board of Dentistry (N.JA.C. 13.30-8.7). Dental records must be comprehensive, organized and legible. All entries should be in ink, signed and dated by the treating dentist or other licensed health care professional who performed services. To the extent that the record is illegible or prepared in a language other than English, the licensee shall provide a typed or written transcription and/or translation at no additional cost to the member.

Upon receipt of a written request from a member or the member's authorized representative and within 14 days thereof, legible copies of the dental record including, if requested, duplicates of models and copies of radiographs, shall be furnished to the member, the member's authorized representative, or a dentist of the member's choosing. "Authorized representative" means a person who has been designated by the member or a court to exercise rights under this section. An authorized representative shall include the member's attorney or an agent of an insurance carrier with whom the member has a contract which provides that the carrier be given access to records to assess a claim for monetary benefits or reimbursement. If the member is a minor, a parent or guardian who has custody (whether sole or joint) shall be deemed an authorized representative. Licensees shall not charge a member for a copy of the dental record when the licensee has affirmatively terminated a member from the practice.

LIBERTY requires that Contracted dentists make available copies of all dental records to the Plan upon request. Records may be requested for grievance resolutions, second opinions or for state/federal compliance. Non-compliance may result in disciplinary actions, up to and including transfer of enrollment or closure to new enrollment. Continued non-compliance may result in termination.

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA)

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

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

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

Our commitment is demonstrated through our actions

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

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

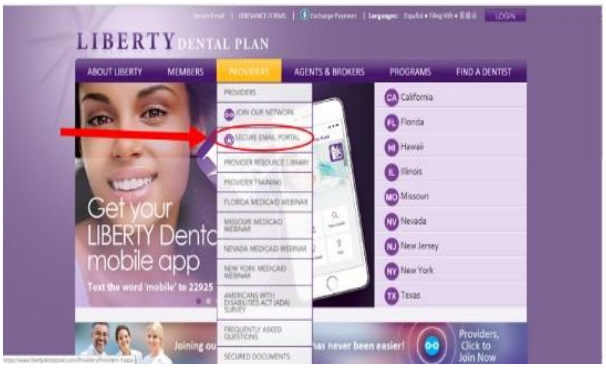
SAFEGUARDING PROTECTED HEALTH INFORMATION (PHI)

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

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

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

1. **Electronic PHI**
   A. Ensure referrals, authorization requests, medical records and other e-PHI are transmitted in a HIPAA compliant manner using secure fax, secure FTP, encrypted email (which requires member authentication to access email content), or LIBERTY's secure web portal* Note the following:
      - Use of PHI (including member name, ID, or other identifying information) in the subject lines of emails or to name e-files is **not** permitted.
      - Use of free email service providers, like Gmail, Hotmail, or Yahoo, is **not** a permitted method for transmitting LIBERTY Member PHI*
      - Transmission of PHI via text is **not** permitted*
      - LIBERTY providers may transmit e-phi to LIBERTY using LIBERTY's HIPAA compliant, secure web portal by following these simple steps:
        - Go to www.libertydentalplan.com
        - Go to Providers menu at top of the page
        - Select Secure Email Portal



   B. Use physical and technical safeguards to ensure that monitors cannot be viewed by unauthorized individuals, and that screens automatically lock on devices, after a reasonable period of inactivity.
   C. Maintain protocols to ensure faxes containing PHI are issued to the correct member, and that increased precautions are applied when faxing especially sensitive information (such as sensitive diagnoses).

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

   D. Review and adhere to LIBERTY's *Secure Use & Transmission of e-PHI* policy, located at https://www.libertydentalplan.com/Resources/Documents/ma_Secure_Use_and_Transmission_of_Electronic_PHI.pdf.

2. **Verbal PHI**
   A. Do not discuss patients in public areas (including waiting rooms, hallways and other common areas), even if you believe you are masking the patient's identity. Ensure conversations within examination rooms or operatories cannot be overheard by those outside of the room. Use heightened discretion when discussing sensitive diagnoses or other sensitive matters, including when such discussions occur with the patient in an exam room or operatory. Best practices include:
      - Implementing appropriate physical safeguards such as closed doors and insulated walls for exam rooms and operatories. Implementing ambient music or white noise to cover conversations in common areas.
      - Arranging waiting areas to minimize one patient overhearing conversations with another.

- Posting a sign requesting that patients who are waiting to sign-in or be seen, do not congregate in reception area.
- Ensuring unauthorized persons cannot overhear phone calls and limiting what is communicated by phone and voicemail to the minimum necessary to accomplish the required purpose. Avoid use of speaker phones.

3. Tangible PHI

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

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

C. Close window blinds to prevent outside disclosure.

D. Do **not** overstuff mailing envelopes; and print mailing addresses accurately and clearly to minimize the possibility that mail is lost in transit.

E. Take precautions to ensure PHI is not lost while transporting from one location to another, and never leaving tangible PHI in an unattended vehicle.

ANTI-DISCRIMINATION

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

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

If you need these services, please contact us at 1-888-844-3344. If you believe LIBERTY has failed to provide these services or has discriminated on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with LIBERTY's Civil Rights Coordinator:

Phone: 888.704.9833
TTY: 800.735.2929
Fax: 714.389.3529
Email: compliancehotline@libertydentalplan.com
Online: https://www.libertydentalplan.com/About-LIBERTY-Dental/Compliance/Contact-Compliance.aspx

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

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building

Washington, D.C. 20201
1-800-368-1019, 800.537.7697 (TDD)
Online at: https://www.hhs.gov/civil-rights/filing-a-grievance/grievance-process/index.html
Grievance forms are available at http://www.hhs.gov/ocr/office/file/index.html

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

CULTURALLY COMPETENT CARE

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

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

LANGUAGE ASSISTANCE SERVICES

The purpose of the Language Assistance Program is to ensure Limited English Proficient (LEP) members have appropriate access to language assistance including special format for hearing and visually impaired members, while accessing dental care.

Interpretation services for Limited English Proficient members (when and where required by state law or group/client arrangement):

- Interpretation services, including American Sign Language, are available at no cost to members, 24 hours a day, 7 days a week by contacting LIBERTY's **Member Services Department.**
- When and where required by law or client group requirement, LIBERTY offers free telephonic interpretation through our language service vendor. When required, this service is available to the member at no cost.
- If member needs interpretation services at the time the member is ready to receive services, please call LIBERTY's Member Services Department. You will need the member's full name, date of birth and ID number, to confirm eligibility and access interpretation services. It is not necessary to arrange for these services in advance. An eligible member shall be entitled to twenty-four (24)-hour access to interpreter services, where available, either through telephone language services or in-person interpreters. LIBERTY discourages the use of family or friends as interpreters. Family members, especially children, should not be used as interpreters in assessments, therapy and other situations where impartiality is critical.

- Providers must also fully inform the member that he or she has the right not to use family, friends or minors as interpreters.
- If a member prefers not to use the interpretation services after s/he has been told that a trained interpreter is available free of charge, the member's refusal to use the trained interpreter shall be documented in the member's dental record, when in a provider setting, or the member's administrative file (call tracking record) in the Member Services setting.
- Language preferences of members will be available to directly contracted dentists upon request through telephone inquiries, and only for those members entitled to receive such services by virtue of state requirement or client group requirement.
- Written Member Informing Materials in threshold languages and alternative formats (including Braille and large font) are available to members at no cost and can be requested by contacting LIBERTY's Member Services Department.
- Assistance in working effectively with members using in-person, telephonic interpreters, other media such as TTY/TDD and remote interpreting services can be obtained by contacting LIBERTY's Member Services Department.

SECTION 9. REFERRAL AND PRIOR AUTHORIZATION GUIDELINES

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

REFFERALS

The PCP or PCD may directly refer the member to a contracted specialist or LIBERTY will assign the referral to a contracted specialist within a reasonable distance to the member. A full listing of contracted specialists can be located at https://www.libertydentalplan.com/New-Jersey/New-Jersey-Dentist-Search.aspx. If a member does not have access to a contracted specialist within a reasonable distance from their home or work, LIBERTY will make the necessary accommodations for covered dental services to be rendered by a non-contracted dentist within a reasonable distance to them at no additional cost other than any applicable copay (if any). In these instances, LIBERTY Member Services may coordinate with the member to identify a desired provider and will confirm that the out of network specialist is within an acceptable distance from their home or workplace. Additionally, they will ensure that member will not incur any costs for covered services.

PRIOR AUTHORIZATION GUIDELINES FOR GENERAL DENTISTS

When submitting a prior authorization, the PCD should submit all necessary information regarding the treatment, including pre-operative radiograph(s) and narratives to LIBERTY through its Provider Web Portal. A dental specialist submitting a prior authorization or receiving a referral which includes services requiring prior authorization is to submit all necessary information regarding the treatment, including pre-operative radiograph(s) and narratives along with a prior authorization request to the plan. If an emergency endodontic service is needed for pain relief, the General Dentist performing the root canal should contact **LIBERTY's Referral Unit** for an emergency authorization number. This will provide conditional authorization. Any service added to an existing prior authorization by virtue of phoning the Referral Unit, will require pre-operative x-ray and narrative when you submit for payment. Any emergency endodontic service must qualify for authorization and will receive clinical review by a Dental Consultant at the time it is reviewed for payment. Upon receipt of a LIBERTY authorization, you may proceed with the services that were approved. After completion of treatment, submit your claim for payment with any post-operative radiographs, when appropriate and required. X-rays and other supporting documentation will not be returned. Please do not submit original x-rays. X-ray copies of diagnostic quality or paper copies of digitized images are acceptable.

LIBERTY shall consider the overall general health, member compliance and dental history, condition of the oral cavity and complete treatment plan when reviewing prior authorizations. Providers may submit several prior authorization requests, for each of the various stages of treatment for complex treatment plans.

Should a provider have a question regarding a denial of a prior authorization request, they may contact the Dental Consultant who rendered the decision. Their name and contact information are included on the EOB.

Services That Require Prior Authorization:

- Orthodontics, periodontics, endodontics, occlusal guards, crowns, removable dentures, fixed bridge work, implants, oral surgery (except D7111 and D7140), general anesthesia, hospital certification surgical cases, and EPSDT services You may refer to the Benefits Schedule for prior authorization details.
- Approved Prior Authorizations are valid for 180 days.
- If the documentation provided supports the approval of a different service than the one submitted for approval, the clinical peer reviewer who evaluated the request for the submitted service(s) may approve a different service which is supported by the submitted documentation

NON-EMERGENCY SPECIALTY REFERRAL

General Dentists are encouraged to communicate the indication for a referral, along with any relevant medical information, in writing to the specialist to whom the member has been referred. It is not necessary to submit referral forms to LIBERTY Dental Plan (LIBERTY) and LIBERTY does not accept any type of referral form for referrals to Non-Participating specialists.

If there is no contracted LIBERTY specialist available within a reasonable proximity to your office, Member Services will provide assistance to re-route the member to another provider for specialty services. The use of an out-of-network dentist must be pre-approved by LIBERTY. At times, LIBERTY Members Services may consult with the member's PCD to identify an OON specialist. The PCD should provide coordination and monitoring as appropriate. LIBERTY will authorize the out-of-network referral and issue a prior authorization for services only if the provider accepts reimbursement from LIBERTY as payment in full and if the requested treatment meets benefit guidelines. LIBERTY Member Services will educate the provider on claim submission protocols to ensure timely payment for services rendered.

A PCD may not be held financially responsible for referral to a non-participating specialist. Failure to use the proper forms and submit accurate information may cause delays in processing or payment of claims.

Referring dentists should assume that any X-rays and other supporting documentation given to the member to take to a referral or sent to a referral specialist will not be returned. It is highly recommended that the General Dentist do not submit original x-rays. X-ray copies of diagnostic quality, including paper copies of digitalized images, should be appropriate for this purpose.

Narrative statements as to the reasons for the specialty referral, and the exact services requested, whenever possible, may be of great assistance to the referral specialist. For out-of-network referral requests to LIBERTY, narrative of the reason that an out-of-network dentist is needed is required to process the out-of-network referral.

All final decisions regarding denials of referrals, prior authorizations, treatment and treatment plans for non-emergency services shall be made by a physician and/or peer physician specialist or by a New Jersey licensed dentist/dental specialist in the case of dental services, or by a licensed mental health and/or behavioral health specialist in the case of behavioral health services. Prior authorization decisions for non-emergency services shall be made within fourteen (14) calendar days or sooner as required by the needs of the enrollee.

EMERGENCY REFERRAL

If emergency specialty care is needed, the Referral Unit can assist with locating a specialist. By calling **LIBERTY** at **888.352.7924**.

If an emergency endodontic service is needed, the Specialist should contact **LIBERTY's Referral Unit** for an emergency authorization number. This will provide tentative conditional authorization. Any service added to an existing prior authorization by virtue of phoning the Referral Unit, will require a pre-operative x-ray and narrative when you submit for payment. Any emergency service must qualify for authorization and will receive clinical review by a Dental Consultant at the time it is reviewed for payment.

Upon receipt of a LIBERTY authorization, you may proceed with all specialty services that were approved. After completion of treatment, submit your claim for payment with any post-operative radiographs, when appropriate and required. **X-rays and other supporting documentation will not be returned. Please do not submit original x-rays. Diagnostic quality x-ray copies or paper copies of digitized images are acceptable.**

REFERRALS TO SPECIALISTS BY THE PRIMARY CARE DENTIST

General dentists may but are not obligated to provide a complete list of requested services or documentation to the specialist. A list of participating specialists can be located at https://www.libertydentalplan.com/New-Jersey/New-Jersey-Dentist-Search.aspx

The referring dentist is not responsible to inform the member of non-covered services provided elsewhere. Unless the member is informed by LIBERTY or WellCare that a particular service to be provided in a referral is not covered, the member cannot be asked to reimburse the specialty provider.

Primary Care Dentists may refer directly to a specialist or submit a referral request to LIBERTY. There are two options to request specialty referral to LIBERTY:

1. **PROVIDER PORTAL:** https://www.libertydentalplan.com/Providers/Provider-Self-Service-Tools/ITransact.aspx
2. **TELEPHONE:** 888.352.7924, Press Option 4

The PCD should provide the following information:

- Member name, Identification Number and Group Name
- Name, address and telephone number of the contracted LIBERTY Specialist (if known)
- LIBERTY requests that you provide notification to the specialist as to what conditions you want evaluated and treated and any other recommended procedures involved, e.g., Procedure code(s), tooth number(s).

- It is also recommended that you provide any narrative or available radiographic materials to assist the specialist.

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

The WellCare member will not be held financially responsible in cases of a referral error, where the assigned Primary Care Dentist does not receive prior approval when referring to a non-contracted specialist. Failure to use the proper forms and submit accurate information may cause delays in processing or payment of claims.

The referring provider which submit the referral request in the form of a letter or as remarks included on an ADA form may be completed and used when making a referral.

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

The NJFC Program has a Direct Referral provision which does not require the use of a specific form. You may refer to any participating Specialist for specialty services. You should provide notification to the specialist as to what conditions you want evaluated and treated and any other recommended procedures involved. You should provide any narrative or available radiographic materials to assist the specialist.

If you cannot locate a participating specialist, please contact LIBERTY's Member Services Department for assistance, or submit a Specialty Care Referral to LIBERTY. In some cases, a member may be redirected to another Primary Care Dentist that may be able to provide the specialty services.

Inform the member that:

- The Specialist will evaluate their necessary services and the services will be subject to prior authorization by LIBERTY unless emergency or urgent in nature.

Referral Guidelines for the Specialists:

- Obtain the appropriate prior authorizations which may include the LIBERTY Specialty Care Authorization and appropriate radiograph(s) from LIBERTY, General Dentist or member directly.
- For services requiring prior authorization, you must submit a prior authorization request to LIBERTY with a copy of any appropriate documentation, e.g., pre-operative periapical radiograph(s) or panoramic radiograph along with the member's Specialty Care Authorization.
- After completion of treatment, submit your claim for payment along with the appropriate supporting documentation, e.g., for endodontic care, a copy of pre-operative and post-operative periapical radiographs, for oral surgery services, for biopsy, attach a copy of the laboratory's report, etc. To avoid delays in claim payment, please attach a copy of the member's Specialty Care Authorization if you received one, or the Plan's authorization form as appropriate.
- Reimbursement of specialty services is contingent upon the member's eligibility with WellCare at the time of service.

PRIOR AUTHORIZATION GUIDELINES FOR PROCEDURES WHICH MAY BE PROVIDED BY EITHER A DENTAL SPECIALIST OR A PHYSCIAN

Specialty care providers, i.e., physician specialists, maxillofacial or oral surgeons or prosthodontists, may provide covered services that are beyond the scope of a general dentist. The specialty care provider must obtain prior authorization from LIBERTY by submitting necessary x-rays and documentation by mail or electronically through the LIBERTY provider web portal.

LIBERTY has a second opinion program that requires prior authorization that can be utilized at the enrollee's option for diagnosis and treatment of dental conditions that are treated within a dental specialty. Member may receive the second opinion within LIBERTY's network, or the Plan may arrange for the Member to obtain a second opinion outside the network at no cost to the Member. The Second Opinion program shall be incorporated into LIBERTY's dental procedures.

PRIOR AUTHORIZATION GUIDELINES FOR TREATMENT IN THE OPERATING ROOM AND AMBULATORY SURGICAL CENTER FOR MEMBERS WITH SPECIAL HEALTH CARE NEEDS (SHCN)

Care for Members with Special Health Care Needs ("SHCN") may require treatment to be performed in a hospital setting/operating room ("OR") or ambulatory surgical center ("ASC") facility setting as an outpatient member service.

Providers must notify LIBERTY during the credentialing and contracting process of all hospital privileges. For payment purposes, completion of a Site Application Form must be completed by the Provider for each OR/ASC location. These forms are available by contacting LIBERTY's Provider Relations Department or by download from LIBERTY's Provider Resource Library: https://www.libertydentalplan.com/Resources/Documents/Site_Application.pdf.

Providers should follow the same guidelines as indicated in the Member's plan benefit schedule when submitting a request for prior authorization and/or payment when dental treatment is performed in an OR or ASC setting. WellCare Member plan benefit schedules include the covered CDT codes, prior authorization requirements, benefit limitations and the specific documentation required for approval. Plan benefit schedules may change from time to time. The most current plan benefit schedules for a specific member can be requested by contacting LIBERTY's Member Services Department at and are also available on the Provider Portal, on the "Member Eligibility" Screen. LIBERTY is responsible for payment of all covered dental procedures, while WellCare is responsible for payment of all approved facility charges (room, board and anesthesia).

LIBERTY offers care management services for SHCN members. These can be requested by contacting our Member Services Department. Our care managers are trained to help members and providers arrange services. They'll work one-on-one to help coordinate oral health care needs.

To do this, they:

- May ask questions to get more information about a member's health conditions;
- Will work with PCPs and PCDs to arrange services needed and to help members understand their illness;

- Will provide information to help members understand how to care for themselves and how to access services, including local resources; and
- Will coordinate authorizations for dentally required hospitalizations by consulting with WellCare's dental and medical consultants in an efficient and time-sensitive manner.

Submission Guidelines

Claims and requests for prior authorization when services are rendered in a facility setting can be submitted to LIBERTY in one of the following ways:

1. **PROVIDER PORTAL**: https://www.libertydentalplan.com/Providers/Provider-Self-Service-Tools/ITransact.aspx
2. **THIRD-PARTY CLEARINGHOUSE**

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 x6**	https://www.tesia.com/	CX083

3. **U.S. MAIL**

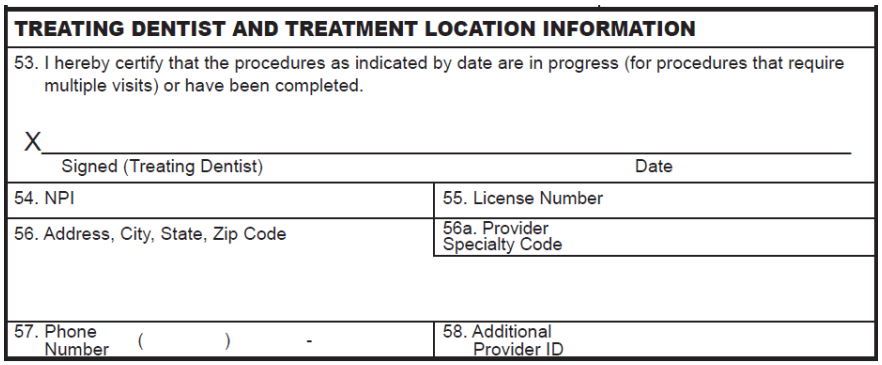
ATTN: CLAIMS DEPARTMENT
LIBERTY Dental Plan PO Box 401086 Las Vegas, NV 89140

Claims billed to LIBERTY with CDT code D9420 (Hospital or ambulatory surgical center call) must include the correct Place of Service Code as indicated by CMS. For a comprehensive Place of Service Code Set List, please visit: https://www.cms.gov/Medicare/Coding/place-of-service-codes/Place_of_Service_Code_Set.html

Place of Service Code(s)	Place of Service Name	Place of Service Description
19	Off Campus-Outpatient Hospital	A portion of an off-campus hospital provider-based department which provides diagnostic, therapeutic (both surgical and nonsurgical), and rehabilitation services to sick or injured persons who do not require hospitalization or institutionalization. (Effective January 1, 2016)
22	On Campus-Outpatient Hospital	A portion of a hospital's main campus which provides diagnostic, therapeutic (both surgical and nonsurgical), and rehabilitation services to sick or injured persons who do not require hospitalization or institutionalization. (Description change effective January 1, 2016)

Place of Service Code(s)	Place of Service Name	Place of Service Description
24	Ambulatory Surgical Center	A freestanding facility, other than a physician's office, where surgical and diagnostic services are provided on an ambulatory basis.

Additionally, all claims billed with CDT code D9420, must include the address of where the treatment was actually rendered (the address of the facility) in box 56 on the standard ADA claim form.



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

When to Request Prior Authorization from WellCare

LIBERTY recommends that Providers coordinate with the OR/ASC setting directly in order to obtain approval from WellCare for the facility charges. WellCare's Authorization Intake Department will process requests for room, board and anesthesia by phone or fax.

Clinical Criteria for Medical Exception

When submitting a request to WellCare for the facility charges, the following must be included:

- Authorization Type – OPH (hospital setting) or AMS (ambulatory surgery center)
- Date of Request
- Date the services are to be completed
- Requesting Provider
- Facility Name
- Place of Service (22 or 24)
- Service Detail: Room, board and anesthesia "Pay Facility Charges Only"
    - CPT Codes are usually 00170 and 41899
- Appropriate ICD-10 Code
  The codes that relate to clinical criteria for medical exceptions/disabilities/special needs are listed below: E75-E756, F03-F0391, F06-F068, F07-F079, F09, F48-F489, F53, F60-F609, F70, F71, F72, F73, F78, F79, F84-F849, F88, F89, F90-F909, F91-F919, G10, G25-G259, G31-G319, G40-G409, G71-G719, G72-G729, G73-G737, G80-G809, G93-G939, P04-P049, Q86, Q90-Q99, R56-R569, S06-S069X9, F819, I6783, P154, P158, P159.

Resubmission of Denied Services

Providers have 365 days from the date of service to request a resubmission or reconsideration of a claim that was previously denied for missing documentation, incorrect coding and/or processing errors.

In cases where prior authorization is denied, the denial documentation contains a detailed explanation of the reason(s) for denial; indicates whether additional information is needed and the process for reconsideration. Additionally, denial documentation includes the name and contact information of the LIBERTY Staff Dentist or Dental Consultant that reviewed and denied the treatment request which will allow the provider an opportunity to discuss the case.

Medical Versus Dental Services

Medical conditions may exist that can exhibit one or more dental components. Examples of medical procedures that have dental components but are covered under the WellCare medical benefit are serious medical conditions such as cleft palate and cleft lip; underdeveloped upper or lower jaw (maxillary/mandibular micrognathia); overdeveloped lower jaw (extreme mandibular prognathism); severe asymmetry (craniofacial anomalies); jaw does not move (ankylosis of the temporomandibular joint); and other significant skeletal deformities (dysplasias).

Dental services that are covered through WellCare's dental benefit via LIBERTY include all common CDT codes outlined in the LIBERTY benefit schedules for WellCare, e.g., diagnostic, preventive, restorative, prosthodontic, endodontic, periodontic and oral surgery.

SECTION 10. CLINICAL DENTISTRY PRACTICE PARAMETERS

The following clinical dentistry criteria, processing guidelines and practice parameters represent the view of the Peer Review Committee of LIBERTY and represent LIBERTY's processing guidelines, benefit determination guidelines and the generally acceptable clinical parameters as agreed upon by consensus of the Peer Review Committee to be professionally recognized best practices and conforms with all current policies and guidelines of the American Dental Association (ADA), the ADA's CDT code descriptors and their required documentation, N.J.A.C. 10:56, N.J.A.C. 13:30 and the NJFC MCO Contract. For a comprehensive list of covered benefits, see Section 14 for instructions.

NEW MEMBER INFORMATION

A. A contemporaneous, permanent dental record shall be prepared and maintained by a dentist for each person seeking or receiving dental services, regardless of whether any treatment is actually rendered or whether any fee is charged. Dentists also shall maintain records relating to charges made to members and third-party carriers for professional services. All treatment records, bills and claim forms shall accurately reflect the treatment or services rendered. Such records shall include, at a minimum:

   1. The name, address, and date of birth of the member and, if a minor, the name of the parent or guardian;
   2. The member's medical history;
   3. A record of results of a clinical examination where appropriate or an indication of the member's chief complaint;
   4. A diagnosis and a treatment plan, which shall also include the material treatment risks and clinically acceptable alternatives, and costs relative to the treatment that is recommended and/or rendered;
   5. The dates of each member visit and an accurate description of all treatment or services rendered and the materials used at each visit;
   6. Radiographs, if any, of a diagnostic quality and a description of all diagnostic models made, identified with the member's name and the date. If the radiographs are sent out of the dental office, the dentist shall retain the originals or a diagnostic copy of the radiographs in the dental record;

7. The date and a description of any medications prescribed, dispensed or sold including the dosage or a copy of any written prescriptions;
8. Copies of any prescriptions to laboratories for dental prostheses;
9. Complete financial data concerning the member's account, including each amount billed to or received from the member or third-party payor and the date of each such bill and payment;
10. Copies of all claim forms submitted to third party payors by a licensee or the licensee's agent or employee;
11. Payment vouchers received from third party payors;
12. A record of any recommendations or referrals for treatment or consultation by a specialist, including those which were refused by the member;
13. The name of the dentist of record consistent with the requirements of N.J.A.C. 13:30-8.15; and
14. If written notations appear in the dental record, the notations shall be legible, written in ink and contain no erasures or white outs. If incorrect information is placed in the record, it shall be crossed out with a single non-deleting line and shall be initialed and dated by the licensee on the date the change was made. If additions are made to the record, the additions shall be initialed and dated by the licensee on the date the change was made.

B. Each dentist or dental auxiliary shall sign or initial each entry on the dental record pertaining to the treatment he or she rendered. If no such signature or initialing appears on the dental record, it shall be presumed that such treatment was rendered by the dentist of record, unless the latter shall establish, to the satisfaction of the Board, the identity of the individual who rendered such treatment.

C. A member record may be prepared and maintained on a personal or other computer provided that the licensee complies with all of the following requirements:

1. The licensee shall use a computer system which contains an internal, permanently activated date recordation for all entries;
2. The computer system shall have the capability to print on demand a hard copy of all current and historical data contained in each member record file;
3. The licensee shall identify each dental record by the member's name and at least one other form of identification so that the record may be readily accessed;
4. The licensee shall post record entries at least once a month so that the entries are permanent and cannot be deleted or altered in any way. The licensee may subsequently make a new entry to indicate a correction to a permanent entry, provided that the new entry generates a permanent audit trail which is maintained in the dental record. The audit trail shall show the original entry, the revised entry, the date of the revised entry, the reason for the change and the identity of the person who authorized the change;

5. The licensee shall prepare a back-up of all computerized dental records at least quarterly, except that if a licensee changes computer systems or software programs, the licensee shall prepare a back-up as of the last date when the system to be replaced shall be used.
    i. For purposes of this section, "back-up" shall include data files and the software programs required to retrieve those files including the operating system and the program file.
    ii. The back-ups shall be clearly dated and marked with an external label as "Backup of computerized data as of (date)."
    iii. The licensee shall maintain and store at least the last three quarterly back-ups onsite.
    iv. The licensee shall maintain and store the fourth quarter (annual) back-up offsite; and

D. The licensee shall provide to the Board upon request any back-up data maintained off premises, together with the following information:
    i. The name of the computer operating system containing the dental record files and instructions on using such system;
    ii. Current passwords;
    iii. Previous passwords if required to access the system; and
    iv. The name of a contact person at the practice management company, if any, that provides technical support for the licensee's computer system.

E. Dental Office shall maintain the Records for the later of: (i) ten (10) years from the termination or expiration of the Agreement or longer if required by law; (ii) seven (7) years after the last date of service; or (iii) in the case of a minor, the later of three (3) years after such minor reaches majority or seven (7) years after the last date of service. Diagnostic and study models used for definitive treatment shall be maintained for at least three years from the date the model is made. Working models may be maintained.

F. Licensees shall provide dental records to the member or the member's authorized representative or another dentist of the member's choosing in accordance with the following:
    1. Upon receipt of a written request from a member or the member's authorized representative and within 14 days thereof, legible copies of the member record including, if requested, duplicates of models and copies of radiographs, shall be furnished to the member, the member's authorized representative, or a dentist of the member's choosing. "Authorized representative" means a person who has been designated by the member or a court to exercise rights under this section. An authorized representative shall include the member's attorney or an agent of an insurance carrier with whom the member has a contract which provides that the carrier be given access to records to assess a claim for monetary benefits or reimbursement. If the member is a minor, a parent or guardian who has custody (whether sole or joint) shall be deemed an authorized representative.
    2. Licensees shall not charge a member for a copy of the dental record when the licensee has affirmatively terminated a member from the practice.

3. To the extent that the record is illegible or prepared in a language other than English, the licensee shall provide a typed or written transcription and/or translation at no additional cost to the member.

G. Licensees shall maintain the confidentiality of dental records, except that:

1. The licensee shall release member records as directed by the Board of Dentistry or the Office of the Attorney General, or by a Demand for Statement in Writing under Oath, pursuant to N.J.S.A. 45:1-18. Such records shall be originals, unless otherwise specified, and shall be unedited, with full member names. To the extent that the record is illegible, the licensee, upon request, shall provide a typed or written transcription of the record. If the record is in a language other than English, the licensee shall also provide a translation. All radiographs, models, and reports maintained by the licensee, including those prepared by other dentists, shall also be provided. The costs of producing such records shall be borne by the licensee.

2. The licensee, in the exercise of professional judgment and in the best interests of the member (even absent the member's request), may release pertinent information about the member's treatment to another licensed health care professional who is providing or who has been asked to provide treatment to the member, or whose expertise may assist the licensee in his or her rendition of professional services.

3. The licensee shall release information as required by statute or rule, such as the reporting of communicable diseases or gunshot wounds or suspected child abuse, or when the member's treatment is the subject of peer review.

H. If a licensee ceases to engage in the practice of dentistry or it is anticipated that he or she will remain out of practice for more than six months, the licensee or a designee shall:

1. Establish a procedure by which members may obtain treatment records or agree to the transfer of those records to another licensee who is assuming the responsibilities of that practice;

2. If the practice will not be attended by another licensee, publish a notice of the cessation and the established procedure for the retrieval of records in a newspaper of general circulation in the geographic location of the licensee's practice, at least once each month for the first three months after the cessation;

3. File a notice of the established procedure for the retrieval of records with the Board of Dentistry;

4. Make reasonable efforts to directly notify any member treated during the six months preceding the cessation of the practice to provide information concerning the established procedure for retrieval of records; and

5. Conspicuously post a notice on the premises of the procedure for the retrieval of records.

I. Dental records need not be maintained in situations where no member-dentist relationship exists, such as where the professional services of a dentist are rendered at the behest of a third party for the purposes of examination and evaluation only, at the behest of the Board or for dental screenings.

J. Services not recorded in the dental record in accordance with the requirements of this section shall be presumed not to have been performed. It shall be the responsibility of the licensee to produce evidence to establish that the non-recorded services were actually performed.

Please refer to Section 14 for instructions on how to access the full benefits schedule.

CLINICAL ORAL EVALUATIONS

A. Periodic oral evaluations (Code D0120) of an established member may only be provided for a member of record who has had a prior comprehensive examination. Periodontal evaluations and oral cancer screenings should be updated at appropriate intervals, dictated by the member's history and risk factors, and should be done at least annually.

B. A problem-focused limited examination (Code D0140) must document the issue substantiating the medical necessity of the examination and treatment.

C. An oral evaluation of every member should include documentation of the oral and physical health history, evaluation of caries susceptibility and development of an oral health regimen.

D. A comprehensive oral evaluation for new or established members (Code D0150) who have been absent from active treatment for at least three years or have had a significant change in health conditions should include the following:

   1. Observations of the initial evaluation are to be recorded in writing and charted graphically where appropriate, including missing or impacted teeth, existing restorations, prior endodontic treatment, fixed and removable appliances.
   2. Assessment of TMJ status and classification of occlusion should be documented.
   3. Full mouth periodontal screening must be documented for all members; for child members with an indication of periodontal disease and all adult members, probing and diagnosis must be documented, including an evaluation of bone levels, gingival recession, inflammation, etiologic factors (e.g., plaque and calculus), mobility, and furcation involvements.
   4. A soft tissue/oral cancer examination of the lips, cheeks, tongue, gingiva, oral mucosal membranes, pharynx and floor of the mouth must be documented for all members, regardless of age.

E. A post-operative office visit for re-evaluation should document the member's response to the prior treatment.

F. A comprehensive periodontal evaluation (D0180) is for members showing signs or symptoms of periodontal disease or significant risk factors such as diabetes or smoking. It includes evaluations of periodontal conditions, probing and charting, evaluation of the dental and medical history and general health assessment and a periodontal treatment plan.

INFORMED CONSENT

A. The dentist should have the member sign appropriate informed consent documents and financial agreements.

B. Following an appropriate informed consent process, if a member elect to proceed with a procedure that is not covered, and has been denied as such by LIBERTY, the member is responsible for the dentist's usual fee.

DIAGNOSTIC IMAGING

Based on the dentist's determination that there is generalized oral disease or a history of extensive dental treatment, an adequate number of images should be taken to make an appropriate diagnosis and treatment plan, per current FDA/ADA radiographic guidelines to minimize the member's exposure. Photographic images may also be needed to evaluate and/or document the existence of pathology in instances where the member cannot tolerate radiographs, when radiographs do not adequately document pathology or when indicated for orthodontic treatment.

A. An attempt should be made to obtain any recent radiographic images from the previous dentist.

B. An adequate number of initial radiographic images should be taken to make an appropriate diagnosis and treatment plan, per current FDA/ADA radiographic guidelines. This includes the ALARA Principle (As Low As Reasonably Achievable) to minimize the member's exposure. It is important to limit the number of radiographic images obtained to the minimum necessary to obtain essential diagnostic information.

C. The member should be evaluated by the dentist to determine the radiographic images necessary for the examination prior to any radiographic survey.

D. Intraoral – complete series (including bitewings) (Code D0210)

   1. Any benefits for periapical and/or bitewing radiographs taken on the same date of service will be limited to a maximum reimbursement of the provider's fee for a complete series.
   2. Any panoramic film taken in conjunction with periapical and/or bitewing radiograph(s) will be considered as a complete series, for benefit purposes only.
   3. Decisions about the types of recall films should also be made by the dentist and based on current FDA/ADA radiographic guidelines, including the complexity of previous and proposed care, caries, periodontal susceptibility, types of procedures and time since the member's last radiographic examination.

E. Diagnostic radiographs should reveal contact areas without cone cuts or overlapping, and periapical films should reveal periapical areas and alveolar bone.

F. Radiographs should exhibit good contrast.

G. Diagnostic digital radiographs should be submitted electronically when possible or should be printed on photographic quality paper and exhibit good clarity and brightness.

H. All radiographs must be mounted, labeled left/right and dated.

I. Intra or extra-oral photographic images should only be taken to diagnose a condition or demonstrate a need for treatment that is not adequately visualized radiographically.

J. Any member refusal of radiographs should be documented.

K. Radiograph duplication fees:

   1. Radiographic image duplication fees are not allowed.
   2. When a member is transferred from one contracted provider to another, diagnostic copies of all radiographic images less than two years old should be duplicated for the second provider.

L. Diagnostic casts (Code D0470) are only considered medically necessary as an aid for treatment planning specific oral conditions.

TESTS, EXAMINATIONS AND REPORTS

A. Tests, examinations and reports may be required when medically necessary to determine a diagnosis or treatment plan for an existing or suspected oral condition or pathology.

B. Oral pathology laboratory procedure/report may be required when there is evidence of a possible oral pathology problem.

PREVENTIVE TREATMENT

A. Dental prophylaxis (Code D1110 and D1120)

- Procedure D1110 applies to members who are 16 years old and older. Allowed twice during a rolling year and a maximum of four times during a rolling year for Special Health Care Needs (SHCN) members which may require prior authorization.
- Procedure D1120 applies to members up to age 16. Allowed twice a rolling year and a maximum of four times during a rolling year for SHCN or members with Early Childhood Caries (ECC) which may require prior authorization.

B. Topical fluoride (Code D1208) treatment is covered twice in a twelve-month period for all members, and as often as once every three months for members with special needs and documentation of medical necessity.

C. Dental Sealant (Code D1351) is covered once every 36 months per tooth, limited to unrestored permanent pre-molars and molars, through age 16.

D. Preventive resin restoration (Code D1352) may be medically necessary to prevent decay in a pit or fissure or as a conservative restoration in a cavitated lesion that has not extended into dentin on a permanent tooth in a moderate to high caries risk member.

E. A space maintainer may be medically necessary to prevent tooth movement and/or facilitate the future eruption of a permanent tooth.

F. Interim caries arresting medicament application (Code D1354) Silver Diamine Fluoride (SDF) is an interim caries arresting liquid medicament clinically applied to control and prevent the further progression of active dental caries. Treatment with Silver Diamine Fluoride will not eliminate the need for restorative dentistry to repair function or aesthetics, but this alternative treatment allows oral health care professionals to temporarily arrest caries with noninvasive methods, particularly with young children that have primary teeth or members with special health care needs. This should be submitted on a per tooth basis.

RESTORATIVE TREATMENT

Amalgam Restorations (Codes D2140-D2161)

Dental amalgam is a cavity-filling material made by combining mercury with other metals such as silver, copper and tin. Numerous scientific studies conducted over the past several decades, including two large clinical trials published in the Journal of the American Medical Association, indicate dental amalgam is a safe, effective cavity-

filling material for children and others. Review of the scientific literature on amalgam safety, the ADA's Council on Scientific Affairs reaffirmed that the scientific evidence continues to support amalgam as a valuable, viable and safe choice for dental patients…" Visit https://www.ada.org/en/member-center/oral-health-topics/amalgam to obtain further information on amalgam topics and references.

The American Dental Association (ADA) agrees with the U.S. Food and Drug Administration's (FDA) decision not to place any restriction on the use of dental amalgam, a commonly used cavity filling material. Refer to the Statement of Dental Amalgam at https://www.ada.org/en/member-center/oral-health-topics/amalgam

A. Restorative procedures for teeth exhibiting a poor prognosis due to gross carious destruction of the clinical crown at/or below the bone level, advanced periodontal disease, untreated periapical pathology or poor restorability are not covered. The choice of restorative materials depends on the nature and extent of the defect to be restored, location in the mouth, stress distribution expected during mastication and esthetic requirements.
    1. The procedures of choice for treating caries or the replacement of an existing restoration not involving or undermining the cusps of posterior teeth is generally amalgam or composite.
    2. Facial or buccal restorations are generally considered to be "one surface" restorations, not three surfaces such as Mesial Facial Distal (MFD) or Mesial Buccal Distal (MBD).
    3. The replacement of clinically acceptable amalgam fillings with an alternative material (composite, crown, etc.) is considered cosmetic and is not covered unless decay or fracture of the existing filling is present.
    4. If a dentist chooses not to provide amalgam fillings, alternative posterior fillings must be made available for LIBERTY members. Any listed amalgam copayments would still apply.
    5. An amalgam restoration includes tooth preparation and all adhesives, liners and bases.
    6. An amalgam restoration may be medically necessary when a tooth has a fracture, defective filling or decay penetrating into the dentin.
    7. An amalgam restoration should have sound margins, appropriate occlusion and contacts and must treat all decay that is evident.

B. Resin-based Composite Restorations (Codes D2330 – D2394)
    1. The procedures of choice for treating caries or the replacement of an existing restoration not involving or undermining the incisal edges of an anterior tooth is composite. Decay limited to the incisal edge only, may still be a candidate for a filling restoration if little to no other surface's manifest caries or breakdown.
    2. Facial or buccal restorations are generally considered to be "one surface" restorations, not three surfaces such as MFD or MBD.
    3. The replacement of clinically acceptable amalgam fillings with alternative materials (composite, crown, etc.) is considered cosmetic and is not covered unless decay or fracture is present.
    4. A resin-based composite restoration includes tooth preparation, acid etching, adhesives, liners, bases and curing.

5. A resin-based composite restoration may be medically necessary when a tooth has a fracture, defective filling, recurrent decay or decay penetrating into the dentin.
6. A composite restoration should have sound margins, appropriate occlusion and contacts and must treat all decay that is evident.
7. If LIBERTY determines that there is a more appropriate procedure code to describe the restoration provided, either number of surfaces, or material used, an alternate procedure code may be approved.

C. Restorations for primary teeth are covered only if the tooth is expected to be present for at least six months.

D. For posterior primary teeth that have had extensive loss of tooth structure or when it is necessary for preventive reasons, the appropriate treatment is generally a prefabricated stainless-steel crown or for anterior teeth, a stainless steel or prefabricated resin crown.

E. A metallic onlay may be considered when there is sufficient tooth structure, but additional cusp support is needed.

F. Crowns/Onlays - Single Restorations Only (Codes D2510 – D2794)

1. Administrative Issues
    a. Providers must document the date when crowns are inserted.
    b. Providers must make every attempt to complete any irreversible procedure started regardless of payment or coverage and only bill for indirect restorations when the service is completed (permanently cemented) or subject to prorate.
    c. Crown services must be documented using valid procedure codes in the American Dental Association's Current Dental Terminology (CDT).
2. A crown or onlay may be medically necessary when the tooth is present and:
    a. The tooth has evidence of decay undermining more than 50% of the tooth (making the tooth weak), when a significant fracture is identified, or when a significant portion of the tooth has broken or is missing due to severe attrition , abrasion and/or erosion and has good endodontic, periodontal and/or restorative prognoses.
    b. There is a significantly defective crown or onlay (defective margins or marginal decay) or there is recurrent decay.
    c. The tooth is in functional occlusion or will serve as an abutment for a fixed or removable partial denture.
    d. When anterior teeth have incisal edges/corners that are undermined or missing because of caries, a defective restoration or are fractured off. The treatment of choice may be a porcelain fused to base metal crown or a porcelain/ceramic substrate crown.
    e. The tooth has a good endodontic, periodontic and restorative prognosis with a minimum crown/root ratio of 50%.

3. Enamel "craze" lines or "imminent" or "possible" fractures: Anterior or posterior teeth that show a discolored line in the enamel indicating a non-decayed defect in the surface enamel and are not a through-and through fracture should be monitored for future changes. Crowns may be a benefit only when there is evidence of true decay undermining more than 50% of the remaining enamel surface, or when there is a through-and-through fracture identified radiographically or photographically, or when a portion of the tooth has actually fractured off and is missing. Otherwise, there is no benefit provided for crown coverage of a tooth due to a "suspected future or possible" fracture.
4. Final crowns for teeth with a good prognosis should be sequenced after performing necessary endodontic and/or periodontal procedures and such teeth should exhibit a minimum crown/root ratio of 50%.
5. Types of Crowns
    a. Stainless steel crowns are primarily used on deciduous teeth and only used on adult teeth due to a member's disability/inability to withstand typical crown preparation.
6. Core Buildup, including any pins when required (Code D2950), must show evidence that the tooth requires additional structure to support and retain a crown.
    a. Core buildup refers to building up of coronal structure when there is insufficient retention for an extra-coronal restorative procedure.
    b. A core buildup is not a filler to eliminate any undercut, box form, or concave irregularity in a preparation.
7. Post and core (Code D2952 and D2954) procedures for endodontically treated teeth include buildups. By CDT definitions, each of these procedures includes a "core." Therefore, a core buildup, cannot be billed with either Codes D2952 or D2954 for the same tooth, during the same course of treatment.
    a. The tooth is functional, has had root canal treatment and the tooth requires additional structure to support and retain a crown.
    b. Post and core in addition to crown (Code D2952), is an indirectly fabricated post and core custom fabricated as a single unit separate from the crown.
    c. Prefabricated post and core in addition to crown (Code D2954) is built around a prefabricated post. This procedure includes the core material.
8. Pin retention (Code D2951) or restorative foundation may be medically necessary when a tooth requires an additional retention for a restoration.
9. A coping (Code D2975) or crown under a partial denture (Code D2971) may be required when submitted documentation demonstrates the medical necessity of the procedure.
10. Repair of a restorative material failure may be medically necessary when submitted documentation establishes restorative material failure.
11. Margins, contours, contacts and occlusion of restorations must be clinically acceptable.

12. Tooth preparation should provide adequate retention and not infringe on the dental pulp.

ENDODONTICS

A. Assessment

1. Diagnostic techniques used when considering possible endodontic procedures may include an evaluation of:
    a. Pain and the stimuli that produce or relieve it by the following tests:
        i. Thermal
        ii. Electric
        iii. Percussion
        iv. Palpation
        v. Mobility
    b. Non-symptomatic radiographic lesions

B. Treatment planning for endodontic procedures may include consideration of the following:

1. Strategic importance of the tooth or teeth
2. Prognosis – endodontic procedures for teeth with a guarded or poor 5-year prognosis (endodontic, periodontal or restorative) are not covered
    a. Excessively curved or calcified canals
    b. Presence and severity of periodontal disease
    c. Restorability and tooth fractures
3. Occlusion
4. Teeth that are predisposed to fracture following endodontic treatment should be protected with an appropriate restoration; most posterior teeth should be restored with a full coverage restoration.

C. Clinical Guidelines

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

6. For a pulpotomy (Code D3220) or pulpal therapy (Code D3221), documentation is required that shows pulpal pathology and a good prognosis that the tooth has a reasonable period of retention and function, or was provided as an emergency measure when extraction was not possible.
7. For endodontic treatment (Codes D3310 – D3330), documentation is required that shows the treatment is medically necessary (i.e., tooth is broken, decayed or previously restored, functional with an unhealthy nerve and the tooth has a good endodontic, periodontal and/or restorative prognosis.
8. For incomplete endodontic treatment (Code D3332), documentation is required that shows endodontic treatment has been started and that a subsequent determination has been made that it cannot be successfully completed.
9. Treatment of a root canal obstruction (Code D3331) may be needed when radiographic evidence shows a canal that is at least 50% closed or blocked.
10. For internal root repair (Code D3333), documentation is required that shows the need to repair a non-iatrogenic perforation.
11. For endodontic retreatment (Codes D3346 – D3348), documentation is required that shows a tooth with previous endodontic treatment that is symptomatic or shows evidence of periapical pathology and/or short/poorly compacted or incomplete fill.
12. For apexification/recalcification (Code D3351), documentation is required that shows the apex of the tooth root(s) is/are incompletely developed.
13. For treatment of root canal obstruction (Code D3331), documentation is required that shows a non-negotiable root canal blocked by foreign bodies, including but not limited to separated instruments, broken posts or calcification of 50% or more of the root.
    a. It is not generally known that a canal obstruction is present until the time of the root canal treatment. Therefore, LIBERTY will not approve a benefit for this procedure when submitted as part of a predetermination request, and/or prior to actual treatment.
    b. LIBERTY acknowledges that the treatment of a root canal obstruction (Code D3331) is a separate, accepted procedure code. This procedure should not be submitted in conjunction with endodontic retreatment procedures Codes D3346, D3347 or D3348, as treatment of a root canal obstruction is considered to be included in endodontic retreatment.
14. For apical surgery (Codes D3410 – D3426), documentation is required that shows apical or lateral pathosis that cannot be treated non-surgically and that the tooth has a good periodontal and restorative prognosis. Endodontic apical surgical treatment should be considered only in specific circumstances, including:
    a. The root canal system cannot be instrumented and treated non-surgically.
    b. There is active root resorption.
    c. Access to the canal is obstructed.
    d. There is gross over-extension of the root canal filling.

e. Periapical or lateral pathosis persists and cannot be treated non-surgically.

f. Root fracture is present or strongly suspected.

g. Restorative considerations make conventional endodontic treatment difficult or impossible.

15. For a periradicular bone graft (Code D3428), documentation is required that shows the disease process has resulted in a deformity and loss of bone.
16. For a retrograde filling (Code D3430), documentation is required that shows evidence of medical necessity for a retrograde filling during periradicular surgery.

PERIODONTICS

Periodontal Screening and Examination

All children, adolescents and adults should be evaluated for evidence of periodontal disease. If pocket depths do not exceed 4 mm and there is no bleeding on probing or evidence of radiographic bone loss, it is appropriate to document the member's periodontal status as being "within normal limits" (WNL).

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

Sequential charting over time to show changes in periodontal architecture is considerably valuable in determining treatment needed or to evaluate the outcome of previous treatment.

Periodontal Treatment Sequencing

D4355 - Full mouth debridement to enable comprehensive evaluation and diagnosis D4355 is defined by the ADA's CDT as: *"The gross removal of plaque and calculus that interfere with the ability of the dentist to perform a comprehensive oral evaluation. This preliminary procedure does not preclude the need for additional procedures."*

Note, this procedure:

- is not a replacement code for procedure D1110

D4341/D4342 - Scaling and root planing (also known as "SRP")

- Treatment follows a periodontal evaluation usually conducted at the examination appointment. The Treatment involves the instrumentation of the crown and root surfaces of the teeth to remove plaque, calculus, biofilm and stains from these surfaces. These procedures are:
- Considered to be within the scope of a PCD or a dental hygienist

- Supported when full mouth periodontal pocket charting demonstrates at least 4 mm pocket depths, bleeding on probing and radiographs reveal evidence of bone loss, loss of attachment and/or the presence of interproximal calculus.
- Scaling and root planing procedures (D4341, D4342) are covered once per quadrant every 3 years or at shorter intervals with documentation of medical necessity.

Definitive or Pre-Surgical scaling and root planing:

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

Two quadrants per appointment, unless otherwise indicated by medical necessity.

Clinical/Coverage Guideline:

If a clinician recommends and/or completes more than two quadrants per appointment, documentation supporting the additional quadrant(s) must be included in the member's records and/or progress notes.

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

D1110 and D4341

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

- Periodontal maintenance D4910 at regular intervals should be instituted following scaling and root planing if the periodontal condition has improved to a controllable level. Periodontal pocket depths and gingival status should be recorded periodically.
- The member's homecare compliance and instructions should be documented.

Clinical/Coverage Guideline:

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

Treatment alternatives such as systemic antibiotics[2] or periodontal surgery instead of procedure D4381 should be considered when:

- Multiple teeth with pocket depths of 5 mm's or deeper exist in the same quadrant

- Procedure D4381 was completed at least 4-weeks after D4341 but a re-evaluation of the member's clinical response confirms that D4381 failed to control periodontitis (i.e. a reduction of localized pocket depths)
- Anatomical defects are present (e.g., infrabony defects)
- Periodontal Surgical Procedures (D4240/41, D4260/61 and related surgical procedures)

Periodontal surgical procedures (especially osseous surgery procedures) are covered when the following factors are present:

- The member should exhibit a willingness to accept periodontal treatment and practice an appropriate oral hygiene regimen prior to consideration for periodontal surgical procedures. (History, narrative and/or progress notes may help to indicate this).
- Case history, including member motivation to comply with treatment and oral hygiene status, should be documented (history, narrative and/or progress notes may help to indicate this).
- Member motivation should be documented in a narrative by the attending dentist and/or by a copy of member's progress notes documenting member follow through on recommended regimens.
- In most cases, there should be evidence of scrupulous oral hygiene for at least three months prior to the prior authorization for periodontal surgery.
- Consideration for a direct referral to a Periodontist would be considered for complex treatment planning purposes. However, the performance of SRP, OHI and other pre- and non-surgical procedures should be performed by the PCD (before or after the periodontal consultation).
- Periodontal surgical procedures are covered only in cases that exhibit a favorable long-term prognosis. Surgical procedures for the retention of teeth that are being used as prosthetic abutments is covered only when the teeth would exhibit adequate bone support for the forces to which they are, or will be, subjected.
- Periodontal pocket reduction surgical procedures may be covered in cases where the pocket depths are 5 mm's or deeper, following soft tissue responses to scaling and root planing. Consideration should be given for long-standing pockets of 5 mm following previous surgical intervention, which may or may not require further surgical intervention.
- Gingival hyperplasia due to prescribed medications can be documented.

Periodontal surgery (especially osseous surgery) procedures may not be covered if:

- pocket depths are 4 mm's or less and appear to be maintainable by non-surgical means (i.e., periodontal maintenance and root planing)
- members are users of tobacco products or diabetics whose disease is not being adequately managed
- Periodontal pocket reduction surgical procedures should result in the removal of residual calculus and granulation tissue with improved physiologic form of the gingival tissues.
- Osseous surgery and regenerative procedures should also correct and reshape deformities in the alveolar bone where indicated.
- Soft tissue gingival grafting should be done to correct gingival deficiencies where appropriate.

- D4249 clinical crown lengthening – hard tissue

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

Clinical/Coverage Guideline:

It would not be considered good clinical practice to perform a periodontal surgical procedure on the same tooth on the same date of service as a final impression for a fixed or removable prosthesis, as healing has not occurred, which could change the architecture substantially affecting the outcome of the prosthesis. LIBERTY will not cover a periodontal surgical procedure on the same tooth on the same date of service as a final impression for a fixed or removable prosthesis.

Clinical/Coverage Guideline:

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

- D4910 - Periodontal maintenance and supportive therapy intervals should be individualized, although three-month recalls are common for many members.

Clinical/Coverage Guideline:

Periodontal Maintenance D4910 is allowable for 3 years (or even longer) when there is a history of periodontal therapy evident in the member's treatment record (by report, by LIBERTY record, or by narrative).

REMOVABLE PROSTHETICS

Providers must document the date of service for these procedures to be the date when prosthetic appliances are completed unless services need to be prorated.

Removable prosthodontic services shall be provided as follows:

- Dentures, both partial and complete, may be prior authorized when submitted evidence indicates masticatory deficiencies likely to impair the general health of the beneficiary. Prefabricated dentures or dentures that are temporary in nature shall not be reimbursable. When submitting a Dental Claim Form for reimbursement of approved complete or partial dentures, the date of service used shall be the date of insertion of the denture(s) unless services are to be prorated.
- The following factors should also be considered when requesting prior authorization for dentures (including immediate dentures);
  i. Age, school status, employment status and rehabilitative potential of the beneficiary (for example, provision of dentures will enhance vocational placement);

ii. Medical status of beneficiary (nature and severity of disease or impairment) and psychological predisposition;

iii. Condition of the oral cavity, including abnormal soft tissue or osseous conditions;

iv. Condition of present dentures, if applicable.

- Generally, prior authorization for partial dentures to replace posterior teeth will not be granted if there are at least eight posterior teeth which in the opinion of a dental consultant are in reasonably good periodontal condition, occlusion and position, or where a prosthesis in one arch will produce equivalent dentition. A partial denture may also be considered when there is at least one missing anterior tooth in the arch.
- With the exception of immediate complete dentures, there shall be a three month wait for healing between the date of the last extraction and the initiation of the denture(s), partial or complete.
  i. Should the provider initiate the denture treatment (that is, take final impressions) prior to the expiration of the three-month healing period, the dentist shall be responsible for all subsequent relines, rebases and/or remaking of the denture(s) if necessary for a six-month period following insertion.

  ii. When all services are to be performed by the same practitioner, the total treatment plan for the extractions, denture(s) and any other dental services shall be submitted and will be reviewed for prior authorization in total. As soon as the extractions are completed, the claim should be submitted for payment for the diagnostic and/or surgical services. After the required period of time for healing has taken place and the denture provided, a second claim should be completed (for the dentures only) and submitted to the fiscal agent marked "continuation of previously authorized treatment plan."
- The fee for a partial denture shall include payment for all necessary clasps and rests. A minimum of two clasps and rests shall be provided.
- The fee for complete maxillary and/or mandibular dentures shall include necessary adjustments for a six-month period following insertion.
  i. The fee for immediate dentures shall include the necessary adjustments and relines for a six-month period following insertion.
- Partial dentures shall be described, indicating material used, position of clasps and teeth to be replaced. Fee includes necessary adjustments for a six-month period following insertion.
- Payment for dentures will be denied or recovered unless all dental procedures are completed in both arches before impressions are taken.
- Dentures shall not be prior authorized when:
  i. Dental history reveals that any or all dentures made in recent years have been unsatisfactory for reasons that are not remedial because of physiological or psychological reasons; or

  ii. Dental history reveals that a denture was provided through any New Jersey State, county, or municipal agency in the seven and one-half year period prior to the date of the current request; or

iii. Repair, relining, or rebasing (jumping) of the beneficiary's present denture will make it serviceable.

- Reimbursement for repairs to complete or partial dentures shall include adjustments for three months. Prior authorization shall be required when the repair exceeds $165.00 for a specialist or $150.00 for a non-specialist.
- Denture relining, rebasing (jumping) or repairing services, except as noted in this section, are reimbursable.

i. Rebasing is the process of refitting a denture by the complete replacement of the denture base material without changing the occlusal relationship of the teeth.

ii. Relining is the process of resurfacing the tissue side of a denture with new base material to make it fit more accurately.

iii. The fee for relining and rebasing shall include all necessary adjustments for a six- month period following insertion.

iv. Adjustments prior to and in conjunction with denture relining, rebasing (jumping) and repair shall not be reimbursable. Adjustments, repairs, relining, and rebasing shall not be reimbursable when new or replacement dentures have been prior authorized.

v. Rebases and relines shall not be reimbursable within 12 months of initial insertion of a denture without prior authorization and shall thereafter be limited to once every 12 months without prior authorization.

vi. The beneficiary's name (first and last names or, where space is a limiting factor, first initial and last name) must be processed into all dentures during the original fabrication or where possible during any subsequent processing, such as repair, relining and rebasing. The social security number shall also be included if space permits. This requirement is consistent with the "Denture I.D. Law" (N.J.S.A. 45:6-19.1 et seq.) and N.J.A.C. 13:30-8.11.

- A maxillofacial prosthetics procedure (Code D5911-D5999 – See Benefit Schedule) may be required when documentation shows medical necessity for functional and/or esthetic augmentation of the mouth or face. This procedure would generally be covered under WellCare's medical benefits.

IMPLANTS

Implant services shall be provided as follows:

1. Implants will not normally be considered for reimbursement. Prior authorization for implants will be limited to requests that demonstrate that a beneficiary has a facial anomaly, deformity or has been unable to function with a complete denture for at least two years and other oral surgical corrections have been unsuccessful in improving the retention of the denture.
2. If extenuating circumstances exist, a prior authorization request shall be submitted to a dental consultant with all supporting documentation and a complete restorative treatment plan, including denture services.

FIXED PROSTHODONTICS

Fixed prosthodontic services shall be provided as follows:

1. Fixed bridges will not normally be reimbursed. If extenuating circumstances exist, any request must be submitted accompanied by recent diagnostic full mouth radiographs and written documentation of the circumstances.
2. Fixed bridges shall be considered as initial replacement of: single anterior tooth for members under the age of 21, direct replacement of preexisting failed/defective bridgework; and for special needs members who cannot function with a removable appliance. Replacement of an existing defective fixed bridge will only be considered for reimbursement if there are no other missing teeth in that arch, there is no radiographic evidence of a periodontal pathology present on recent radiographs and the abutment teeth have a favorable long-term prognosis.
3. If there are fewer than eight posterior teeth in reasonably good occlusion and periodontal condition, a partial denture will be recommended by the dental consultant.

ORAL SURGERY

A. Extractions (Codes D7111 – D7251)
    1. Each dental extraction should be based on a clearly recorded diagnosis for which extraction is the treatment of choice of the dentist and the member.
    2. For extraction of a deciduous tooth (Codes D7111 and D7140) there must be evidence of medical necessity showing that the tooth has pathology and will not exfoliate soon or a member complaint of acute pain.
    3. Extractions may be indicated in the presence of non-restorable caries, untreatable periodontal disease, pulpal and periapical disease not amendable to endodontic therapy, to facilitate surgical removal of a cyst or neoplasm, or when overriding medical conditions exist, providing compelling justification to eliminate existing or potential sources of oral infection.
        a. Extractions of erupted teeth
            i. An uncomplicated extraction (Code D7140) of an erupted or exposed root includes removal of all tooth structure, minor smoothing of socket bone and closure, as necessary. Extraction of an erupted tooth may be needed when the tooth has significant decay, is causing irreversible pain and/or infection, or is impeding the eruption of another tooth.
            ii. A surgical extraction of an erupted tooth (Code D7210) requires removal of bone and/or sectioning the tooth, including elevation of a mucoperiosteal flap if indicated.
        b. An impacted tooth is "An unerupted or partially erupted tooth that is positioned against another tooth, bone, or soft tissue so that complete eruption is unlikely." (CDT)
            i. Extraction of a soft tissue impaction (Code D7220) is a tooth with the occlusal surface covered by soft tissue, and extraction requires elevation of a mucoperiosteal flap.

ii. Extraction of a partial bony impaction (Code D7230) is a tooth with part of the crown covered by bone and requires elevation of a mucoperiosteal flap and bone removal.

iii. Extraction of a completely bony impaction (Code D7240) is a tooth with most or all of the crown covered with bone and requires elevation of a mucoperiosteal flap and bone removal.

iv. Extraction of a complicated completely bony extraction (Code D7241) requires documentation of unusual surgical complications.

c. Removal of residual tooth roots (Code D7250) requires cutting of soft tissue and bone and includes closure.

d. Coronectomy (Code D7251) is an intentional partial removal of an impacted tooth when a neurovascular complication is likely if the entire impacted tooth is removed.

e. The prophylactic removal of an impacted or unerupted tooth or teeth that appear(s) to exhibit an unimpeded path of eruption and/or exhibit no active pathology is not covered. During our clinical review of requests for extraction of impacted and/or erupted teeth, LIBERTY may determine that treatment better fits the description of a different, more appropriate procedure code. In that situation, LIBERTY may approve the extraction under a different code.

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

ii. Pericoronitis is considered to be pathology. By definition, completely covered and unerupted third molars cannot exhibit pericoronitis.

iii. Narratives describing the presence of pericoronitis on a fully erupted tooth are ambiguous. In such cases, the radiographic or photographic presentation will be the determining factor in the determination of coverage.

f. Orthodontic-related extractions are covered if the orthodontic case has been prior authorized.

B. Other Surgical Procedures

1. Removal of residual tooth roots (Code D7250) may be needed when the residual tooth root is pathological or is interfering with another procedure.

2. Sinus perforation or oroantral fistula closure (Code D7260) requires documentation that there is a pathological opening into the sinus.

3. Tooth re-implantation and/or stabilization of an accidentally evulsed or displaced tooth (Code D7270) requires documentation that a tooth or teeth have been accidentally evulsed or displaced.

4. A biopsy of oral tissue (Codes D7285 and D7286) requires documentation that there is a suspicious lesion in the mouth that needs evaluation and the harvesting of oral tissue.

5. A surgical procedure to facilitate tooth movement (Codes D7292 – D7295) requires documentation that demonstrates the medical necessity of a surgical procedure to facilitate appropriate tooth positioning.

C. Alveoloplasty - Preparation of Ridge (Codes D7310 – D7321) requires documentation that demonstrates the medical necessity for the surgical recontouring of the alveolus.

D. Vestibuloplasty (Codes D7340 and D7350) (a surgical procedure to increase relative alveolar ridge height) requires documentation that demonstrates the medical necessity of enhancing the alveolar ridge to facilitate successful prosthetic restoration.

E. Excision of soft tissue or intra-osseous lesions (Codes D7410 – D7461) requires documentation of the presence of an intra-oral lesion and the medical necessity to remove it.

F. Excision of bone tissue (Codes D7471 – D7473) (an exostosis) requires documentation that a bony growth interferes with the ability to function or wear a prosthesis.

G. Reduction of an osseous tuberosity (Code D7485) requires documentation that shows a large tuberosity that interferes with the ability to wear a prosthesis.

H. Incision and drainage of an abscess (Codes D7510 - D7521) requires documentation that shows an oral infection that requires drainage.

I. Removal of a foreign body (Code D7530), non-vital bone or a tooth fragment requires documentation that it is medically necessary to remove it.

J. Open/closed reduction of a fracture (Codes D7610 – D7640) requires documentation that demonstrates evidence of a broken jaw.

K. Reduction of dislocation (Codes D7810 and D7820) and management of other temporomandibular joint dysfunctions require documentation showing a dislocation or other pathological condition of the temporomandibular joint.

L. Repair of traumatic wounds (Code D7910) and other repair procedures requires documentation showing that it is medically necessary to suture a traumatic wound and/or other repair procedures.

M. A bone replacement graft (Code D7950) requires documentation that demonstrates the need for ridge preservation for planned implants or prosthetic reconstruction.

N. A frenulectomy (Code D7960) requires documentation that demonstrates evidence that a muscle attachment is interfering with proper oral development function or treatment.

O. Excision of hyperplastic tissue (Code D7970) or reduction of a fibrous tuberosity (Code D7972) requires documentation that demonstrates the medical necessity of removing redundant soft tissue to facilitate a removable prosthesis.

P. Excision of pericoronal gingiva (Code D7971) requires documentation that demonstrates the medical necessity of removing inflammatory or hypertrophied tissues surrounding partially erupted or impacted teeth.

ORTHODONTICS

The following standards and procedures apply to the provision of orthodontic services for children in the Medicaid/NJ FamilyCare (NJFC) programs.

Orthodontic Consultation (D9310) - must include a visual examination and may also include a completed HLD (NJ-Mod3) Assessment Tool by the attending provider or a provider in the same group. This consultation does not require prior authorization, can be provided once a year and will be linked to the provider and not to the patient (which allows for a second opinion with a different provider).

Pre-orthodontic Treatment Visit (D8660) - includes the diagnostic workup, clinical evaluation, orthodontic treatment plan and completion of HLD (NJ-Mod3) assessment tool.

The HLD (NJ-Mod3) is only required for consideration of comprehensive orthodontic treatment. The HLD (NJ-Mod3) is completed by the dentist that will be rendering the orthodontic treatment.

The HLD (NJ-Mod3) Index and instructions are accessible at https://www.libertydentalplan.com/Resources/Documents/ma_NJ_Orthodontic_Evaluation_NJ_Mod3_Index_Form.pdf

If the HLD (NJ-Mod3) Assessment Tool has an "X" and correctly documented clinical criteria found in sections1-6A and 15 of the assessment tool or a total score that is equal to or greater than 26, the pre-orthodontic treatment work-up can proceed. A total score of less than 26 points on the HLD (NJ-Mod3) Assessment Tool requires documentation of the extenuating circumstances, functional difficulties and/or medical anomaly be included in the submission.

- The visit does not require prior authorization and should occur with the expectation that the case will be completed prior to the client exceeding the age of eligibility for the benefit;
- This service can be provided once a year and will be linked to the provider and not to the patient;
- The orthodontic work-up includes the consultation; therefore, consultation will not be reimbursed separately.

Minor Treatment to Control Harmful Habits

Minor treatment can be used for the correction of oral habits in any dentition. Approval for treatment to control harmful habits when not part of a limited, interceptive or comprehensive case will include appliances, removable or fixed, insertion, all adjustments, repairs, removal, retention · and treatment visits to the provider of placement. Replacement of appliances due to loss or damage beyond repair is allowed once and thereafter requires prior authorization and can be considered with documentation of incident and documentation of medical necessity.

For prior authorization, a narrative of the clinical findings, treatment plan, estimated treatment time with prognosis and diagnostic photographs and/or models shall be submitted and maintained in the treatment records.

Upon completion of the case pre-treatment and post-treatment photographs must be submitted.

Orthodontic Treatment Services

Limited, Interceptive and Comprehensive orthodontic services **must be prior authorized**. Limited and Interceptive orthodontic services will be considered for the treatment of the primary dentition, permanent dentition or mixed dentition. Comprehensive orthodontic services will be considered for treatment of the permanent dentition. Comprehensive orthodontic treatment is a coordinated diagnosis and treatment leading to the improvement of a patient's craniofacial dysfunction and/or dentofacial deformity which may include anatomical, functional

and/or esthetic relationships. Treatment may utilize fixed and/or removable orthodontic appliances and may also include functional and/or orthopedic appliances in growing and non-growing patients. Adjunctive procedures to facilitate care may be required. Comprehensive orthodontics may incorporate treatment phases focusing on specific objectives at various stages of dentofacial development.

Prior authorization determinations shall be made, and notice provided to the provider within ten (10) days of receipt of all necessary information.

In cases where prior authorization is denied, the denial decision must be made by an orthodontist, documentation must contain a detailed explanation of the reason(s) for denial; indicate whether additional information is needed and the process for reconsideration. Additionally, denial documentation must include the name and contact information of the Orthodontic consultant that reviewed and denied the treatment request which will allow the treating provider an opportunity to discuss the case.

An approved case must be started within six (6) months of receiving the approval.

Limited Orthodontic Treatment

Limited orthodontic treatment can be considered for treatment not involving the entire dentition and can be used for corrections in any dentition.

For prior authorization the following shall be submitted:

- Narrative of clinical findings, treatment plan and estimated treatment time;
- Diagnostic photographs;
- Diagnostic X-rays or digital films;
- Diagnostic study models or diagnostic digital study cast images; and
- The referring Primary Care dentist must provide attestation that all needed preventive and dental treatment services have been completed. A copy **must** be submitted with the orthodontic treatment request.

The reimbursement for the service includes the appliance, insertion, all adjustments, repairs, removal, retention and treatment visits to the provider of placement. Therefore, the case shall be completed even if eligibility is terminated at no additional charge to the member. Replacement of retainers or removable appliances due to loss or damage beyond repair requires prior authorization and can be considered with documentation of medical necessity.

If it is determined that limited orthodontic treatment is part of a comprehensive treatment plan which will occur within less than 12 months, it will be considered part of the comprehensive case and will not be reimbursed separately. In this case, the prior authorization should be submitted for comprehensive orthodontic treatment with an attached treatment plan that indicates the limited treatment phase including the expected time frame for this and the expected initiation (month/year) of the comprehensive treatment.

Upon completion of the case pre-treatment and post-treatment photographs must be submitted.

Interceptive and Comprehensive Orthodontic Treatment

For prior authorization requests the following shall be submitted:

- The completed HLD (NJ-Mod3) assessment tool for comprehensive orthodontic treatment;
- Narrative of clinical findings for dysfunction or deformity and dental diagnosis;
- The interceptive or comprehensive orthodontic treatment plan and estimated treatment time;
- Attestation from the referring dentist that all needed preventive and dental treatment services have been completed;
- Diagnostic study models or diagnostic digital study models;;
- Diagnostic photographs (which may suffice in place of models);
- Diagnostic x-rays, digital x-rays or cephlometric film with tracing (when applicable); and,
- When applicable:
  - Medical diagnosis and surgical treatment plan
  - Detailed documentation of extenuating circumstances
  - Detailed documentation from **a mental health professional** as described in the managed care contract indicating the psychological or psychiatric diagnosis, treatment history and prognosis and an attestation stating and substantiating that orthodontic correction will result in a favorable prognosis of the mental/psychological condition.

Interceptive Orthodontics

Interceptive treatment can be considered for localized tooth movement and may be for redirection of ectopic eruptions, correction of dental crossbites or recovery of space in the primary or transitional dentition. Approval for the interceptive treatment when not part of the comprehensive case will include all appliances, insertion, all adjustments, repairs, removal, retention and treatment visits and initial retainers to the provider of placement. Replacement of retainers or removable appliances due to loss or damage beyond repair requires prior authorization and documentation of medical necessity.

If it is determined that interceptive orthodontic treatment is part of a comprehensive treatment plan which will occur within less than 12 months, it will be considered part of the comprehensive case and will not be reimbursed separately In this case, the prior authorization should be submitted for comprehensive orthodontic treatment with an attached treatment plan that indicates the interceptive treatment phase, including the expected time frame and expected initiation (month/year) of comprehensive treatment.

Upon completion of the case, pre-treatment and post-treatment diagnostic photographs must be submitted.

Comprehensive Orthodontics

Eligibility should be checked prior to each visit.

LIBERTY reimburses for periodic treatment visits (D8670) which are billed for the date of service. A maximum of 24 units of 08670 are allowed for each comprehensive orthodontic case, which is expected to last no longer than 36 months from the date of banding.

The reimbursement for comprehensive treatment is requested using the date the appliances are placed and billed as D8080. The date of each periodic visit (D8670) **is billed separately** on the date of service. Services reimbursed through these codes will include all appliances, **their** insertions, adjustments, repairs and removal as well as the retention phase of treatment to the provider of placement.

Initial retainer(s) are included with the service; however, replacement of retainers or removable appliances due to loss or damage beyond repair is allowed once. If additional replacements are needed, the service requires prior authorization and can be considered with documentation of the incident and medical necessity.

Reimbursement for orthodontic services includes the placement **and removal** of all appliances and brackets; therefore should it become necessary to remove the bands following or due to loss of eligibility, non-compliance or elective discontinuation of treatment by the parent, guardian or patient the **appliance shall be removed with no additional reimbursement to the provider of placement because reimbursement for comprehensive orthodontics includes this service.** In cases where treatment is discontinued, a "Release from Treatment" letter must be provided by the dental office which documents the reason for discontinuing care and releases the dentist from the responsibility of completing the case. The release form must be reviewed and signed by the parent/guardian and patient, and a copy maintained in the patient's records.

Requesting Prior Authorization

Prior authorization for comprehensive orthodontic treatment will only be considered for the **late mixed and permanent dentitions.** Comprehensive orthodontic treatment will be considered at two points of care: the beginning of treatment through the mid-point and the continuation of treatment to completion. This will allow the consultant to evaluate the progress of treatment.

Beginning Treatment

In addition to submission requirements already noted, the prior authorization form to request the beginning phase of treatment should be completed for procedure code D8080 and the treatment visits with a maximum number of units for treatment visits to be considered on any one prior authorization being twelve (12);

- The case start date is considered to be the banding date which must occur within six (6) months of approval;
- If the prior authorization expires before all approved units are used, a prior authorization may be submitted for the remaining units along with an explanation that includes the original prior authorization number and why treatment did not occur within the active time of the prior authorization.

Continuation Treatment

- Prior authorization for the continuation of treatment visits for the continuation of the case shall be submitted after completing the first twelve (12) units of treatment visits or at the mid-point of treatment.
- The maximum number of additional treatment visits allowed to continue the case is twelve (12).
- If the prior authorization expires before all approved units were used, a prior authorization may be submitted for the remaining units along with an explanation that includes the original prior authorization number and why treatment did not occur within the active time of the prior authorization.
- The following shall be included with the prior authorization to continue treatment:

- A copy of the treatment notes;
- Documentation of any problems with compliance;
- Attestation from the current primary care dentist that recall visits occurred and that all needed preventive and dental treatment services have been completed;
- Pre-treatment and current treatment diagnostic photographs and/or diagnostic panoramic radiographs to show status and to demonstrate case progression;
- A copy of the initial approval if the case was started under a different NJ FamilyCare Medicaid MCO or FFS program.

Prior Authorization for Orthodontic Services Transferred or Started Outside of the NJFC/Medicaid Program

For continuation of care for transfer cases whether they were or were not started by another NJFC/Medicaid provider, a prior authorization must be submitted to request the remaining treatment visits to continue a case with a maximum of twelve (12) per prior authorization to be considered. The following must be submitted with the prior authorization:

- A copy of the initial orthodontic case approval (if applicable);
- Attestation from the referring or treating general dentist that preventive and dental treatment services have been completed;
- A copy of the orthodontic treatment notes if available from provider that started the case (if available);
- Recent diagnostic photographs and/or panoramic radiographs and if available pre-treatment images ;
- The date when active treatment was started;
- The expected number of months to complete the case along with the number of units for treatment visits with maximum number of 24 units allowed; and,
- If applicable, a new treatment plan and documentation to support the treatment change if re-banding is planned.

A case in treatment cannot be denied if the member is eligible for orthodontic coverage based on age.

Orthognathic Surgical Cases with Comprehensive Orthodontic Treatment

- The surgical consult, treatment plan and approval for surgical case must be included with the request for prior authorization of the orthodontic services;
- Prior authorization and documentation requirements are the same as those for comprehensive treatment and shall be submitted by the treating orthodontist;
- The parent/guardian and patient should understand that loss of eligibility at any time during treatment will result in the loss of all benefits and payment by the NJFC Medicaid program.

Conclusion of Active Treatment

- Attestation of case completion must be submitted to document that active treatment had a favorable outcome and that the case is ready for retention.
- Procedure code 08680, orthodontic retention shall be submitted for prior authorization along with

recent panoramic film and photographs when the active phase of orthodontic treatment is completed.

- Once approved, the bands can be removed, and the case placed in retention.

Documentation for Completion of Comprehensive Cases – Final Records

The following **must** be submitted to document the completion of comprehensive cases:

- Final diagnostic photographs and/or panoramic radiograph;
- Final diagnostic study models or diagnostic digital study models must be taken and be available upon request.

If this is not received, reimbursement provided may be recovered until required documentation is submitted.

Behavior Not Conducive to Favorable Treatment Outcomes

It is the expectation that the case selection process for orthodontic treatment take into consideration the member ability over the course of treatment to:

- Tolerate the treatment;
- Keep multiple appointments over several years;
- Maintain an oral hygiene regimen; and,
- Be cooperative and complete all needed preventive and treatment visits.

If it is determined that treatment is not progressing because the patient is exhibiting non-compliant behavior which may include any of the following: multiple missed orthodontic or general dental appointments, continued poor oral hygiene, failure to maintain the appliances or untreated dental disease, discontinuation of treatment can be considered.

- A letter must be sent to the parent/guardian and/or patient that documents the factors of concern, the corrective actions needed and informs that failure to comply can result in the discontinuation of treatment with de-banding.
- A copy of this letter and the patient treatment records must be sent to LIBERTY with a copy to The Bureau of Dental Services, PO Box 712, Trenton, NJ 08625.

If the case is discontinued for reasons other than the completion of treatment (D8695), the "Release from Treatment" letter should be signed by parent/guardian and/or patient.

- For members enrolled in WellCare, a copy of the signed form and the patient treatment records must be sent to LIBERTY. **The reimbursement for appliance placement includes their removal,** however, prior authorization to allow reimbursement can be considered when removal is performed by a provider that did not start the case.

For prior authorization questions, please contact:

ATTN: CLAIMS DEPARTMENT

LIBERTY Dental Plan
PO Box 401086
Las Vegas, NV 89140

ADJUNCTIVE SERVICES

A. Unclassified Treatment

1. Palliative Treatment (Code D9110)
   a. Typically reported on a "per visit" basis for emergency treatment of dental pain.
   b. The submitted documentation must show the presenting issue and/or the emergency treatment provided that was medically necessary for the procedure.

B. Anesthesia

1. Local or regional block anesthesia in or not in conjunction with operative or surgical procedures (Code D9210):
   a. Local or regional block anesthesia is considered to be part of and included in conjunction with operative or surgical procedures.
   b. Submitted documentation must show that it is necessary to anesthetize part of the mouth when it is not in conjunction with operative or surgical procedures.
2. Deep Sedation/General Anesthesia or Intravenous moderate sedation/analgesia (Codes D9223 and D9243)
   a. Anesthesia time begins when the doctor administering the anesthetic agent initiates the appropriate anesthesia and non-invasive monitoring protocol and remains in continuous attendance of the member. Anesthesia services are considered completed when the member may be safely left under observation of trained personnel and the doctor may leave the room to attend to other members or duties.
   b. The level of anesthesia is determined by the anesthesia provider's documentation of the anesthetics effect upon the central nervous system and not dependent on the route of administration. It is expected that dentists performing anesthesia on members be properly licensed by their state's regulatory body and comply with all monitoring requirements dictated by the licensing body.
   c. LIBERTY provides benefits for covered General Anesthesia ("GA") or Intravenous ("IV") Sedation in a Dental Office Setting ONLY when medical necessity is demonstrated by the following requirements, conditions and guidelines:
      i. A medical condition that requires monitoring (e.g., cardiac, severe hypertension);

ii. An underlying medical condition exists which would render the member non-compliant without the GA or IV Sedation (e.g., cerebral palsy, epilepsy, developmental/intellectual disability, Down's syndrome);

iii. Documentation of failed conscious sedation (if available);

iv. A condition where severe infection would render local anesthesia ineffective.

3. Requirements for Documentation:
   a. The medical necessity for extraction treatment with GA or IV Sedation in a dental office setting must be clearly documented in the member's dental record and submitted by the treating dentist;

4. Prior authorization and submission requirements:
   a. Prior to providing GA or IV Sedation in a dental office setting, all necessary medical and dental documentation, including the dental treatment plan, must be reviewed and approved by LIBERTY.
   b. Submit the member's dental record, health history, charting of the teeth and existing oral conditions, diagnostic radiographs (except where not available due to conditions listed above) and intra-oral photographs.
   c. Submit a written narrative documenting the medical necessity for general anesthesia or IV Sedation;
   d. Treatment rendered as an emergency, when prior authorization was not possible, requires submission of a complete dental treatment plan and a written narrative documenting the medical necessity for the GA or IV Sedation.

5. The dental office has established, implemented and provided LIBERTY with approved sedation and general anesthesia policies and procedures that comply with the American Dental Association Guidelines for the Use of Sedation and General Anesthesia by Dentists.

6. Use of Nitrous Oxide (Code D9230) requires documentation of medical necessity to alleviate discomfort or anxiety associated with dental treatment (once per visit).

7. Non-intravenous Conscious Sedation (Code D9248) (Includes non-IV minimal and moderate sedation)
   a. This is a medically controlled state of depressed consciousness while maintaining the member's airway, protective reflexes and the ability to respond to stimulation or verbal commands. It includes non-intravenous administration of sedative and/or analgesic agent(s) and appropriate monitoring.
   b. The submitted documentation must demonstrate the medical necessity of non-IV conscious sedation.
   c. The level of anesthesia is determined by the anesthesia provider's documentation of the anesthetics effect upon the central nervous system and not dependent on the route of administration.

C. Professional Consultation (Code D9310)

1. This is a member encounter with a practitioner whose opinion or advice regarding evaluation and/or management of a specific problem; it may be requested by another practitioner or appropriate source and it includes an oral evaluation.

2. The consulted practitioner may initiate diagnostic and/or therapeutic services.
3. The submitted documentation must demonstrate the medical necessity of assistance in determining the treatment required for a specific condition.
4. Only diagnostic services may be provided on same date of service as a consultation visit.

D. Professional Visits (Codes D9410 – D9430)
   1. Hospital, house, extended care or ambulatory surgical center call
      a. Includes nursing homes, private residences, long term care facilities, hospice sites, institutions, hospitals or ambulatory surgical centers.
      b. Services delivered to the member on the date of service are documented separately using the applicable procedure codes.
      c. The submitted documentation must demonstrate the medical necessity of treatment outside of the dental office.
   2. Office visit for observation or case presentation during regularly scheduled hours
      a. This is for an established member and is not performed on the same day as evaluation.
      b. The submitted documentation must demonstrate the medical necessity of an office visit or case presentation during regularly scheduled office hours.

E. Drugs (Codes D9610 – D9630)
   1. Administration of one or more parenteral drugs or dispensing of drugs or medicaments for home use require submitted documentation demonstrating the medical necessity of the drugs or medicaments for treating a specific condition.

F. Miscellaneous Services
   1. Application of a desensitizing medicament or resin (Codes D9910, D9911)
      a. D9910 is reimbursed at a per visit for application of topical fluoride and D9911 is reimbursed at a per tooth basis for adhesive resin.
      b. This is not to be used for bases, liners or adhesives under restorations.
      c. This requires documentation demonstrating the medical necessity of a desensitizing medicament or resin.
   2. Behavior Management (Code D9920)
      a. This should be reported in addition to treatment provided and should be reported in 15-minute increments.
      b. Documentation submitted must demonstrate the medical necessity of managing the member's behavior, emotional and/or developmental status to allow the dentist to provide treatment.
   3. Treatment of post-surgical complications or unusual circumstances (by report) (Code D9930) must provide documentation demonstrating the medical necessity of the procedure.
   4. Occlusal Guard (Codes D9944/D9945)

a. This is a removable dental appliance designed to minimize the effects of bruxism and other occlusal factors.
b. This must be supported by documentation demonstrating the medical necessity fabricating, adjusting or repairing/relining an occlusal guard to minimize the effects of bruxism.

5. Occlusal analysis or adjustment (Codes D9951 – D9952) requires documentation demonstrating the medical necessity of the process to reshape occlusal surfaces.
6. Odontoplasty (Codes D9971) requires documentation demonstrating the medical necessity of the process for other than exclusively cosmetic concerns.

RETROSPECTIVE REVIEW

Prospective and retrospective review will require documentation that demonstrates medical necessity. This documentation can include diagnostic radiographic or photographic images, the results of tests or examinations, descriptions of conditions in progress notes and/or a written narrative providing additional information. In cases where objective information (such as diagnostic images) conflicts with subjective information (such as written descriptions), objective information will be given preference in making a determination.

Retrospective review of services that had been previously prior authorized will require documentation confirming that the procedure(s) was (were) completed as authorized and within the standard of care as defined by LIBERTY's Clinical Criteria Guidelines and Practice Parameters.

In all situations, applicable Plan/Program specific guidelines supersede the information contained in LIBERTY's Clinical Criteria Guidelines and Practice Parameters document.

SECTION 11. QUALITY MANAGEMENT

COMPLIANCE STATEMENT

LIBERTY operates in compliance with all WellCare policies and procedures, as well as NJFC contract and all NJ Department of Banking and Insurance (DOBI) HMO regulations.

UTILIZATION MANAGEMENT

In the provision of treatment of NJ FamilyCare/Medicaid beneficiaries, N.J.A.C. 10:56 for dental services and N.J.A.C. 10:54 for physician services shall be followed for the provisions of the respective services. In addition, the following standards shall be followed:

a. There is no limit to the frequency of necessary dental services for the placement or replacement of amalgam or composite restorations or crowns. The standard of practice requires a provider to eradicate pathology and to repair or replace defective restorations to restore form and function. Frequency limits may apply for reimbursement of these services to the same provider.

b. Frequency limits for the following diagnostic and preventive services: oral evaluations, intraoral complete series, panoramic film, bitewings, dental prophylaxis, topical fluoride application, fluoride varnish and sealants, are not transferable when the enrollee is seen by a new dentist who is not a Member of the same group or shared health care facility, or practitioners sharing a common record.

c. Additional diagnostic, preventative and periodontal services shall be available beyond the frequency limitations of every six months and be allowed every three months to enrollees with special needs when medical necessity for these services is documented and submitted for consideration. Documentation shall include the expected prognosis and improvement in the oral condition associated with the increased frequency for the requested service.

d. Replacement of partial or complete dentures cannot be denied based solely on frequency if request includes documentation of medical necessity, inability to repair the existing denture or loss resulting from theft, fire or accident.

e. When dental service(s) are denied, written notice to a provider or Member must be provided and shall include the following:
    1. The specific service denied, including the tooth, quadrant or site if a dental denial;

2. The specific reason(s) for the denial, and where appropriate, reference the policy or regulation;
3. If the documentation provided supports the provision of a different service(s) than the one(s) requested for approval, the clinical peer who reviewed the service(s) may approve the service(s) which are supported by the submitted documentation.
4. The name and contact information for the dentist, physician or other clinical peer that reviewed and denied the service, in accordance with requirements of the State Board of New Jersey;
5. The process and required documentation needed for reconsideration of the service or alternative treatment and information on the availability of the reviewing dentist or physician for telephone communication to discuss denial(s) with the treating provider.
6. Information sent to the Member to describe the reason for the denial also shall be in layman terms.

f. WellCare and/or LIBERTY shall comply, as applicable, to the provisions of P.L. 2007, c.259 and any regulations promulgated to implement this act which concerns dental decisions.

PROHIBITED ACTIONS

Neither LIBERTY's UM Committee nor its utilization review agent shall take any action with respect to a member or a health care provider that is intended to penalize or discourage the member or the member's health care provider from undertaking an appeal, dispute resolution or judicial review of an adverse determination. Additionally, neither the LIBERTY's UM Committee nor its utilization review agent shall take any punitive action against a Provider who requests an expedited resolution or supports a Member's appeal.

MEMBER APPEALS

Member appeals including Medicaid Fair Hearings and Independent Utilization Review Organization (IURO) are handled directly by WellCare.

Appeal Process for UM Determinations

WellCare has policies and procedures for the appeal of utilization management determinations and similar determinations. In the case of a Member who is receiving a service (from WellCare, another Contractor, or the Medicaid Fee-for-Service program) prior to the determination, WellCare Health Plans will continue to provide the same level of service while the determination is in appeal.

WellCare (as per the definition in 42 CFR §435.923) will:

- provide a Member
- a Provider acting on behalf of a Member with the Member's written consent
- or an authorized representative acting on behalf a Member

Any UM decision resulting in a denial, termination, or other limitation in the coverage of and access to healthcare services in accordance with the NJ Medicaid Contract may be appealed. WellCare uses State-mandated Notice of Action template letters. These template letters explain the appeal process upon the notice of action and at the conclusion of each stage in the appeal process. Members and Providers will be provided with a written explanation of the appeal process upon the conclusion of each stage in the appeal process.

Notice of Action

Action means, at a minimum, any of the following:

- An adverse determination under a utilization review program; Denial of access to specialty and other care;
- Denial of continuation of care; Denial of a choice of Provider;
- Denial of coverage of routine patient costs in connection with an approved clinical trial;
- Denial of access to needed drugs;
- The imposition of arbitrary limitation on Medically Necessary services; Denial in whole or in part, of payment for a benefit;
- Denial or limited authorization of a requested service, including the type or level of services;
- The reduction, suspension or termination of a previously authorized service;
- Failure to provide services in a timely manner; and Denial of a service based on lack of Medical Necessity.

Hearings

If WellCare provides a hearing to the Member on the appeal, the Member will have the right to representation. WellCare will permit the Member to be accompanied by a representative of the Member's choice to any proceedings and grievances. Such hearing will take place in community locations convenient and accessible to the Member.

WellCare will provide the Member a reasonable opportunity, in person and in writing, to present evidence and testimony and make legal and factual arguments. WellCare will inform the Member of the limited time available for this sufficiently in advance of the resolution time frame for appeals, including in cases where expedited resolution has been requested.

WellCare will inform Members of the limited time available to present evidence and testimony, in person and in writing, and make legal and factual arguments in the case of an expedited appeal resolution. WellCare will inform Members sufficiently in advance of resolution time frames for appeals.

WellCare will provide the Member or their authorized representative the Member's case file (including medical records, other documents and records, and any new or additional evidence considered, relied upon or generated by WellCare) in connection with the appeal of the Adverse Benefit Determination. The case file will be provided free of charge, and sufficiently in advance of the resolution time frames for standard and expedited appeals.

Appeals Process

The appeal process will consist of an internal review by WellCare and an optional external review by an independent utilization review organization (IURO) administered by the DOBI. Medicaid/NJ FamilyCare A and NJ FamilyCare ABP Members also have access to the Fair Hearing process.

The Member, Provider acting on behalf of a Member with the Member's written consent, or authorized representative acting on behalf of the Member, will have 60 days from receipt of the notification of Adverse Benefit Determination to request an internal appeal. Appeals may be requested orally or in writing. Appeals

requested orally will be followed by a written, signed appeal (except for expedited appeal requests, for which this is not required).

The internal appeal process will consist of an internal review wherein physicians and/or other healthcare professionals selected by WellCare who are trained in or who practice in the same specialty as would typically manage the case at issue (who have not been involved in the Adverse Benefit Determination, and are not subordinates of the individuals involved in the initial determination) review the facts of the case and render a decision. All such internal appeals will be concluded as soon as possible in accordance with the medical exigencies of the case. Which in no event will exceed 72 hours from WellCare receipt of the appeal request in the case of appeals from determinations regarding:

- Urgent or emergency care
- An admission
- Availability of care Continued stay
- Healthcare services for which the claimant received emergency services but has not been discharged from a facility
- In addition, appeals wherein WellCare determines (based on a Member request) or the Provider demonstrates (while making the request on the Member's behalf or in supporting the Member's request) that expedited resolution is Medically Necessary, immediate action is necessary because taking the time for a standard resolution could seriously jeopardize the Member's life, physical or mental health, or ability to attain, maintain or regain maximum function. There is a 30-calendar daytime frame in the case of all other appeals. If WellCare denies a request for expedited appeal, it will transfer the appeal to the standard resolution time frame, which cannot exceed 30 calendar days from receipt of the appeal request (with the possibility of an extension of up to 14 calendar days).
- Any Member, Provider acting on behalf of a Member with the Member's written consent, or authorized representative acting on behalf of the Member, may appeal an adverse internal appeal determination to an independent utilization review organization (IURO). There will be a 60-day time frame which will begin upon receipt of the adverse internal appeal determination to file a written request for an external (IURO) appeal.

If WellCare fails to adhere to notice requirements (format and content of notifications) or timing requirements (resolution time frames for the Internal Appeal stage), the Member is deemed to have exhausted WellCare appeal process, and will have immediate access to the External (IURO) appeal and Fair Hearing.

WellCare may extended the resolution timeframe from an expedited appeal by up to 14 calendar days if a Member requests an extension or it WellCare shows (upon DMAHS's request) that additional information is necessary, and that the delay is in the Member's interest. WellCare will need to demonstrate to DMAHS's satisfaction that an adequate determination cannot be made without additional information.

In the event that WellCare extends the resolution time frame for an expedited appeal not at the request of the Member, it will:

- Make reasonable efforts to give the Member prompt oral notice of the delay;

- Give the Member written notice (within 2 calendar days) of the reason for the decision to extend the time frame, as well as inform the Member of the right to file a grievance if he or she disagrees with that decision; and
- Resolve the appeal as expeditiously as the Member's condition requires, but no later than the expiration date of the extension.

External (IURO)

The external (IURO) appeal process is administered by DOBI and is used for the review of the appropriate utilization and Medical Necessity of covered healthcare services. The services below may not be eligible for the external (IURO) appeal process.

- Adult Family Care Assisted Living Program
- Assisted Living Services when the denial is not based on Medical Necessity Caregiver/participant training
- Chore services
- Community Transition Services
- Home Based Supportive Care Home Delivered Meals
- PCA
- Respite (Daily and Hourly) Social Day Care
- Structured Day Program -- when the denial is not based on Medical Necessity
- Supported Day Services -- when the denial is not based on the diagnosis of TBI

Utilization Management Appeals

Appropriate clinical personnel will be involved in the investigation and resolution of all UM appeals. The processing of all such appeals will be incorporated in WellCare's quality management activities and will be reviewed periodically (at least quarterly) by the Medical Director/Dental Director.

Continuation of Benefits

The MCO will automatically continue the Member's benefits during internal and external (IURO) appeals if all of the following conditions are met:

- The Member, Provider or authorized representative files the appeal timely; The appeal involves the termination, suspension or reduction of a previously authorized course of treatment;
- The services were ordered by an authorized Provider (e.g., a network Provider); and
- The appeal request is made on or before the final day of the previously approved authorization, or within 10 calendar days of WellCare sending the notification of Adverse Benefit Determination, whichever is later.

In the event that WellCare fails to meet its obligation to send the notification of Adverse Benefit Determination at least 10 calendar days prior to the final day of the previously approved authorization, WellCare will automatically extend the authorization to a date 10 calendar days after the date on which the notification was sent.

If the Member or Provider does not satisfy the conditions listed above, they may not be eligible for continuation of benefits. However, the Member or Provider will still have 60 days from receipt of the notification of Adverse Benefit Determination to request an internal appeal.

Fair Hearings

Medicaid/NJ FamilyCare A and NJ FamilyCare ABP Members can request a Fair Hearing within 120 days from the date of the notice of action letter following an adverse determination resulting from an internal appeal.

For Members who request the Fair Hearing Process, continuation of benefits will be requested in writing within 10 calendar days of the date of the notice of action letter following an adverse determination resulting from an internal or external (IURO) appeal, or on or before the final day of the previously approved authorization, whichever is later.

If a Member requests continuation of services while his or her Fair Hearing is pending and the outcome is not in their favor, the Member may be required to pay for the cost of the services furnished while the Fair Hearing was pending.

Duration of Continued or Reinstated Benefits

WellCare will continue the Member's benefits while an appeal or Fair Hearing is pending until one of the following occurs:

- The Member withdraws the appeal or request for Fair Hearing;
- The Member fails to request a Fair Hearing and continuation of benefits within 10 calendar days after WellCare sends the notification of adverse resolution of the Member's external appeal; or
- A Fair Hearing results in a decision adverse to the Member

Effectuation of Reversed Appeal Resolutions

For services furnished while, the appeal is pending. WellCare or the State Fair Hearing officer reverses a decision to deny authorization of services, and the Member receives the disputed services while the appeal is pending, WellCare will pay for those services, in accordance with the NJ Medicaid Contract.

If the final resolution of the Internal Appeal, External (IURO) Appeal or Fair Hearing reverses a decision to deny, limit or delay services that were not furnished while the appeal was pending, WellCare will authorize or provide the disputed services promptly and as expeditiously as the Member's health condition requires but no later than 72 hours from the date it receives notice reversing the determination.

Expedited Resolution of Appeals

WellCare will establish and maintain an expedited review process for appeals.

WellCare will ensure that the expedited resolution of an appeal and notice to affected parties is no longer, than 72 hours after WellCare receives the appeal.

This language shall not be interpreted as removing any legal rights of Members under State or federal law, including the right to file judicial actions to enforce rights or request a Fair Hearing for Medicaid Members in accordance with their rights under State and federal laws and regulations.

All written notices to Medicaid/NJ FamilyCare A and NJ FamilyCare ABP Members will include a statement of their right to access the Fair Hearing process within 120 days of the date of the notice of action letter following an adverse determination resulting from an internal appeal.

You can file an Internal Appeal by:

1. Calling WellCare Health Plans of New Jersey at **1-888-453-2534** (TTY **711**);

   AND

2. Writing to:

   WellCare Health Plans of New Jersey
   Attn: Appeals Department
   P.O. Box 31368
   Tampa, FL 33634

   Or

   WellCare Health Plans of New Jersey
   Attn: Medication Appeals
   P.O. Box 31398
   Tampa, FL 33634

If you call first, you must follow up your phone request by writing to WellCare Health Plans of New Jersey at the address in #2 above.

In your letter, you should include an explanation for the reason you are appealing our decision and then sign your request for an appeal.

Right to Representation

You have the right to represent yourself, have someone else represent you, or have legal representation. If you would like legal representation and are not able to pay for it, you can contact one of the following:

- Legal Services of New Jersey at www.LSNJLawHotline.org or call Legal Services of New Jersey at **1-888-576-5529**;
- Disability Rights New Jersey (DRNJ) at advocate@drnj.org or call DRNJ at **1-800-922-7233** (TTY **711**) for free legal and advocacy services for people with disabilities; or
- Community Health Law Project (CHLP) at chlpinfo@chlp.org or call CHLP at **1-973-275-1175** to be directed to the appropriate office serving your county. A list of CHLP offices can also be found at www.chlp.org.

Medicaid Fair Hearings can be requested via mail at:

State of New Jersey
Division of Medical Assistance and Health Services Fair Hearing Unit
P.O. Box 712
Trenton, NJ 08625-0712; OR

Faxed along with required information to **1-609-588-2435**.

TEMPORARY CHANGES TO THE APPEAL PROCESS DURING COVID-19

If you disagree with this decision, you (or your provider, with your written consent) can choose to appeal to an Independent Utilization Review Organization (IURO). You also have a right to request a Medicaid Fair Hearing.

External Independent Utilization Review Organization Appeal Process

You can now request a review by an Independent Utilization Review Organization (IURO). To request that the IURO review your Appeal, you must complete the forms provided with this letter and return them within 60 days of receipt of this letter to the following address:

NJ Department of Banking and Insurance
Consumer Protection Services
Office of Managed Care
P.O. Box 329
Trenton, New Jersey 08625-0329

You can also call their toll-free telephone number at 1-888-393-1062 to ask for an IURO appeal and for assistance. Although you have 60 days to file an appeal to the IURO, if you are receiving these services and want your services to continue automatically during the IURO appeal, you must request your appeal on or before the final day of the previously approved authorization, or within 10 calendar days of the date of this letter, whichever is later. **If you do not request your appeal within this timeframe, the services will not continue during the appeal.** The IURO will decide your Appeal within 45 calendar days. If you or your treating provider believe that this 45-calendar-day timeframe for resolving your appeal is too long and could harm your health, the IURO will decide your appeal within no more than 48 hours after they receive your appeal. This is called an expedited, or fast, appeal. You may ask for an expedited, or fast, appeal if you are an inpatient in a facility, if the care you received was for an urgent or emergency health concern, or if it is medically necessary and taking 45 calendar days to decide the appeal could seriously harm you in some way.

You or your treating provider should call the Department of Banking and Insurance at 1-888-393-1062 to make this request for an expedited, or fast, appeal. We will let you know the IURO's decision on your appeal within ten (10) business days of their decision.

If you want to request a review of your appeal by the Independent Utilization Review Organization (IURO), please send your request by email to ihcap@dobi.nj.gov. You can also fax it to **609-633-0807** or **609-964-4195**. Applications sent by mail will not be accepted by the IURO at this time. Please download the form at https://www.nj.gov/dobi/chap352/352ihcapform_medicaid.docx.

If you do not have access to a computer or a fax machine, or you need help filing your appeal, please call the Department of Banking and Insurance (DOBI). They are in charge of the IURO appeal process. They can be reached at **1-800-446-7467** or **609-292-7272**.

Note: You still must send your request within 60 days of the date on the enclosed letter.

If you want to request a Medicaid Fair Hearing, you now have 240 days from the date on the enclosed letter. The process to request a Fair Hearing is the same as shown in the letter. Please fax it to **609-588-2435**. You can also mail it to:

Division of Medical Assistance and Health Services
Fair Hearing Unit
P.O. Box 712
Trenton, NJ 08625-0712

PROVIDER GRIEVANCES

Network and non-network providers may submit grievances for matters including administrative issues, not related to payment disputes or utilization management decisions. Formal provider grievances address issues where a provider is not satisfied with LIBERTY's policies and procedures. Providers will not be penalized for filing a grievance. All provider grievances will be resolved fairly, in accordance with the covered benefits and consistent with LIBERTY's policies and procedures.

Provider grievances must be submitted in writing and filed no later than forty-five (45) days from the date that the issue occurred that initiated the grievance. Provider grievances will be acknowledged in writing within five (5) calendar days and resolved within thirty (30) calendar days.

ATTN: GRIEVANCE & APPEALS

LIBERTY Dental Plan
PO Box 26110
Santa Ana, CA 92799-6110

PROVIDER APPEALS

Providers who are not satisfied with the LIBERTY's utilization or claim denial decision, or the Plan's resolution to a grievance can request an appeal disputing LIBERTY's decision. Provider appeals must be submitted in writing and filed no later than ninety (90) days from the date grievance determination, or the date of the Explanation of Payment or Denial Letter. Provider appeals will be acknowledged in writing within five (5) calendar days and resolved within thirty (30) calendar days.

ATTN: GRIEVANCE & APPEALS

LIBERTY Dental Plan
PO Box 26110
Santa Ana, CA 92799-6110

LIBERTY has thirty (30) days to review the case for Medical Necessity and conformity to applicable guidelines. Cases submitted without the necessary documentation will be denied for lack of information, and the Provider must submit the requested documentation within sixty (60) calendar days of the denial to re-open the case. The case will remain closed if documents and records are received after the sixty (60) calendar day timeframe.

The provider grievances and appeals process outlined above are not applicable to disputes between LIBERTY and the provider regarding the terms, conditions or termination or any other matter arising under contract. If you have concerns related to contracting issues, please contact the Provider Relations Department for further assistance.

AVAILABILITY OF ASSISTANCE

If a Provider submits an appeal on behalf of a Member, the Provider must obtain and supply LIBERTY with a copy of a signed document from the member indicating consent for the appeal to be filed on his/her behalf. If LIBERTY does not receive such a document, the appeal cannot be processed. Providers may not file a Grievance or an Appeal on behalf of a Member without written consent from the Member as the Authorized Representative.

TIMELY FILING

Provider grievances and appeals filed after the time periods referenced above will be denied for untimely filing. LIBERTY will consider the untimely provider grievance or appeal only if the following information is provided:

- Documentation supporting that the claim was submitted within the timely filing requirements
- Documentation that demonstrates good cause

FORMS

The New Jersey DOBI has developed a Health Care Provider Application to Appeal a Claim Determinations form for your use. LIBERTY has also created Provider Complaint and Dispute forms for your use. These forms are optional and are not required. The forms are available at the following:

- New Jersey DOBI: www.state.nj.us/dobi/chap352/352implementnotice.html
- LIBERTY: www.libertydentalplan.com/providers/provider-resource-library.aspx

PROGRAM FOR INDPENDENT CLAIM PAYMENT ARBITRATION (PICPA)

After you have participated in LIBERTY's appeal process and you are still dissatisfied with the outcome of your claim payment dispute, you may be eligible to file for independent arbitration, in accordance with New Jersey regulations. To qualify for independent arbitration, you must meet the following requirements:

- The claim amount in dispute is $1,000.00 or more.
- Claims that are aggregated to meet the threshold limit, must also meet the following criteria as specified by the New Jersey Department of Banking and Insurance:
  - Exhausted LIBERTY's appeal process for claim payment reconsideration
  - Must be submitted timely; untimely claims will be removed from aggregation. In the event the remaining claims do not meet the threshold limit, none of the claims will be considered.
  - The disputed claim amounts should be aggregated by LIBERTY and by the enrollee or by CDT code.
- Providers must complete the Health Care Provider Application to Dispute a Claims Determination form. Copies of the form are available through the New Jersey Department of Banking and Insurance website.
- Claim(s) cannot be eligible for dispute under the IHCAP.
- Providers must include the fee for arbitration as required by New Jersey Department of Banking and Insurance. Information on the fee amount can be located through the New Jersey Department of Banking and Insurance.
- All requests for arbitration must be made within 90 days of the most recent adverse determination regarding the claim(s).

SECTION 12. FRAUD WASTE AND ABUSE

COMPLIANCE STATEMENT

LIBERTY operates in compliance with all WellCare policies and procedures, as well as NJFC contract and all NJ Department of Banking and Insurance (DOBI) HMO regulations.

FRAUD, WASTE, AND ABUSE PROGRAM DESCRIPTION

LIBERTY is committed to conducting its business in an honest and ethical manner and to operate in strict compliance with all regulatory requirements that relate to and regulate our business and dealings with our employees, members, providers, business associates, suppliers, competitors and government agencies. LIBERTY takes provider fraud, waste and abuse seriously. We engage in considerable efforts and dedicate substantial resources to prevent these activities and to identify those committing violations. LIBERTY has made a commitment to actively pursue all suspected cases of fraud, waste and abuse and will work with law enforcement for full prosecution under the law.

LIBERTY promotes provider practices that are compliant with all federal and state laws on fraud, waste, abuse and overpayment. Our expectation is that providers will submit accurate claims, not abuse processes or allowable benefits, and exercise their best independent judgment when deciding which services to order for their members.

Our policies in this area reflect that both LIBERTY and providers are subject to federal and state laws designed to prevent fraud and abuse in government programs, federally funded contracts and private insurance. LIBERTY complies with all applicable laws, including Federal False Claims Act, state false claims laws and makes a person liable to pay damages to the Government if he or she knowingly:

- Conspires to violate the False Claims Act (FCA)
- Carries out other acts to obtain property from the Government by misrepresentation
- Knowingly conceals or knowingly and improperly avoids or decreases an obligation to pay the Government
- Makes or uses a false record or statement supporting a false claim

- Presents a false claim for payment or approval

As a provider, you are responsible to:

- Comply with all federal and state laws and LIBERTY requirements regarding fraud waste and abuse and overpayment;
- Ensure that the claims that you (or your staff or agent) submit and the services you provide do not amount to fraud, waste or abuse, and do not violate any federal or state law relating to fraud, waste or abuse;
- Ensure that you provide and bill only for services to members that are medically necessary for services that were rendered, and consistent with all applicable requirements, regulations, policies and procedures;
- Ensure that all claims submissions are accurate;
- Notify LIBERTY immediately of any suspension, revocation, condition, limitation, qualification or other restriction on your license, or upon initiation of any investigation or action that could reasonably lead to a restriction on your license, or the loss of any certification or permit by any federal authority, or by any state in which you are authorized to provide healthcare services;

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

"Fraud" 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.

Examples of fraud may include:

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

"Waste" 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.

Examples of waste may include:

- Over-utilization of services; and,
- Misuse of resources.

"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 to abuse one's position or authority. "Abuse" does not necessarily lead to an allegation of "fraud" but it could.

Examples of abuse **may** include:

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

"Overpayment" means any funds that a person receives or retains under Medicaid and Medicare and other government funded healthcare programs to which the person, after applicable reconciliation, is not entitled under such healthcare program. Overpayment includes any amount that is not authorized to be paid by the healthcare program whether paid as a result of inaccurate or improper cost reporting, improper claiming practices, fraud, abuse or mistake.

REPORTING SUSPECTED FRAUD, WASTE, AND ABUSE OR OVERPAYMENT

LIBERTY expects providers and their staff and agents to report any suspected cases of fraud, waste, abuse or overpayments. LIBERTY will not retaliate against you if you inform us, the federal government, state government or any other regulatory agency with oversight authority of any suspected cases of fraud, waste or abuse.

To ensure ongoing compliance with federal law, if you determine that you have received an overpayment from LIBERTY, you are contractually obligated to report the overpayment and to return the overpayment to LIBERTY within thirty (30) calendar days after the date on which the overpayment was identified. You must also notify LIBERTY in writing of the reason for and claims associated with the overpayment.

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

Reports may be made to LIBERTY via one of the following methods:

- **Corporate Compliance Hotline**: 888.704.9833
- **Compliance Unit email**: compliancehotline@libertydentalplan.com
- **Special Investigations Unit Hotline**: 888.704.9833
- **Special Investigations Unit email**: SIU@libertydentalplan.com

Reports to the Corporate Compliance Hotline may be made 24 hours a day/seven days a week. Callers may choose to remain anonymous. All calls will be investigated and remain confidential.

Via U.S. mail:

ATTN: SPECIAL INVESTIGATIONS UNIT
LIBERTY Dental Plan PO Box 26110 Santa Ana, CA 92799-6110

NON-RETALIATION POLICY

LIBERTY will not retaliate against you or any of our employees, agents and contractors for reporting suspected cases of fraud, waste, overpayments or abuse to us, the federal government, state government, or any other regulatory agency with oversight authority. Federal and state law also prohibits LIBERTY from discriminating against an employee in the terms or conditions of his or her employment because the employee initiated or otherwise assisted in a false claims action. LIBERTY also is prohibited from discriminating against agents and contractors because the agent or contractor initiated or otherwise assisted in a false claims action.

FRAUD, WASTE, AND ABUSE TRAINING AND EDUCATION

LIBERTY encourages providers in our Medicare and Medicaid provider network to actively pursue information on their role in treating Medicare and Medicaid enrollees. CMS, Medicaid and Medicare information can be accessed directly at www.cms.gov.

As a provider in our Medicaid and/or Medicare network, and in order to treat Medicare and/or Medicaid members, you agree to:

- Comply with any CMS, LIBERTY or Medicaid/Medicare Advantage health plan training requirements including, but not limited to, annual completion of Medicaid/Medicare Fraud, Waste and Abuse training, review and distribution of LIBERTY's Code of Conduct.
- It is the owning providers responsibility to ensure that all staff and providers complete Medicaid/Medicare Fraud, Waste and Abuse training, and review LIBERTY's Code of Conduct within ninety (30) days of hire.

LIBERTY provides, free of charge, Fraud, Waste and Abuse Prevention Training for all contracted providers and any other downstream entity that you contract with to provide health, and/or administrative services on behalf of LIBERTY.

This training is available on-line at https://www.libertydentalplan.com/Providers/Provider-Training-1.aspx. Upon completion, you will be able to print out a certificate/attestation.

Organizations must retain a copy of all documentation related to this training for a period of no less than 10 years – including methods of training, dates, materials, sign-in sheets, etc.

SECTION 13. FORMS AND RESOURCES

Electronic forms, including, but not limited to the following are available for download by visiting LIBERTY's Provider Resource Library at https://www.libertydentalplan.com/Providers/Provider-Resource-Library.aspx

- Select "New Jersey" from the drop-down menu
- Click "Continue" and select the appropriate form
    - AAP Oral Health Risk Assessment Tool – for PCPs
    - ADA Caries Risk Assessment Form (Age 0-6) - for PCDs
    - ADA Caries Risk Assessment Form (Over age 6) - for PCDs
    - NJ Orthodontic Evaluation HLD (NJ-Mod3) Index Form & Instructions

SECTION 14. BENEFITS SCHEDULE

All NJFC Members: Plans A, B, C, D, ABP, MLTSS and FIDE SNP (dual eligible Medicare/Medicaid) have the same comprehensive dental benefit package which include diagnostic, preventive, restorative, endodontic, periodontal, prosthetic, oral and maxillofacial surgical and other adjunctive general services.

The NJFC Benefits Schedule is available by contacting Provider Relations or within LIBERTY's website at:

Site: https://www.libertydentalplan.com/Secured-Documents.aspx

Password: 2020NJFC