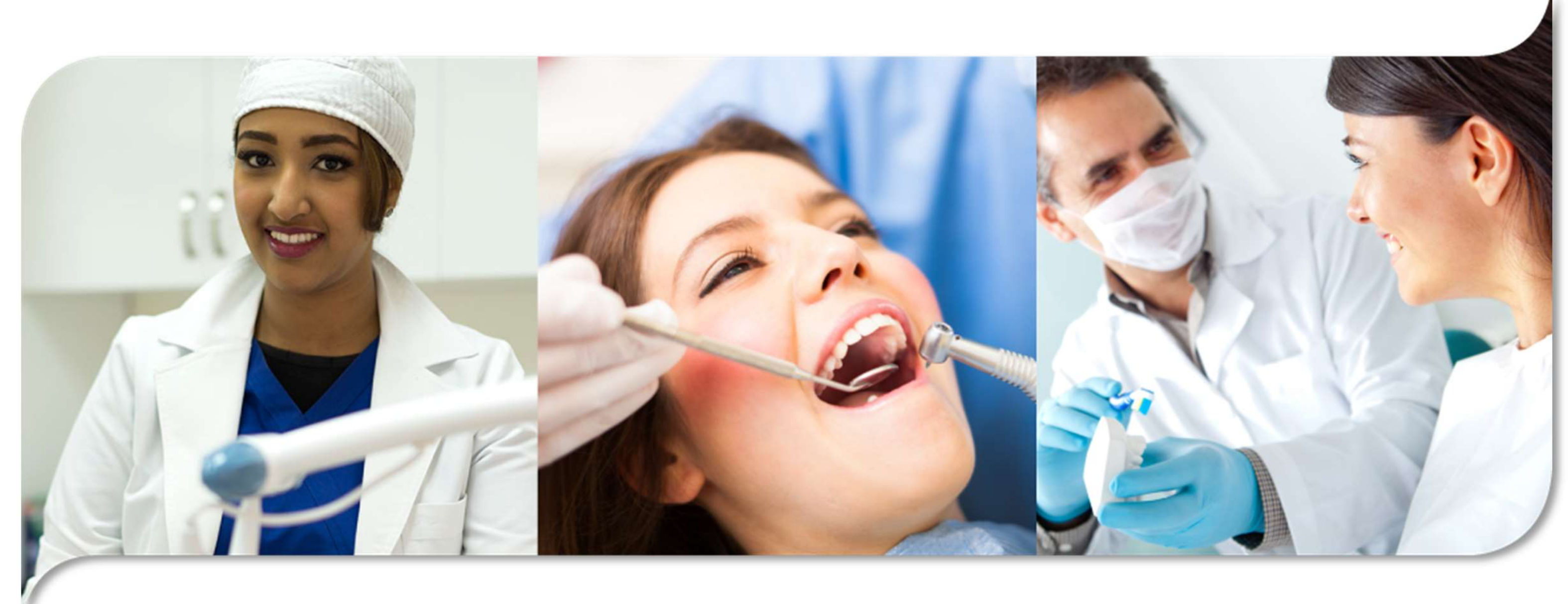
Nevada Medicaid
Provider Reference Guide



www.libertydentalplan.com/NVMedicaid

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SECTION 1 – LIBERTY DENTAL PLAN INFORMATION

Introduction

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

The intent of this Provider Reference Guide is to help each Participating Provider and their staff members become familiar with the administration of LIBERTY Dental Plan. Please note that this Provider Reference Guide serves only as a summary of certain terms of the Provider Agreement between you (or the contracting dental office/facility) and LIBERTY Dental Plan, and that additional terms and conditions of the Provider Agreement apply. In the event of a conflict between a term of this Provider Reference Guide and a term of the Provider Agreement, the term of the Provider Agreement shall control. You will receive a copy of the fully executed Provider Agreement at time of your activation on LIBERTY Dental Plan's network; however, you may also obtain a copy of the Provider Agreement at any time by submitting a request to prinquiries@libertydentalplan.com or by contacting Professional Relations at **888.700.0643**.

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

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

Our Mission

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

<table>
<tr><th colspan="4">PROVIDER CONTACT and INFORMATION GUIDE</th></tr>
<tr><th>Important Phone Numbers & General Information</th><th>Eligibility & Benefits Verification</th><th>Claims Inquiries</th><th>Provider Web Portal (i-Transact)</th></tr>
<tr>
<td rowspan="3">LIBERTY Provider Service Line
888.700.0643

Eligibility & Benefits: option 1
Specialty Referrals: option 2
Claims: option 3
Contracting: option 4

Hours:
Live representatives are available M-F, 5 am to 5 pm Pacific time

Professional Relations Department
888.700.0643 option 4
888.401.1129(fax)

LIBERTY Dental Plan
ATTN: Professional Relations
P.O. Box 401086
Las Vegas, NV 89140

email:
prinquiries@libertydentalplan.com</td>
<td>Provider Portal (iTransact)
www.libertydentalplan.com

or

Telephone
888.700.0643 option 1</td>
<td>Provider Portal (iTransact)
www.libertydentalplan.com

or

Telephone
888.700.0643 option 3</td>
<td rowspan="3">www.libertydentalplan.com

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

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

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

Your “Access Code” can be found on your LIBERTY Welcome Letter. If you cannot locate your access code, or need help with the login process, please call:
888.700.0643 for assistance, or email:
support@libertydentalplan.com</td>
</tr>
<tr><th>Referral Submission & Inquiries</th><th>Claims Submissions</th></tr>
<tr>
<td>Provider Portal (iTransact)
www.libertydentalplan.com

Telephone
888.700.0643 option 2

Regular Referrals by Mail:

LIBERTY Dental Plan
ATTN: Referral Department
P.O. Box 401086
Las Vegas, NV 89140

Emergency Referrals
All requests for emergency specialty care should be made by calling:
888.700.0643 option 2</td>
<td>Provider Portal (i-Transact)
www.libertydentalplan.com

EDI
Payer ID #: CX083

Paper Claims by Mail:

LIBERTY Dental Plan
ATTN: Claims Department
P.O. Box 401086
Las Vegas, NV 89140</td>
</tr>
</table>

SECTION 2 – PROFESSIONAL RELATIONS

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

Plan Contracting

Education on LIBERTY Members and Benefits

Opening, Changing, Selling or Closing a Location

Adding or Terminating Associates

Credentialing Inquiries

Change in Name or Ownership

Taxpayer Identification Number (TIN) Change

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

	LIBERTY Dental Plan ATTN: Professional Relations P.O. Box 401086 Las Vegas, NV 89140		Professional Relations Team M-F from 8 am – 5 pm Pacific time **888.700.0643** press option 4
	Email at prinquiries@libertydentalplan.com		

Medicaid Reimbursement
Contracted Medicaid network dentists are compensated on a Medicaid fee-for-service reimbursement model. Offices are required to submit claims for all services rendered. It is recommended that claims be submitted daily or weekly to ensure timely payment. For additional information regarding payment and eligibility, please visit the secure provider portal at www.libertydentalplan.com/NVMedicaid.

SECTION 3 – ONLINE SERVICES

LIBERTY Dental Plan 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

Verify Member Eligibility and Benefits

View Office and Contact Information

Submit Referrals and Check Status

Access Benefit Plans

View Claims History

View Assigned Members

Submit Prior Authorizations

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

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

If you are unable to locate your Office Number and/or Access Code, please contact our Professional Relations Department at **888.700.0643** or email prinquiries@libertydentalplan.com for assistance.

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

SECTION 4 – ELIGIBILITY

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

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

Please note that each member will be assigned to a dental home. A dental home (or Primary Care Dentist- "PCD") consists of general dentists and pediatric dentists. Members can select a different primary care dentist by contacting Member Services at **888.700.0643** or by using the self-service option at www.libertydentalplan.com/NVMedicaid. Members must seek treatment at their assigned dental home; otherwise claims may be denied.

How to Verify Eligibility

Several options are available to verify eligibility:

- **Provider Portal**: www.libertydentalplan.com - The member's last name, first name and any combination of member number, policy number, or date of birth will be required *(DOB is recommended for best results)* Please select My Members to ensure that members are **assigned** to your office before providing care. Reference our Provider Portal User Guide for more information how to access our provider portal.

- Telephone: Speak with a live representative from 5 a.m. to 5 p.m. Pacific time, Monday through Friday by contacting our Provider Service Line at **888.700.0643**, Option 1.

Member Identification Cards

Members should present their ID card at each appointment. Members can print an ID card from LIBERTY's website. 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 visit the online web portal for verification of eligibility. Please note that due to possible eligibility status changes, this information does not guarantee payment and is subject to change without notice.

Care for Members with Special Needs

We offer care management services to children and adults with special health care needs. 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 illness. Our goal is to help members with special needs understand how to take control 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 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

SECTION 5 – CLAIMS AND BILLING

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

Electronic Submission

LIBERTY strongly encourages the electronic submission of claims. This convenient feature helps reduce costs, streamline administrative tasks and expedite claim payment turnaround time for providers. There are two options to submit electronically - directly through the provider portal or by using a clearinghouse.

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

LIBERTY currently accepts electronic claims/encounters from providers through the clearinghouses listed below. If you do not have an existing relationship with a clearinghouse, please contact one of your choice to begin electronic claims submission. The EDI vendors LIBERTY accepts 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**	www.tesia.com	CX083

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

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

Paper Claims

Paper claims must be submitted on 2012 ADA-approved claim forms. Please mail all paper claim/encounter forms to:

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

Claims Submission Requirements

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

All claims must be submitted to LIBERTY for payment for services no later than 6 months or (180 days) after the date of service.

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.

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

ICD-10 Codes

As a state-mandated requirement, please be sure to include at least one ICD-10 code when submitting your claims. This is a requirement by the Division of Health Care Financing and Policy (DHCFP) and LIBERTY must comply. If you need assistance in identifying the appropriate ICD-10 codes, you can reference either one of the following:

- CDT 2018 Coding Companion (Help Guide for the Dental Team)
- Coding & Insurance Manual (A comprehensive resource for reporting pediatric dental services)

Below is a sample of how you can code ICD-10 on a claim form:

RECORD OF SERVICES PROVIDED

	24. Procedure Date (MM/DD/CCYY)	25. Area of Oral Cavity	26. Tooth System	27. Tooth Number(s) or Letter(s)	28. Tooth Surface	29. Procedure Code	29a. Diag. Pointer	29b. Qty.	30. Description	31. Fee
1	10/01/2015					D0120	A	1		$28.00
2	10/01/2015					D1110	A	1		$55.00
3	10/01/2015			30	O	D2140	B	1		$105.00
4	10/01/2015			11		D7140	C	1		$72.00
5										
6										
7										
8										
9										
10										

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

1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16

32 31 30 29 28 27 26 25 24 23 22 21 20 19 18 17

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

34a. Diagnosis Code(s) (Primary diagnosis in "A") A Z01.21 B K02.62 C K03.81 D

31a. Other Fee(s)

32. Total Fee $260.00

35. Remarks

"Clean" Claims

A "clean claim" is a claim submitted on a Standard ADA form, and is one that can be processed without obtaining additional information from the provider of service or a third party. A "clean claim" includes all attachments and supplemental information or documentation which provides reasonably relevant information or information necessary to determine payer liability.

The following information must be included on every claim form for the claim to be considered complete:

- Provider name and address
- Member name, date of birth, and member ID number
- Date(s) of service
- CDT and ICD-10 diagnoses code(s)
- Revenue
- Billed charges for each service or item provided
- Provider Tax ID number and/or social security number, and
- Name and state license number of attending dentist

Emergency services or out-of-network urgently needed services do not require authorization, however, in order to be considered "complete," the claim must include both:

- A diagnosis which is immediately identifiable as emergent or out-of-network urgent
- The dental records required to determine medical/necessity/urgency

Claims Status Inquiry

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

1. Provider Portal: http://www.libertydentalplan.com/NVMedicaid
2. Telephone: **888.700.0643**, Press Option 3

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

- Missing documentation
- Incorrect coding
- Processing errors

Claims overpayment

The following paragraphs describe the process that will be followed if LIBERTY determines that it has overpaid a claim. Claims submitted by any contracted provider who is not licensed when the services were rendered will be considered overpayments.

Notice of Overpayment of a Claim

If LIBERTY determines that it has overpaid a claim, LIBERTY will notify the provider in writing through a separate notice clearly identifying the claim; the name of the patient, the date of service and a

clear explanation of the basis upon which LIBERTY believes the amount paid on the claim was in excess of the amount due, including interest and penalties on the claim.

Contested Notice

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

No Contest

If the provider does not contest LIBERTY's notice of overpayment of a claim, the provider must reimburse LIBERTY within 45 working days of the provider's receipt of the notice of overpayment. If the provider fails to reimburse LIBERTY within 45 working days of receiving the notice, LIBERTY is authorized to offset the uncontested notice of overpayment of a claim from the provider's current claim submissions.

Offsets to Payments

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

SECTION 6 – COORDINATION OF BENEFITS

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

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

Medicaid provides coverage to each eligible beneficiary of the state assistance program. LIBERTY treats each beneficiary as a member. Medicaid is NOT a group plan and therefore each member has his own coverage. Medicaid is a state and federally funded program.

If a member has another coverage it would always be primary. Medicaid is always the carrier of last resort*. Thus, Medicaid 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 Medicaid 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 Medicaid fee schedule.

* If the provider is participating as a Ryan White Grant Provider; in that case, the grant would be carrier of last resort.

SECTION 7 – PROFESSIONAL GUIDELINES AND STANDARDS OF CARE

THIS SECTION PREVAILS ONLY WHEN MEDICAID HAS NOT ADDRESSED A PARTICULAR CIRCUMSTANCE OR CONDITION.

Primary Care Dentist Provider Responsibilities and Rights

- Provide and/or coordinate all dental care for member
- Perform an initial dental assessment
- Provide a written treatment plan to members upon request that identifies covered services and optional or non-covered services; and clearly identifies the costs associated of each option; the plan must be understandable by a prudent layperson with general knowledge of oral health issues
- Provide an informed consent discussion and supporting materials for all dental services and procedures for which the member has questions or concerns
- Treatment plans and informed consent documents must be signed by the member or responsible party to show understanding of the treatment plan and agreement with the treatment plan and the financial terms
- Work closely with specialty care providers to promote continuity of care
- Maintain adherence to LIBERTY's Quality Management and Improvement Program
- Identify dependent children with special health care needs and notify LIBERTY of these needs
- Notify LIBERTY of a member death
- Arrange coverage by another provider when away from dental facility
- Ensure that emergency dental services are available and accessible 24 hours a day, 7 days a week through primary care dentist
- Maintain scheduled office hours
- Maintain dental records for 10 years for adults and up to seven years beyond the age of majority for children
- Provide updated credentialing information upon renewal dates
- Provide requested information upon receipt of patient grievance/complaint 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 generally accepted clinical principles, criteria, guidelines and any published parameters of care

Specialty Care Providers Responsibilities & Rights

- All the responsibilities and rights of the primary care dentist listed above

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

Anti-Discrimination

Discrimination is against the law. LIBERTY Dental Plan ("LIBERTY") complies with all applicable federal civil rights laws and does not discriminate, exclude people or treat them differently on the basis of race, color, national origin, age, disability, or sex. LIBERTY takes affirmative action to ensure that recipients are provided access to covered medically necessary services without regard to race, national origin, creed, color, gender, gender identity, sexual preference, religion, age, and health status, physical or mental disability, except where medically indicated. Prohibited practices include, but are not limited to the following:

- Denying or not providing an enrolled recipient a covered service or available facility
- Providing an enrolled recipient, a covered service which is different, or is provided in a different manner, or at a different time from that provided to other recipients, other public or private patients, or the public at large
- Subjecting an enrolled recipient to segregation or separate treatment in any manner related to the receipt of any covered medically necessary service, except where medically indicated
- The assignment of times or places for the provision of services on the basis of race, national origin, creed, color, gender, gender identity, sexual preference, religion, age, physical or mental disability, or health status of the recipient to be served
- Prohibiting, or otherwise restricting, a health care professional acting within the lawful scope of practice, from advising or advocating on behalf of a recipient who is his or her patient:
    - For the recipient's health status, dental care, or treatment options, including any alternative treatment that may be self-administered
    - For any information the recipient needs in order to decide among all relevant treatment options
    - For the risks, benefits and consequences of treatment or non-treatment
    - For the recipient's right to participate in decisions regarding his or her health care, including the right to refuse treatment, and to express preferences about future treatment decisions
- Employing or contracting with providers excluded from participation in federal health care programs. [42 CFR 438.214(d)]
- Charging a fee for medically necessary covered service or attempting to collect a co-payment.

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 **888.700.0643**.

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

Phone: **888.704.9833**
TTY: **800.735.2929**
Fax: **888.273.2718**
Email: compliance@libertydentalplan.com
Online: https://www.libertydentalplan.com/About-LIBERTY-Dental/Compliance/Contact-Compliance.aspx

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

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1.800.368.1019, **800.537.7697** (TDD)
Online at: https://ocrportal.hhs.gov/ocr/portal/lobby.jsf
Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html

National Provider Identifier (NPI)

In accordance with the Health Insurance Portability and Accountability Act (HIPAA), LIBERTY Dental Plan requires a National Provider Identifier (NPI) for all HIPAA-related transactions, including claims, claim payment, coordination of benefits, eligibility, referrals and claim status.
As outlined in the Federal Regulation, The Health Insurance Portability and Accountability Act of 1996 (HIPAA), covered providers must also share their NPI with other providers, health plans, clearinghouses, and any entity that may need it for billing purposes.

How to Apply for an NPI

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

- Web based application: http://nppes.cms.hhs.gov/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.

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.

Standards of Accessibility

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

FOR PRIMARY CARE DENTISTS:

Type of Appointment	Appointment Waiting Time
Routine and Preventive Care	**Within 6 weeks**
Therapeutic or Diagnostic	**Within 14 days**
Urgent Care	**Within 24 hours / 7 days a week**
Referrals to Specialty Care	**Within 30 days**
After-Hours / Emergency Availability	**24 hours a day, 7 days a week**. All providers must have at least one of the following: • Answering service that will contact provider (or provider on call) on behalf of the member • Call forwarding system that automatically directs members to call the provider (or the provider on call) • Answering system with explicit instructions on how to reach the provider and emergency instructions with assurance of a reasonable call-back (within 1-3 hours) in most cases Calls involving life-threatening conditions or imminent loss of limb or functions may be referred to the 9-1-1, emergency medical services, emergency room or urgent care facilities in the community as per regionally available resources.
Scheduled Appointment Wait Time*	**30 minutes recommended; should not exceed 60 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**

FOR SPECIALISTS:

Type of Appointment	Appointment Waiting Time
Routine Care	**Within 30 days of referral**
Preventive Care	**Within 6 weeks**
Therapeutic or Diagnostic	**Within 14 days**
Urgent Care	**Within 3 days of referral**
Emergency Appointments	**Within 24 hours of referral**

After-Hours / Emergency Availability	**24 hours a day, 7 days a week**. All providers must have at least one of the following: • Answering service that will contact provider (or provider on call) on behalf of the member • Call forwarding system that automatically directs members to call the provider (or the provider on call) • Answering system with explicit instructions on how to reach the provider and emergency instructions with assurance of a reasonable call-back (within 1-3 hours) in most cases Calls involving life-threatening conditions or imminent loss of limb or functions may be referred to the 9-1-1, emergency medical services, emergency room or urgent care facilities in the community as per regionally available resources.
Scheduled Appointment Wait Time*	**30 minutes recommended; should not exceed 60 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**

*"Scheduled Appointment Wait 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.

Language Assistance Program (LAP)

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

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

Interpretation services for limited English proficient patients:

- When and where required by law or client group requirement, LIBERTY Dental offers free telephonic interpretation through our language service vendor. When required, the member must be fully informed that this service is available to him or her at no cost.
- To engage an interpreter once the member is ready to receive services, please call **1.888.700.0643**. You will need the member's LIBERTY Dental ID number, date of birth and the member's full name to confirm eligibility and access interpretation services. It is not necessary to arrange for these services in advance. An eligible member is entitled to 24-hour access to interpreter services, where available, either through telephone language services or in-person interpreters.
- LIBERTY Dental 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 when 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 must 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 are available to members at no cost and can be requested. For more information regarding alternate formats, please visit www.libertydentalplan.com.
- Assistance in working effectively with members using in-person and telephonic interpreters and other media such as TTY/TDD and remote interpreting services can be obtained by contacting LIBERTY's Member Services Department at **866.609.0418**.

Health Insurance Portability and Accountability Act (HIPAA)

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

LIBERTY 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 and Quality Management Program requirements, and that members' Protected Health Information (PHI) may be shared with LIBERTY. This sharing is provided for in the HIPAA law, which permits 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.

LIBERTY has appointed a Privacy Officer to develop, implement, maintain and oversee 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 PHI.

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

Prior Authorization guidelines for Primary Care Dentists

Please see Section 12 for the schedule of benefits and list of services that require prior authorization. You must submit a prior authorization request to the Plan with a copy of pre-operative radiograph(s) and justifying narrative, as well as any other information regarding the treatment. Refer to the benefit schedule for prior authorization requirements.

If an emergency service is needed, the primary care dentist should contact LIBERTY at **888.700.0643** for an emergency authorization number. This will provide conditional authorization. Any service added to an existing prior authorization by virtue of phoning LIBERTY, will require pre-operative radiograph and narrative when you submit for payment. Any emergency service must qualify for authorization and will receive clinical review by a dental consultant when it is reviewed for payment. When you receive LIBERTY authorization, you may proceed with the non-emergency services that were approved. After you complete treatment, submit your claim for payment with any post-operative radiographs, when appropriate and required. Radiographs and other supporting documentation will not be returned. Please do not submit original radiographs. Radiograph copies of diagnostic quality or paper copies of digitized images are acceptable.

Submit prior authorization requests before the member's appointment. An approved prior authorization does not confirm eligibility nor guarantee payment of claims.

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. If the primary care provider is not available to see an emergency patient within 24 hours, it is his/her responsibility to make arrangements to ensure that emergency services are available. A dental emergency means a member's oral health is in serious danger. An emergency is a condition that could cause:

- Bodily injury
- Damage to an organ or other body part
- Harm to a member's health (this includes to a pregnant woman and her unborn baby)

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 patient is unable to access emergency care within our guidelines and must seek services outside your facility, you may be held financially responsible for the total costs of such services for any member for whom you are the primary care dentist of record. Emergency dental services provided in a hospital, emergency room or ambulatory surgery center are provided as part of the medical MCO benefit.

Facility Physical Access for the Disabled

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

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

The ADA sets requirements for new construction of and alterations to buildings and facilities, including health care facilities. In addition, all buildings, including those built before the ADA went into effect,

are subject to accessibility requirements for existing facilities. Detailed service and facility requirements for disabled individuals can be found by visiting www.ada.gov.

Appointment Rescheduling

When a provider or member must reschedule an appointment, the appointment must 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 must be scheduled according to the same standards as initial appointments.

Interpreter

24-hour access to interpreter services must be available to all LEP members at no charge; face-to-face interpreters must be available if requested.

Early and Periodic Screening, Diagnostic and Treatment (EPSDT) Benefits

As required by federal law, LIBERTY provides comprehensive, diagnostic and preventive dental services to eligible recipients under the age of 21, if such services are medically necessary to correct or better a defect, condition, or physical or mental illness that exceeds the state's Medicaid benefit. This provision includes emergency, preventive and therapeutic services for dental disease that, if left untreated, may become acute dental problems or cause irreversible damage to the teeth or supporting structures. Enrollees have the right to EPSDT benefits that ensure children and adolescents receive appropriate preventive dental and specialty dental services. For more information please refer to the American Academy of Pediatrics Bright Futures Periodicity Schedule at https://www.aap.org/en-us/Documents/periodicity_schedule.pdf

Prior Authorization of EPSDT Dental Services

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

Treatment of Minors

Care cannot be provided without a parent or legal guardian's consent for un-emancipated members under age 18, with the exception of emergency care. Parents or legal guardians also retain the right to access their child's dental records even if the child requests they not be shared. Members under age 18 may be emancipated minors if they are married, have a child, are pregnant or are emancipated by court order. Emancipated minors may consent to and make their own decisions about their dental care and parents or legal guardians no longer have the right to access their records without consent.

Continuity and Coordination of Care

Continuity of care between the primary care dentist and any specialty care dentist must be available and properly documented. Communication between the primary care dentist and dental specialist must occur when members are referred for specialty dental care. LIBERTY expects primary care dentists to follow up with the member and the specialist to ensure referrals are occurring to serve the member's best interests. Specialist providers are encouraged to send treatment reports back to the referring primary care dentist providers to ensure continuity of care occurs according to generally accepted clinical criteria.

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

LIBERTY ensures appropriate and timely continuity of care for all plan members and will honor claims for services previously approved by the state or another carrier for up to 120 days after January 1, 2018.

Infection Control

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

Compliance with the Standards of Accessibility

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

Dental Records Standards

Dental record standards include the following, at minimum:

- Patient identification number: Each page or electronic file in the records contains the patient's name or patient ID number
- Personal/demographic data: Personal/biographical data includes: age, sex, race, ethnicity, primary language, disability status, address, employer, home and work telephone numbers, and marital status
- Entry date: All entries are dated
- Provider identification: All entries are identified as to author
- Legibility: The record is legible to someone other than the writer. A second reviewer should evaluate any record judged illegible by one clinical reviewer
- Allergies: Medication allergies and adverse reactions are prominently noted on the record. Absence of allergies (no known allergies: NKA) is noted in an easily recognizable location
- Dental history (for patients seen three or more times): Dental history is easily identified including serious accidents, operations, and illnesses. For children, dental history relates to prenatal care and birth and preventive services
- Diagnostic information
- Medication information
- Identification of current problems: Significant illnesses, dental conditions and health maintenance concerns are identified in the dental record
- Smoking, alcohol, or substance abuse: Notation concerning cigarettes, alcohol and substance abuse is present for patients 12 years and over and seen three or more times
- Consultations, referrals, and specialist reports: Notes from any consultations are in the record. Consultation, lab, and radiograph reports filed in the chart have the ordering dentist/physician's initials or other documentation signifying review. Consultation and significantly abnormal lab and imaging study results have an explicit notation in the record of follow-up plans
- Emergency care

Patient Visit Data

Documentation of individual encounters must provide adequate evidence of, at minimum:

- History and physical examinations: Comprehensive subjective and objective information is obtained for the presenting complaints
- Plan of treatment
- Diagnostic tests
- Therapies and other prescribed regimens
- Follow-up: Encounter forms or notes have a notation, when indicated, concerning follow-up care, calls, or visits. Specific time to return is noted in weeks, months, or as needed. Unresolved problems from previous visits are addressed in subsequent visits
- Referrals and results
- All other aspects of patient care, including ancillary services

Dental Records Availability

Member dental records must be kept and maintained in compliance with applicable state and federal regulations. Complete dental records of active or inactive patients must be accessible for at least 10 years, even if the facility is no longer under contract. Dental records must be furnished to members and/or their representatives no later than 30 days after the request has been made. If a member transfers to a new office, all records must be forwarded to the new provider within 10 business days of receipt of the request.

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

Contracted dentists must make available to the Plan upon request, copies of all member records. Records may be requested for grievance resolutions, second opinions or state/federal compliance. The dentist must make records available at no cost to the Plan or the member. Non-compliance may result in disciplinary actions, up to and including transfer of enrollment or closure to new enrollment. Continued non-compliance may result in termination by the Plan.

Treatment Plan Guidelines

All members must be given an appropriate written treatment plan containing an explanation of benefits and related costs.

Medicaid Plan Non-Covered Services: Non-covered options can be discussed with the member; however, any non-covered option must be presented on a separate treatment plan. The treatment plan must clearly state that the service is not covered, that the member has been informed of the covered options and elects the non-covered optional service(s), and that the member understands and accepts the financial responsibility. Failure to properly inform a Medicaid member of non-coverage of a particular procedure may result in the care being deemed "medically necessary" by the state regulatory agency. In such cases, when the appeal determines that the member was not properly notified, you may have to provide the contested service at no charge to the Plan or the member.

Alternate and/or Elective/non-covered Procedures and Treatment Plans: LIBERTY Dental members cannot be denied their plan benefits if they do not choose "alternative or elective/non-covered" procedures. All accepted or declined treatment plans must be signed and dated by the member or his/her guardian and the treating dentist.

Definition of Medical Necessity

We approve care that is "medically necessary" and "appropriate"

This means:

- The treatment or supplies are needed to evaluate, diagnose, correct, alleviate, ameliorate/prevent the worsening of, or cure a physical or mental illness or condition and meet accepted standards of dentistry
    - 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, or pain, or results in illness or infirmity
    - Will follow accepted medical practices
- Services are patient-centered and take into account the individuals' needs, clinical and environmental factors, and personal values. The criteria do not replace clinical judgment and every treatment decision must allow consideration of the individual's unique situation
- 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
- Services are provided as needed when there is no better or less costly covered care, service or place available
- Services are provided in a manner that is no more restrictive than that used in the State Medicaid and CHIP programs as indicated in State statutes and regulations, the Title XIX and Title XXI State Plans, and other State policy and procedures, including the Medicaid Services Manual (MSM)

Caries risk assessment

The ADA has developed a form to assess caries for the 0-20 population age group. Please see link to form in Section 14 or download the form from the ADA website.

Second Opinions

Members or treating providers may request a consultation with another network dentist or specialist at no cost for a second opinion to confirm the diagnosis and/or treatment plan. To request a second opinion on a member's behalf, contact Member Services at **888.700.0643**.

Recall, Failed or Cancelled Appointments

Contracted dentists are expected to have an active recall system for established patients who fail to keep or cancel appointments. Missed or cancelled appointments should be noted in the patient's record.

Member Rights and Responsibilities

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

- To be treated with respect, giving due consideration to the member's right to privacy and the need to maintain confidentiality of the member's medical and dental information
- To be given information about the plan and its services, including covered services
- To request a printed copy of the Member Handbook at least once per year or more frequently if necessary
- To be able to choose a primary care dentist within the contractor's network

- Freedom to change their primary care dentist upon request for any reason and as frequently as needed. Instructions on this procedure are provided and outlined in the Member Handbook
- To participate in decision making regarding their own dental care including the member's preference about future treatment decisions, and the right to refuse treatment
- To have access to the grievance and appeal system and file a grievance about the organization or the care received, excluding adverse benefit determinations; either verbally or in writing.
- To receive interpretation services in their preferred language
- To have access to all medically necessary dental service provided in Federally Qualified Health Centers, Rural Health Clinics or Indian Health Service Facilities, and access to emergency dental services outside the contractor's network pursuant to federal law
- To request a State fair hearing, including information on the circumstances under which an expedited fair hearing is possible
- To have access to, and where legally appropriate, receive copies of, amend or correct their dental record
- To be provided disenrollment requirements and limitations and to disenroll upon request
- To receive written member-informing materials in alternative formats (including Braille, large size print, and audio format) upon request and in a timely fashion appropriate for the format being requested
- To be given information about the definitions of emergency care
- To be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation
- To receive information on available treatment options and alternatives, presented in a manner appropriate to the member's condition and ability to understand
- Freedom to exercise these rights without adversely affecting how they are treated by the contractor, providers, or the state;
- Freedom from LIBERTY prohibiting a provider from advising on behalf of a member;
- To have access to the contractor's health education programs and outreach services in order to improve dental health
- To request a second opinion, including from a specialist at no cost
- To formulate advance directives

Each member of LIBERTY has the responsibility to behave according to the following standards:

- Provide accurate and updated information to contracting dentists, dental office staff and LIBERTY administrative staff to provide care (to the extent possible)
- Not allow any other person to use their ID card
- Communicate changes in demographic or dependent information, or other changes that would affect eligibility
- Notify LIBERTY of any other insurance coverage
- Respect and follow the policies and guidelines given by LIBERTY's contracting dentists, dental office staff and LIBERTY administrative staff with respect and courtesy

- Cooperate with LIBERTY's contracting dentist in following a prescribed course of treatment; including instructions and oral health care recommendations/guidelines provided
- Actively participate in treatment decisions
- Keep scheduled appointments or communicate with the dental office at least 24 hours in advance to cancel an appointment
- Be responsible for being on time to scheduled appointments
- Communicate and provide feedback on their needs and expectations to their dental office and to LIBERTY
- Report any suspected provider fraud/abuse
- Know and follow LIBERTY's guidelines in seeking dental care

SECTION 8 - CLINICAL DENTISTRY PRACTICE PARAMETERS

The following clinical dentistry criteria, processing guidelines and practice parameters represent the view of the Peer Review Committee of LIBERTY Dental Plan. They 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. In some cases, guidance is given about procedure codes services that may not be within the scope of benefits of all LIBERTY benefit plans. Please consult each benefit plan's Evidence of Coverage, Schedule of Benefits or other plan materials to determine plan-by-plan variations.

NEW PATIENT INFORMATION

REGISTRATION INFORMATION SHOULD INCLUDE:

1. Name, sex, birth date, address and telephone number, cell phone number, e-mail address, name of employer, work address and telephone number, language of preference
2. Name and telephone number of person(s) to contact in an emergency
3. For minors, name of parent(s) or guardian(s) and telephone numbers, if different from above
4. Pertinent information relative to the patient's chief complaint and dental history, including any problems or complications with previous dental treatment, previous dentist/dental clinic and date of last dental examination
5. Medical History - There should be a detailed medical history form consisting of questions which require a "Yes" or "No" response, including:
    a. Patient's current health status
    b. Name and telephone number of physician and date of last visit
    c. History of hospitalizations and/or surgeries
    d. Current medications, including dosages and indications
    e. History of drug and medication use (including Fen-Phen/Redux and bisphosphonates)
    f. Allergies and sensitivity to medications (including antibiotics) or materials (including latex)
    g. Adverse reaction to local anesthetics
    h. History of diseases or conditions:
        i. Cardiovascular disease, including history of abnormal (high or low) blood pressure, heart attack, stroke, rheumatic fever or heart murmur, existence of pacemakers, valve replacements and/or stents and bleeding problems, etc.

ii. Pulmonary disorders including COPD, tuberculosis, asthma and emphysema
iii. Nervous disorders, including psychiatric treatment
iv. Diabetes, endocrine disorders, and thyroid abnormalities
v. Liver or kidney disease, including hepatitis and kidney dialysis
vi. Sexually transmitted diseases
vii. Disorders of the immune system, including HIV status/AIDS
viii. Other viral diseases
ix. Musculoskeletal system, including prosthetic joints and when they were placed
x. History of cancer, including radiation or chemotherapy

6. Pregnancy
   a. Document the name of the patient's obstetrician and estimated due date
   b. Follow current guidelines in the ADA publication, Women's Oral Health Issues
7. The medical history form must be signed and dated by the patient or patient's parent or guardian
8. Dentist's notes following up patient comments, significant medical issues and/or consultation with a physician should be documented on the medical history form or in the progress notes
9. Medical alerts for significant medical conditions must be uniform and conspicuously located on the monitor for paperless records or on a portion of the chart used and visible during treatment and should reflect current conditions
10. The dentist must sign and date all baseline medical histories after review with the patient. If electronic dental records are used, indication in the progress notes that the medical history was reviewed is acceptable
11. The medical history should be updated at appropriate intervals, dictated by the patient's history and risk factors, and must be documented at least annually and signed by the patient and dentist

CLINICAL ORAL EVALUATIONS

A. Periodic oral evaluations (Code D0120) of an established patient may only be provided for a patient of record who has had a prior comprehensive evaluation (code D0150). Periodontal evaluations and oral cancer screenings should be updated at appropriate intervals, dictated by the patient'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 (EOB/EOP Remark Code: MM014)
C. An oral evaluation of a patient less than seven years of age 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 patients (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 (necessary for adults) and/or classification of occlusion (necessary for minors) should be documented

3. Full-mouth periodontal screening must be documented for all patients; for those patients with an indication of periodontal disease, probing and diagnosis must be documented, including a radiographic 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 patients, regardless of age

E. A post-operative office visit for re-evaluation should document the patient's response to the prior treatment (EOB/EOP Remark Code: MM014)

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 patient elects to proceed with a procedure that is not covered, the member is responsible for the dentist's usual fee.

   a. **Medicaid Plan Non-Covered Services:** Non-covered options can be discussed with the member however; any non-covered option must be presented on a separate treatment plan. The treatment plan must clearly state that the service is not covered, that the member has been informed of the covered options and elects the non-covered optional service(s), and that the member understands and accepts the financial responsibility. Failure to properly inform a Medicaid member of non-coverage of a particular procedure may result in the care being deemed "medically necessary" by the state regulatory agency. In such cases, when the appeal determines that the member was not properly notified, you may have to provide the contested service at no charge to LIBERTY or the member.

   b. **Alternate and/or Elective/non-covered Procedures and Treatment Plans:** LIBERTY Dental members cannot be denied their plan benefits if they do not choose "alternative or elective/non-covered" procedures. All accepted or declined treatment plans must be signed and dated by the member or his/her guardian and the treating dentist.

PRE-DIAGNOSTIC SERVICES

A. Patient screening, which includes a state or federal mandate, is used to determine the patient's need to see a dentist for diagnosis.
B. Assessment of a patient is performed to identify signs of oral or systemic disease, malformation or injury, and the potential need for diagnosis and treatment.

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 patient's exposure. Photographic images may also be needed to evaluate

and/or document the existence of pathology and are only payable as part of medically necessary, authorized orthodontic cases.

1. An attempt should be made to obtain any recent radiographic images from the previous dentist.
2. 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 patient's exposure. It is important to limit the number of radiographic images obtained to the minimum necessary to obtain essential diagnostic information. (EOB/EOP Remark Code: MM020)
3. The dentist should evaluate the patient to determine the radiographic images necessary for the examination before any radiographic survey.
4. Intraoral – complete series (including bitewings) (Code D0210)

Note: D0210 is a radiographic survey of the whole mouth, usually consisting of 14-22 periapical and posterior bitewing images intended to display the crowns and roots of all teeth, periapical areas and alveolar bone.

    1. Benefits for this procedure are determined within each plan design.
    2. 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.
    3. Any panoramic film taken in conjunction with periapical and/or bitewing radiograph(s) will be considered as a complete series, for benefit purposes only.
    4. 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 patient's last radiographic examination.
5. Diagnostic radiographs should reveal contact areas without cone cuts or overlapping, and periapical films should reveal periapical areas and alveolar bone.
6. Radiographs should exhibit good contrast.
7. Diagnostic digital radiographs should be submitted electronically when possible or should be printed on photographic quality paper and exhibit good clarity and brightness.
8. All radiographs must be mounted, labeled left/right and dated.

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. (EOB/EOP Remark Code: MM0350). Intra- or extra-oral photos are only payable as part of medically necessary, authorized orthodontic cases.

9. Any patient refusal of radiographs should be documented.
10. Radiograph duplication fees:
    1. Radiographic image duplication fees are not allowed.
    2. When a patient 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.
11. Diagnostic casts (Code D0470) are only considered medically necessary as an aid for treatment planning for specific oral conditions. (EOB/EOP Remark Code: MM047)

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. (EOB/EOP Remark Codes: MM041, MM047)
B. Oral pathology laboratory procedure/report may be required when there is evidence of a possible oral pathology problem. (EOB/EOP Remark Code: MM0472).

PREVENTIVE TREATMENT

A. Dental prophylaxis (Code D1110 and D1120) may be medically necessary when documentation shows evidence of plaque, calculus or stains on tooth structures. (EOB/EOP Remark Code: MM111)
B. Topical fluoride (Codes D1206 and D1208) treatment may be medically necessary when documentation shows evidence of the need for this preventive procedure. (EOB/EOP Remark Code: MM120)
C. A sealant (Code D1351) or 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 molar tooth in a moderate to high caries risk patient. (EOB/EOP Remark Code: MM135)
D. A space maintainer (Codes D1510 – D1525) may be medically necessary to prevent tooth movement and/or facilitate the future eruption of a permanent tooth. (EOB/EOP Remark Code: MM150)
E. Recognizing medical conditions that may contribute to or precipitate the need for additional prophylaxis procedures, supported by the patient's physician. Verify plan benefits before performing additional prophylaxis procedures in excess of plan limitations.
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 and reduce dental hypersensitivity. Treatment with silver diamine fluoride will not eliminate the need for restorative dentistry to repair function or aesthetics, but this alternative treatment allows clinicians to temporarily arrest caries with noninvasive methods, particularly with young children who have primary teeth. This should be submitted on a per-tooth basis.

RESTORATIVE TREATMENT

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. (EOB/EOP Remark Codes: MMPROG, MMPROGR)
B. Amalgam Restorations (Codes D2140-D2161)
   1. Dental amalgam is a cavity-filling material made by combining mercury with other metals such as silver, copper and tin. Numerous scientific studies conducted over the past several decades, including two large clinical trials published in the April 2006 Journal of the American Medical Association, indicate dental amalgam is a safe, effective cavity-filling material for children and others. And, in its 2009 review of the scientific literature on amalgam safety, the ADA's

Council on Scientific Affairs reaffirmed that the scientific evidence continues to support amalgam as a valuable, viable and safe choice for dental patients…"

2. On July 28, 2009, the American Dental Association (ADA) agreed 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:
   a. 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
   b. Facial or buccal restorations are generally considered to be "one surface" restorations, not three surfaces such as MFD or MBD (EOB/EOP Remark Code: MMMOD)
   c. 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 (EOB/EOP Remark Code: MMTRT)
   d. If a dentist chooses not to provide amalgam fillings, alternative posterior fillings must be made available for LIBERTY patients. Any listed amalgam copayments would still apply
   e. An amalgam restoration includes tooth preparation and all adhesives, liners and bases (EOB/EOP Remark Code: MMINC)
   f. An amalgam restoration may be medically necessary when a tooth has a fracture, defective filling or decay penetrating into the dentin (EOB/EOP Remark Code: MM214)
   g. An amalgam restoration should have sound margins, appropriate occlusion and contacts, and must treat all decay that is evident (EOB/EOP Remark Code: MM241)

C. Resin-based Composite Restorations (Codes D2330 – D2394)
   1. Composite is the procedure of choice for treating caries or replacing an existing restoration not involving or undermining the incisal edges of an anterior tooth. Decay limited to the incisal edge may still be a candidate for a filling restoration if little to no other surfaces 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. (EOB/EOP Remark Code: MMMOD)
   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. (EOB/EOP Remark Code: MMTRT)
   4. A resin-based composite restoration includes tooth preparation, acid etching, adhesives, liners, bases and curing. (EOB/EOP Remark Code: MMINC)
   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. (EOB/EOP Remark Codes: MM230, MM231)
   6. A composite restoration should have sound margins, appropriate occlusion and contacts and must treat all decay that is evident. (EOB/EOP Remark Code: MM232)
   7. If LIBERTY determines 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. (EOB/EOP Remark Codes: MM230M, MM232M, MM240M, MM241M)

8. Restorations for primary teeth are covered only if the tooth is symptomatic, proximal to permanent teeth, or expected to be present for six months or longer. (EOB/EOP Remark Code: MM290)
9. 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.
10. A resin infiltration of an incipient smooth surface lesion (decalcification) is appropriate for smooth surface lesions with some or minor enameloplasty. (EOB/EOP Remark Code: MM2990)

D. Crowns - Single Restorations Only (Codes D2712 – D2791)
   1. Administrative Issues
      a. Providers may document the date of service for these procedures to be the date when final impressions are completed (subject to review)
      b. Providers must complete any irreversible procedure started regardless of payment or coverage and only bill for indirect restorations when the service is completed (permanently cemented)
      c. Crown services must be documented using valid procedure codes in the American Dental Association's Current Dental Terminology (CDT)
   2. A crown 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 and has good endodontic, periodontal and/or restorative prognoses (EOB/EOP Remark Codes: MM272, MM273, MM237R, MM274, MM274E, MM275, MM275P) and is not required due to wear from attrition, abrasion and/or erosion (EOB/EOP Remark Code: MM2LIM)
      b. There is a significantly defective crown (defective margins or marginal decay) or there is recurrent decay (EOB/EOP Remark Code: MM270)
      c. The tooth is in functional occlusion EOB/EOP Remark Code: MM271)
      d. When anterior teeth have incisal edges/corners that are undermined or missing because of caries or a defective restoration, or are fractured off, a labial veneer may not be sufficient. The treatment of choice may be a porcelain fused to base metal crown or a porcelain/ceramic substrate crown. (EOB/EOP Remark Code: MM296)
      e. The tooth has a good endodontic, periodontic and restorative prognosis with a minimum crown/root ratio of 50% and a life expectancy of at least five years. (EOB/EOP Remark Code: MMPROG_)
   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, 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. (EOB/EOP Remark Code: MM272)

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. When bicuspid and anterior crowns are covered, the benefit is generally porcelain fused to a base metal crown or a porcelain/ceramic substrate crown
   b. When molar crowns and bicuspids are indicated due to caries, an undermined or fractured cusp or the necessary replacement of a restoration due to pathology, the benefit is usually a base metal crown or PFM
   c. Porcelain/ceramic substrate crowns and porcelain fused to metal crowns on molars may be susceptible to fracture during occlusal function. Depending on the properties of the material used, it may not be consistent with good clinical practice to routinely use all-porcelain/ceramic restorations on molar teeth
   d. Stainless steel crowns (Codes D2930 – D2933) are primarily used on deciduous teeth and only used on adult teeth due to a patient'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 (EOB/EOP Remark Code: MM291). Otherwise, the service will be considered included as part of the crown restoration.
   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. (EOB/EOP Remark Code: MMINC)
   a. The tooth is functional, has had root canal treatment and requires additional structure to support and retain a crown (EOB/EOP Remark Codes: MM295, MM299)
   b. Post and core in addition to crown (Code D2952), is an indirectly fabricated post and core custom fabricated as a single unit
   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 or restorative foundation may be medically necessary when a tooth requires a foundation for a restoration. (EOB/EOP Remark Code: MM2951)
9. A coping (Code D2975) or crown under a partial denture may be required when submitted documentation demonstrates the medical necessity of the procedure. (EOB/EOP Remark Code: MM297)
10. Repair of a restorative material failure may be medically necessary when submitted documentation establishes restorative material failure. (EOB/EOP Remark Code: MM298)
11. Outcomes: Standards set by the specialty boards shall apply.
    a. Margins, contours, contacts and occlusion must be clinically acceptable

b. Tooth preparation should provide adequate retention and not infringe on the dental pulp
c. Crowns should be designed with a minimum life expectancy or service life of five years

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 five-year prognosis (endodontic, periodontal or restorative) are not covered (EOB/EOP Remark Code: MMPROG)
      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 direct or indirect pulp caps, documentation is required that shows a direct or near exposure of the pulp. Direct or indirect pulp cap procedures are not considered bases and liners. (EOB/EOP Remark Code: MM310)
      a. The ADA defines an Indirect Pulp Cap (D3120) as a nearly exposed pulp that is covered with a protective dressing to protect the pulp from additional injury and to promote healing via secondary dentin formation. Placing a protective covering under a deep filling to help avoid sensitivity or pulpal irritation is not a billable service and is included in the fee for the restoration.

   b. Indirect pulp capping (re-mineralization) is indicated to attempt to minimize the possibility of pulp exposure in very deep caries in vital teeth.
7. For a pulpotomy (Code D3220) or pulpal therapy (Codes D3230 and D3240), documentation is required that shows pulpal pathology and a good prognosis that the tooth has a reasonable period of retention and function. (EOB/EOP Remark Codes: MM320, EOB/EOP Remark Code: MM232)
8. 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 more than 50% of the tooth structure is sound) and the tooth has a good endodontic, periodontal and/or restorative prognosis. (EOB/EOP Remark Codes: MM330, MM300, MM331E, MM331P, MM331R)

Note: LIBERTY may determine that a different, more appropriate procedure code better describes the endodontic treatment performed and may make our determination based on the alternate code (EOB/EOP Remark Code: MM330M)

9. For apexification/recalcification (Codes D3351 – D3353), documentation is required that shows the apex of the tooth root(s) is/are incompletely developed. (EOB/EOP Remark Code: MM335)
10. 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 (EOB/EOP Remark Code: MM340P) and restorative (EOB/EOP Remark Code: MM340R) prognosis. (EOB/EOP Remark Code: MM340) 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

Note: LIBERTY may determine that the apical surgery requested could have a better/equivalent outcome with a different endodontic procedure code (EOB/EOP Remark Code: MM340M)

11. For a retrograde filling (Code D3430), documentation is required that shows evidence of medical necessity for a retrograde filling during periradicular surgery. (EOB/EOP Remark Code: MM3430)
12. For a surgical or endodontic implant procedure (Code D3460), documentation is required that shows evidence of medical necessity for the procedure. (EOB/EOP Remark Code: MM345)
13. Endodontic irrigation
    a. Providers are contractually obligated to not charge more than the listed copayment for covered root canal procedures whether the dentist uses BioPure, diluted bleach, saline, sterile water, local anesthetic and/or any

other acceptable alternative to irrigate the canal (EOB/EOP Remark Code: MMINC)

b. Providers may not unbundle dental procedures to increase reimbursement from LIBERTY or enrollees. The provider agreement and plan addenda determine what enrollees are to be charged for covered dental procedures. BioPure as an alternative allowed on LIBERTY dental plans at no additional cost, whether or not a choice is presented to the member.

PERIODONTICS

A. Evaluations
   1. 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 patient's periodontal status as being "within normal limits" (WNL).
   2. In many cases a periodontal screening activity such as visual inspection, PSR® (Periodontal Screening and Recording) evaluation of each sextant or other mechanism may provide sufficient information to make a diagnosis or treatment plan.
   3. Comprehensive oral evaluations should include the following:
      a. Quality and quantity of gingival tissue
      b. Documentation: six-point periodontal probing for each tooth
      c. The location of bleeding, exudate, plaque and/or calculus
      d. Significant areas of recession, mucogingival problems, level and amount of attached gingiva
      e. Mobility
      f. Open or improper contacts
      g. Furcation involvement
      h. Occlusal contacts or interferences
   4. After a comprehensive evaluation, a diagnosis and treatment plan should be completed.
   5. Sequential charting over time to show changes in periodontal architecture is of considerable value in determining treatment needed or evaluating the outcome of previous treatment.

B. Periodontal treatment sequencing
   1. Full mouth debridement to enable comprehensive evaluation and diagnosis (Code D4355) is "The gross removal of plaque and calculus that interfere with the ability of the dentist to perform a comprehensive oral evaluation. This preliminary procedure does not preclude the need for additional procedures." (CDT)(EOB/EOP Remark Code: MM430)
      a. In most cases, this procedure would be followed by a comprehensive evaluation at a subsequent appointment. This rescheduling may allow some initial soft tissue response and shrinkage before full mouth periodontal probing is performed.
      b. This procedure must be supported by radiographic or photographic evidence of heavy calculus, is not a replacement code for a prophylaxis and is not appropriate on the same day as procedure comprehensive oral evaluation or a comprehensive periodontal evaluation (codes D0150 or D0180). (EOB/EOP Remark Code: MM430)

2. Scaling in the presence of generalized moderate or severe gingival inflammation (Code D4346) is "The removal of plaque, calculus and stains from supra- and sub-gingival tooth surfaces when there is generalized moderate or severe gingival inflammation in the absence of periodontitis. It is indicated for patients who have swollen, inflamed gingiva, generalized suprabony pockets, and moderate to severe bleeding on probing. It should not be reported in conjunction with prophylaxis, scaling and root planing, or debridement procedures." (EOB/EOP Remark Code: MM4346)
    a. This procedure is for generalized moderate to severe gingival inflammation
    b. The ADA suggests that "generalized" would apply when 30% or more of the patient's teeth at one or more sites are involved, which is analogous to the AAP definition of generalized chronic periodontitis
    c. The Loe & Silness Gingival Index can be a guideline for defining "moderate to severe inflammation"
        i. Moderate inflammation - redness, edema, glazing; bleeding on probing
        ii. Severe inflammation - marked redness and edema, ulceration; tendency toward spontaneous bleeding
        iii. This is a therapeutic procedure, to treat a diagnosed disease.
        iv. It is based on a diagnosis, not on intensity of treatment required.
        v. It is appropriate for patients who do not have periodontitis (i.e. attachment loss).
        vi. It is performed after a periodic or comprehensive exam.
        vii. It can be performed on same date of service as the exam.
        viii. It is a full-mouth procedure, not a per-quadrant procedure.
        ix. Can be used for any age patient, and in any dentition stage (note that benefits vary by each member's plan design).
        x. "...in conjunction with..." means on the same date of service. Prophylaxis and scaling and root planing procedures may be performed at a future date, after Code D4346, as long as the codes thereafter are used appropriately
        xi. Periodontal Maintenance (Code D4910) is not appropriate as a follow-up to Code D4346, since Code D4346 isn't performed to treat periodontal disease
        xii. Consider this procedure code when the patient's periodontium is not healthy, and the periodontal disease diagnosis is limited to soft tissue (gingivitis) and is generalized but has not progressed to the advanced disease stage with bone loss (periodontitis)
        xiii. Should be submitted with documentation of periodontal chart and/or intra oral photos
3. Scaling and Root Planing or SRP (Codes D4341, D4342)
    a. Treatment involves the instrumentation of the crown and root surfaces of the teeth to remove plaque, calculus, biofilm and stains from these surfaces. The absence of calculus should be evident on post-treatment radiographs.
        i. This treatment is considered to be within the scope of a general dentist or a dental hygienist
        ii. It is common for radiographs to reveal evidence of bone loss of attachment and/or the presence of interproximal calculus. It is supported when full mouth periodontal pocket charting demonstrates at least 4 mm pocket depths. (EOB/EOP Remark Code: MM400) If LIBERTY determines

that there are too few teeth with a good prognosis in each quadrant, we may approve an alternate, more appropriate code (EOB/EOP Remark Code: MM400M)

iii. Scaling and root planing procedures (Codes D4341, D4342) are generally not performed in the same quadrants or areas for two years following initial completion of these services. In the interim, any localized scaling and root planing would be included within periodontal maintenance procedure (Code D4910)

b. Scaling and root planing is not meant to be reported for an enhanced prophylaxis. If there is no bone loss, a more appropriate code might be selected (Codes D1110 or D4346). Rather, it is the judicious removal of deposits on the root surface in the presence of periodontal disease. In most cases some form of local anesthesia would be indicated to properly render the scaling and root planing procedure. Thus, it would not be considered good clinical practice to perform scaling and root planing in the absence of anesthetic.
c. It would not be considered good clinical practice to perform more than two quadrants of SRP at the same visit (or, in most cases, on the same date of service) unless a medical or other condition is present that would justify such AND there is demonstration of sufficient clinical treatment time to adequately perform judicious scaling and root planing of the submitted quadrants. Per clinical review, in the absence of such information, LIBERTY may limit the approval to no more than two quadrants on any given date of service. (EOB/EOP Remark Code: MM401)
d. Definitive or pre-surgical scaling and root planing:
   a. For early stages of periodontal disease, this procedure is used as definitive non-surgical treatment and the patient may not need to be referred to a periodontist based upon tissue response and the patient's oral hygiene.
      i. For later stages of periodontal disease, the procedure may be considered pre-surgical treatment and the patient may need to be referred to a periodontist, again based on tissue response and the patient's oral hygiene
      ii. LIBERTY requires that both definitive and pre-surgical scaling and root planing be provided at a primary care facility before considering referral requests to a periodontal specialist
      iii. Local anesthetic 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
      iv. Home care oral hygiene techniques should be introduced and demonstrated
      v. A re-evaluation following scaling and root planing should be performed. This re-evaluation should be performed at least four to six weeks later and include: a description of tissue response; pocket depth changes; sites with bleeding or exudate; evaluation of the patient's homecare effectiveness.
e. It is usually not appropriate to perform Codes 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.

4. Periodontal maintenance (Code 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 patient's home care compliance and instructions should be documented.
    a. Periodontal maintenance and supportive therapy intervals should begin not less than four weeks following primary care treatment of periodontal disease, and should be individualized, although three-month recalls are common for many patients (EOB/EOP Remark Code: MM491)
    b. Periodontal Maintenance (Code D4910) may be allowed for three years (or longer) when there is a history of periodontal therapy evident in the patient's treatment record (by report, by LIBERTY record, or by narrative) (EOB/EOP Remark Code: MM490)
5. Periodontal Irrigation (Code D4921)
    a. Periodontal irrigation in the presence of significant gingival inflammation is an elective procedure needed when there is significant gingival inflammation (EOB/EOP Remark Code: MM4921). If an enrollee chooses to not have irrigation with other procedures (i.e., Codes D1110, D4355, D4341, D4342 or D4910), contracted dentists may not limit the enrollee's access to other benefited procedures.
    b. A patient's refusal of irrigation does not constitute grounds for requesting a patient transfer
6. Localized delivery of antimicrobial agents via a controlled release vehicle into diseased crevicular tissue, per tooth (Code D4381)
    a. Locally-delivered antimicrobials are defined by ADA as adjunctive to periodontal therapy and were intended for use in refractory or non-responsive periodontal pockets. It would not be considered good clinical practice within the standard application of Code D4381 to provide this service until after a clinical area was determined to be refractory or non-responsive to standard surgical or non-surgical pocket reduction techniques.
    b. Benefits are not available for localized delivery of antimicrobial when performed with Codes D4341 or D4342 in the same quadrant on the same date of service. (EOB/EOP Remark Code: MM438)
    c. Dentists may consider the appropriate use of local delivery antimicrobials for chronic periodontitis patients as an adjunct to periodontal scaling and root planing (Codes D4341 or D4342) AFTER the following steps:
        i. A clinician has completed periodontal scaling and root planing and allowed a minimum four-week healing period. Then, the patient's pockets are re-probed and re-evaluated to determine the clinical response to the scaling and root planing (EOB/EOP Remark Code: MM439)
        ii. Re-evaluation confirms that several teeth have localized residual pocket depths of 5 mm or greater, plus inflammation
        iii. LIBERTY dental consultants may approve a benefit for localized delivery of antimicrobial agents for non-responsive cases following scaling and root planing on a "by report" basis:
            - In such cases, benefits may be approved for two teeth per quadrant in any 12-month period (EOB/EOP Remark Code: MM439)

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

iv. Treatment alternatives such as systemic antibiotics or periodontal surgery instead of localized delivery of antimicrobial agents may be considered when:
- Multiple teeth with pocket depths of 5 mm or greater exist in the same quadrant
- Localized delivery of antimicrobial agents was completed at least four weeks after scaling and root planing but a re-evaluation of the patient's clinical response confirms that localized delivery of antimicrobial agents failed to control periodontitis (i.e., a reduction of localized pocket depths)
- Anatomical defects are present (i.e., intrabony defects)

7. Periodontal Surgical Procedures

a. Periodontal surgical procedures are covered when the following factors are present:

i. The patient should exhibit a willingness to accept periodontal treatment and practice an appropriate oral hygiene regimen before consideration for periodontal surgical procedures. (Documentation should include history, narrative and/or progress notes).

ii. Case history, including patient motivation to comply with treatment and oral hygiene status, should be documented. (Documentation should include history, narrative and/or progress notes).

iii. In most cases, there should be evidence of scrupulous oral hygiene for at least three months before the pre-authorization for periodontal surgery.

iv. Consideration for a direct referral to a periodontist would be considered on a "by report" basis for complex treatment planning purposes. However, the performance of scaling and root planing, oral hygiene instructions and other pre- and non-surgical procedures should be performed by the general dentist (before or after the periodontal consultation).

v. 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.

vi. Gingivectomy/gingivoplasty (Codes D4210 - D4212) periodontal pocket reduction surgical procedures may be covered when the pocket depths are five 5 mm or greater, following soft tissue responses to scaling and root planing documented at a periodontal maintenance procedure. Consideration should be given for long-standing pockets of five mm following previous surgical intervention, which may or may not require further surgical intervention. (EOB/EOP Remark Codes: MM402, MM4210)

vii. Gingival flap (Codes D4240 and D4241) procedures may be covered when the pocket depths are five mm or greater, following soft tissue responses to scaling and root planing documented at a periodontal maintenance procedure, and it is necessary to allow debridement of the

root surfaces and removal of granulation tissue. (EOB/EOP Remark Code: MM424)

viii. Periodontal osseous pocket reduction surgical procedures (Codes D4260 and D4261) may be covered when the pocket depths are five mm or greater following soft tissue responses to scaling and root planing documented at a periodontal maintenance procedure, and there is objective evidence of periodontal bone deformity. Consideration should be given for long-standing pockets of five mm following previous surgical intervention, which may or may not require further surgical intervention. (EOB/EOP Remark Code: MM4260)

If LIBERTY determines that there are too few teeth with a good prognosis in each quadrant, we may approve an alternate, more appropriate code. (EOB/EOP Remark Code: MM426M)

b. Periodontal osseous surgery pocket-reduction procedures:
    i. May not be covered if:
        a) Pocket depths are four mm or less and appear to be maintainable by non-surgical means (i.e., periodontal maintenance and root planing)
        b) Patients are smokers or diabetics whose disease is not being adequately managed
    ii. Periodontal pocket reduction surgical procedures should result in the removal of residual calculus and granulation tissue with improved physiologic form of the gingival tissues.
    iii. Osseous surgery and regenerative procedures should also correct and reshape deformities in the alveolar bone where indicated.

c. Clinical crown lengthening (hard tissue) (Code D4249)
    i. This procedure is used to allow a restorative procedure or crown with little or no tooth structure exposed to the oral cavity. (EOB/EOP Remark Code: MM440)

    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.
    ii. 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 tooth / tissue / bone architecture, substantially affecting the outcome of the prosthesis. (EOB/EOP Remark Code: MM441)
    iii. 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 patient a separate fee for Code D4249 if it is performed on the same tooth on the same day as preparation and final impressions for a crown.

d. Bone replacement grafting (Codes D4263 and D4264) in conjunction with osseous surgery involves the use of grafts to stimulate periodontal osseous regeneration when the disease process has led to a documented deformity of the bone surrounding a tooth or teeth. (EOB/EOP Remark Code: MM426)

e. Biologic materials and/or guided tissue regeneration (Codes D4265 – D4267) may be used during osseous surgery to help correct a documented deformity of the bone surrounding a tooth or teeth and is necessary to aid in osseous regeneration. (EOB/EOP Remark Code: MM425)
f. Soft or connective tissue grafting (Codes D4277 and D4278) may be used to correct a documented mucogingival defect when:
   i. Marginal tissue is insufficient, and the tooth or teeth have a good prognosis (EOB/EOP Remark Code: MM428) (i.e., periodontal prognosis (EOB/EOP Remark Code: MM428P), endodontic prognosis (EOB/EOP Remark Code: MM428E) and restorative prognosis (EOB/EOP Remark Code: MM428R))
   ii. Mucogingival grafting is required in presence of gingival recession or lack of keratinized gingiva and generally requires intra-oral photographic evidence of the mucogingival defect. (EOB/EOP Remark Code: MM427) Affected teeth must have good endodontic prognosis (EOB/EOP Remark Code: MM427E), periodontal prognosis (EOB/EOP Remark Code: MM427P) and restorative prognosis (EOB/EOP Remark Code: MM427R)

Note: LIBERTY may determine that the graft requested is better described under a different procedure code. (EOB/EOP Remark Codes: MM427M, MM428M).

8. Provisional splinting (Codes D4320 and D4321) may be necessary when documentation demonstrates the need for interim stabilization of mobile teeth (EOB/EOP Remark Code: MM432)

REMOVABLE PROSTHETICS

Processing Guideline: Providers may only submit claims for completed procedures; therefore, removable prosthetics should not be billed to LIBERTY before the delivery date.

A. Complete Dentures (Codes D5110 and D5120)
   1. Complete dentures are the appliances of last resort, particularly in the mandibular arch. Patients should be fully informed of their significant limitations. A complete denture may not be covered if some teeth are still present in the arch and extraction of the remaining teeth is not necessary. (EOB/EOP Remark Code: MM500)
   2. Establishing vertical dimension is considered to be a part of and included in the fee/process for fabricating a complete denture (standard, interim or immediate). Therefore, benefits for a complete denture are not limited or excluded in any way simply because of the necessity to establish vertical dimension.
   3. An immediate complete or removable partial denture includes routine post-delivery care, adjustments and soft liners for six months. A conventional complete or removable partial denture includes routine post-delivery care and adjustments and soft liners for three months.
   4. Proper patient education and orientation to the use of removable complete dentures should be part of the diagnosis and treatment plan. Educational materials regarding these prostheses are highly encouraged to avoid misunderstandings and grievances, and to manage patient expectations.
B. Immediate Complete Dentures (Code D5130 and D5140)

1. These covered dentures are inserted immediately after a patient's remaining teeth are removed. While immediate dentures give the patient the benefit of never having to be without teeth, they must be relined (refitted on the inside) during the healing period after the extractions have been performed.
2. An immediate complete denture includes routine post-delivery care, adjustments and soft liners for six months.
3. An immediate complete denture is not a benefit as a temporary denture. Subsequent complete dentures are not a benefit within a five-year period of an immediate denture.
4. If prior services are found to be clinically defective due to inadequate technical quality, the providers are expected to replace, or correct services rendered by them at no additional charge to the member.

C. Partial Dentures (Codes D5211 – D5281)
    1. A removable partial denture is normally not indicated for a single tooth replacement of non-functional second or third molars (i.e., no opposing occlusion).
    2. Removable partial dentures are generally indicated when posterior teeth (See MSM 1000 for specific coverage requirements) require replacement on both sides of the same arch or multiple edentulous areas are present (excluding non-functional second or third molars). (EOB/EOP Remark Code: MM520) Remaining teeth must have a good endodontic prognosis (EOB/EOP Remark Codes: MM250E, MM521E) and a good periodontal prognosis (EOB/EOP Remark Codes: MM520P, MM521P).
    3. An interim partial denture may be needed when the remaining teeth have a good prognosis and the patient has an existing partial denture that is not serviceable (EOB/EOP Remark Code: MM502) or an initial partial denture is being performed and the patient has several missing teeth on both sides of the same arch. (EOB/EOP Remark Code: MM504)
    4. For a treatment plan that includes both a fixed bridge and a removable partial denture in the same arch, the removable partial denture is considered the covered service.
    5. A unilateral removable partial denture is rarely appropriate. Best practices include replacing unilateral missing teeth with a fixed bridge or implant. (EOB/EOP Remark Code: MM520)
    6. Endodontic, periodontal and restorative treatment should be completed before fabrication of a removable partial denture.
    7. Abutment teeth should be restored before the fabrication of a removable partial denture and would be covered if the teeth meet the same standalone benefit requirements of a single crown.
    8. Removable partial dentures should be designed so they do not harm the remaining teeth and/or periodontal tissues, and to facilitate oral hygiene.
    9. Materials used for removable partial dentures must be strong enough to resist breakage during normal function, nonporous, color stable, esthetically pleasing, non-toxic and non-abrading to the opposing or supporting dentition.
    10. Partial dentures with acrylic clasps (such as Valplast or others, also known as "Combo Partials") are considered under the coverage for Codes D5213 and D5214.

D. Proper patient education and orientation to the use of immediate complete or partial dentures should be part of the diagnosis and treatment plan. Educational

materials regarding these prostheses are highly encouraged to avoid misunderstandings and grievances, and to manage patient expectations.

E. Replacement of an existing complete or partial denture:
   1. Removable complete or partial dentures are not covered for replacement if an existing appliance can be made satisfactory by reline or repair. (EOB/EOP Remark Codes: MM501, MM521)
   2. Complete or partial dentures are not covered if a clinical evaluation reveals the presence of a satisfactory appliance, even if a patient demands replacement due to their own perceived functional and/or cosmetic concerns.
F. Complete or partial denture adjustments (Codes D5410 – 5422):
   1. An immediate complete or removable partial denture includes routine post-delivery care, adjustments and soft liners for six months.
   2. A conventional complete or removable partial denture includes routine post-delivery care and adjustments for three months.
   3. A prospective or retrospective request for a complete or partial denture adjustment must include documentation that the appliance is ill fitting. (EOB/EOP Remark Code: MM541)
G. Repairs to complete and partial removable dentures (Codes D5511 – D5671) must include documentation that demonstrates the appliance is broken or in need of repair. (EOB/EOP Remark Code: MM560)
H. Relines for complete and partial removable dentures (Codes D5730 – D5761):
   1. Supporting soft tissues and bone shrink over time, resulting in decreased retention and/or stability of the appliance.
   2. A rebase or reline of a partial or complete denture would be covered (subject to plan limitations) if documentation demonstrates that the appliance is ill fitting and may be corrected by rebasing or relining, resulting in a serviceable appliance. (EOB/EOP Remark Code: MM570)
I. Interim removable partial dentures (Codes D5820 and D5821)
   1. These appliances are only intended to temporarily replace extracted teeth during the healing period, before fabrication of a subsequent, covered, fixed or removable partial denture. Benefits may not exist for both an interim and definitive partial denture.
   2. The submitted documentation must show that the existing partial denture is unserviceable. (EOB/EOP Remark Code: MM582)
   3. Removable partial dentures are covered when posterior teeth require replacement on both sides of the same arch or multiple edentulous areas are present (excluding non-functional second or third molars) and the remaining teeth have a good prognosis. (EOB/EOP Remark Codes: MM583, MM483M)
J. Tissue conditioning (Codes D5850 and D5851) may be required when documentation shows that the tissue under a removable appliance is unhealthy or must be treated before a new appliance is made or an existing one is rebased or relined. (EOB/EOP Remark Code: MM585)
K. A precision attachment (Code D5862) or the replacement of a part of a precision or semi-precision attachment requires documentation that it is medically necessary to stabilize a removable appliance. (EOB/EOP Remark Code: MM586)

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 patient.
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 (within the next six months) (EOB/EOP Remark Code: MM710) or a patient complaint of acute pain.
3. Extractions may be indicated in the presence of non-restorable caries, untreatable periodontal disease, pulpal and periapical disease not amenable 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. (EOB/EOP Remark Code: MM721)
   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. (EOB/EOP Remark Code: MM700)
      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. (EOB/EOP Remark Code: MM722) 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. (EOB/EOP Remark Code: MM722M)

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 decisive factor in determining coverage.

B. Other Surgical Procedures
   1. Residual tooth roots (Code D7250) may need to be removed when the residual tooth root is pathological or is interfering with another procedure (EOB/EOP Remark Code: MM725)
   2. Sinus perforation or oroantral fistula closure (Code D7260) requires documentation that there is a pathological opening into the sinus (EOB/EOP Remark Code: MM726)
   3. Tooth re-implantation and/or stabilization of an accidentally evulsed or displaced tooth (Code D7270) requires documentation that a tooth or teeth has been accidentally evulsed or displaced (EOB/EOP Remark Code: MM727)
   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 (EOB/EOP Remark Code: MM728)
   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 (EOB/EOP Remark Code: MM729)

C. Alveoloplasty-Preparation of Ridge (Codes D7310 – D7321) requires documentation that demonstrates the medical necessity for the surgical recontouring of the alveolus. (EOB/EOP Remark Code: MM731)
D. 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. (EOB/EOP Remark Code: MM741)
E. Excision of bone tissue (Codes D7472 and D7473) (an exostosis) requires documentation that a bony growth interferes with the ability to function or wear a prosthesis. (EOB/EOP Remark Code: MM747)
F. Incision and drainage of an abscess (Codes D7510 - D7521) requires documentation that shows an oral infection requiring drainage. (EOB/EOP Remark Code: MM751)
G. Removal of a foreign body (Code D7530), non-vital bone or a tooth fragment requires documentation that it is medically necessary to remove it. (EOB/EOP Remark Code: MM753)
H. Open/closed reduction of a fracture (Codes D7610 – D7640) requires documentation that demonstrates evidence of a broken jaw. (EOB/EOP Remark Code: MM760)
I. 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. (EOB/EOP Remark Code: MM781)
J. 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. (EOB/EOP Remark Code: MM791)

K. A frenulectomy (Code D7960) requires documentation that demonstrates evidence that a muscle attachment is interfering with proper oral development or treatment. (EOB/EOP Remark Code: MM796)
L. 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. (EOB/EOP Remark Code: MM797)
M. 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. (EOB/EOP Remark Code: MM7971)

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. (EOB/EOP Remark Code: MM911)
  2. Fixed Partial Denture Sectioning (Code D9120)
     a. This procedure involves separation of one or more connections between abutments and/or pontics when some portion of a fixed prosthesis is to remain intact and serviceable following sectioning and extraction or other treatment. It includes all recontouring and polishing of retained portions.
     b. The submitted documentation must show it is medically necessary to section and remove part of a fixed partial denture and that the remaining tooth or teeth has a good prognosis. (EOB/EOP Remark Code: MM912)

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. (EOB/EOP Remark Code: MM921)
  2. Deep Sedation/General Anesthesia or Intravenous moderate sedation/analgesia (Codes D9223 and D9243). For dental codes related to general or IV anesthesia, the provider must show the actual beginning and end times in the recipient's dental record
     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 with the patient. Anesthesia services are considered completed when the patient may be safely left under observation of trained personnel and the doctor may leave the room.
     b. The level of anesthesia is determined by the anesthesia provider's documentation of the anesthetic's effect upon the central nervous system and does not depend on the route of administration. It is expected that dentists performing anesthesia on patients 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 (EOB/EOP Remark Code: MM920):
    i. A medical condition that requires monitoring (e.g., cardiac, severe hypertension);
    ii. An underlying medical condition exists which would render the patient non-compliant without the GA or IV sedation (e.g., cerebral palsy, epilepsy, developmental/intellectual disability, Down 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 treatment with GA or IV sedation in a dental office setting must be clearly documented in the patient's dental record and submitted by the treating dentist;
    b. Pre-authorization and submission requirements:
        i. Before GA or IV sedation is performed in a dental office setting, all necessary medical and dental documentation, including the dental treatment plan, must be reviewed and approved by LIBERTY.
        ii. Submit the patient'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.
        iii. Submit a written narrative documenting the medical necessity for general anesthesia or IV sedation;
        iv. Treatment rendered as an emergency, when pre-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.
    c. 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.
4. The following oral surgical procedures may qualify for GA or IV Sedation:
    a. Removal of impacted teeth;
    b. Surgical root recovery from maxillary antrum (sinus);
    c. Surgical exposure of impacted or unerupted cuspids (for orthodontic cases, the orthodontic treatment must have been approved in advance);
    d. Radical excision of lesions in excess of 1.25 cm.
    e. Children under the age determined by applicable state regulations with an extensive treatment plan may qualify for a GA or IV sedation benefit.
5. Use of nitrous oxide (Code D9230) requires documentation of medical necessity to alleviate discomfort or anxiety associated with dental treatment (once per visit). (EOB/EOP Remark Code: MM923)
    a. *Processing Guideline: Nitrous Oxide is considered inclusive with Non-Intravenous Conscious Sedation (Code D9248).*

6. Non-intravenous Conscious Sedation (Code D9248) (includes non-IV minimal and moderate sedation)
    a. This is a medically controlled state of depressed consciousness that still maintains the patient's airway, protective reflexes and ability to respond to stimulation or verbal commands. It includes non-intravenous administration of sedative and/or analgesic agent(s) and appropriate monitoring.
        i. The submitted documentation must demonstrate the medical necessity of non-IV conscious sedation. (EOB/EOP Remark Code: MM924)
        ii. The level of anesthesia is determined by the anesthesia provider's documentation of the anesthetic's effect upon the central nervous system and does not depend on the route of administration.

C. Professional Consultation (Code D9310)
    1. This is a patient encounter with a practitioner whose opinion or advice is sought 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.
        a. *Processing Guideline: Code D9310 will not be paid if definitive services are performed on the same date of service.*
    3. The submitted documentation must demonstrate the medical necessity of assistance in determining the treatment required for a specific condition. (EOB/EOP Remark Code: MM931)

D. Professional Visits (Codes D9410 and D9420)
    1. Hospital, house, extended care or ambulatory surgical center call
        a. Includes nursing homes, long-term care facilities, hospice sites, institutions, hospitals or ambulatory surgical centers.
        b. Services delivered to the patient 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. (EOB/EOP Remark Code: MM942)
    2. Office visit for observation or case presentation during or after regularly scheduled hours (Code D9440)
        a. This is for an established patient 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 or after regularly scheduled office hours. (EOB/EOP Remark Code: MM943)

E. Drugs (Codes D9610 – D9630)
    1. Administration of one or more parenteral drugs or dispensing of drugs or medicaments for home use requires documentation demonstrating the medical necessity of the drugs or medicaments for treating a specific condition. (EOB/EOP Remark Code: MM963)

F. Miscellaneous Services
    1. Treatment of post-surgical complications or unusual circumstances (by report) (Code D9930) must provide documentation demonstrating the medical necessity of the procedure.
    2. Occlusal Guard (Code D9940)
        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 of fabricating, adjusting or repairing/relining an occlusal guard to minimize the effects of bruxism or TMJ symptoms/pathology. (EOB/EOP Remark Code: MM994)

RETROSPECTIVE REVIEW

Prospective and retrospective review will require documentation that demonstrates medical necessity. This documentation can include diagnostic radiographic or photographic images (EOB/EOP Remark Code: MM0350), 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 pre-authorized will require documentation confirming that the procedure(s) was (were) completed as authorized and within the standard of care as defined by Liberty Dental Plan's Criteria Guidelines and Practice Parameters. (EOB/EOP Remark Code: MMPROG)

SECTION 9 - SPECIALTY CARE REFERRAL GUIDELINES

The following guidelines outline the specialty care referral process. Failure to follow the referral process may cause delays in treatment.

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

Non-Emergency Specialty Referral Submission and Inquiries

The primary care dentist must submit a referral request to the Plan for prior approval. The three options for submitting a specialty care referral are:

Provider Portal: www.libertydentalplan.com
Fax: **888.401.1129**
Mail: LIBERTY Dental Plan
Attn: Referral Department
P.O. Box 401086
Las Vegas, NV 89140

If no contracted LIBERTY specialist is available within a reasonable distance of your office, Member Services will provide assistance in referring the member to a non-contracted specialist.

If a referral is made by the member's assigned primary care dentist without prior approval, the referring office may be held financially responsible. Failure to use the proper referral request and submit accurate information may delay claim processing or payment.

The LIBERTY Specialty Care Referral Request must be completed and used when making a referral. Radiographs and other supporting documentation will not be returned. It is highly recommended not to submit original radiographs. Radiograph copies of diagnostic quality, including paper copies of digitalized images, are acceptable.

Emergency Referral

Emergency referrals apply when members are experiencing pain, swelling, bleeding or trauma. If an emergency specialty care referral is needed, the Referral Unit can issue an emergency authorization number to the primary care dentist by calling LIBERTY's Referral Unit at **888.700.0643** Option 2.

Referral Guidelines for the Primary Care Dentist

Specialty care referrals for endodontic, periodontic and oral surgical procedures are required if services are beyond the scope of the primary care dentist. The member's primary care dentist must initiate the referral request=. The specialty care referral request should be submitted to LIBERTY along with radiograph(s) and supporting documentation. Referrals to a pediatric dentist are not required.

FQHCs and Indian Health Service facilities can directly refer members to a contracted specialist.

The primary care dentist should confirm the need for a referral and that the referral criteria are met. Complete a LIBERTY Specialty Care Referral Request and provide the:

- Member's name, LIBERTY identification number, group name and group number
- Name, address and telephone number of the contracted LIBERTY network specialist
- Procedure code(s) and tooth number(s), which requires referral

Inform the member that:

- Only services approved by LIBERTY will be covered;
- The member will be financially responsible for non-covered services provided by the Specialist;
- Payment by the Plan is subject to eligibility at the time services are rendered.

Referral Guidelines for Specialist

The specialist should obtain the LIBERTY Specialty Care Authorization and pre-operative radiograph(s) from LIBERTY Dental Plan, the primary care dentist or the member.

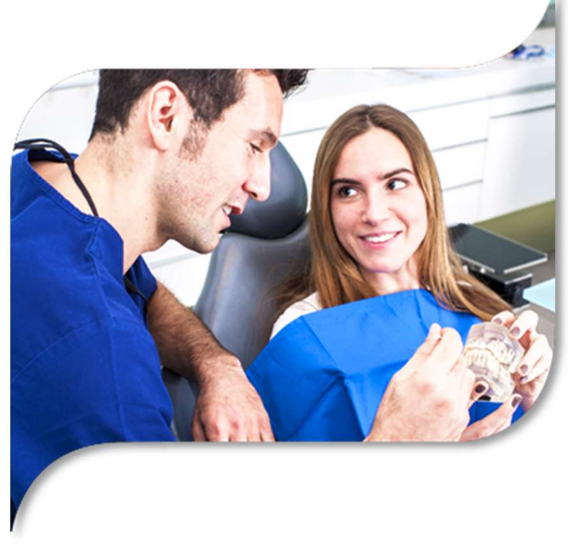
For any services not listed on the original authorization form from LIBERTY Dental Plan, you must submit a prior authorization request to the Plan with a copy of pre-operative radiograph(s) and a copy of the member's LIBERTY Specialty Care Authorization.

If an emergency service is needed but has not been listed on the original authorization form, contact LIBERTY's Referral Unit at **888.700.0643** for an emergency authorization number.

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

SECTION 10- QUALITY MANAGEMENT

Purpose, Goals and Objectives



Purpose

The purpose of LIBERTY Dental Plan's (LIBERTY) Quality Management and Improvement Program (QMI) is to ensure that licensed dentists are reviewing the quality of care provided, that quality-of-care problems are identified and corrected, and that follow-up is planned when indicated. The QMI Program continuously and objectively assesses dental patient care services and systems for all members, including members with special healthcare needs. Ongoing monitoring of compliance with prescribed standards ensures a constant process of quality improvement that encompasses clinical and nonclinical functions.

LIBERTY's QMI Program provides a structured and comprehensive review of the quality and appropriateness of care delivered by the entire network of dental providers. LIBERTY documents all quality improvement initiatives, processes and procedures in a formal QMI Plan. The Dental Director, or his/her designee, oversees the QMI Program and ensures that day-to-day quality assurance functions are carried out in compliance with dental program contracts and applicable requirements.

Goals/Objectives

The goal of the QMI Program is to comprehensively identify and address the quality of dental care and service to our members. The QMI Program provides a review of the entire range of care to establish, support, maintain and document improvement in dental care. These goals are achieved through the ongoing, objective assessment of services, systems, issues, concerns and problems that directly and indirectly influence the member's dental health care.

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

Program Scope
LIBERTY's QMI Program includes the following components: dental management, credentialing, standards of care, dental records, utilization review, peer review, environmental health and safety/infection control, member rights and responsibility, and member and provider grievances. The QMI document describes the programs and processes and activities that make up this integrated effort.

- Providing immediate and responsive feedback to members, providers, and the public as appropriate
- Policy and procedure development
- Annual QMI evaluation and report
- Annual QMI Work Plan development
- Identification of quality issues and trends
- Monitoring of quality measurements
- Quality-of-care focus studies
- Monitoring of the provider network
- Review of acceptable standards of dental care
- Continuing provider education
- Member health education

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

- **Accessibility of care**: the ease and timeliness with which patients can obtain the care they need when they need it by network providers
- **Appropriateness of care**: the degree to which the correct care is provided, given the current community standards
- **Continuity of care**: the degree to which the care patients need is coordinated among practitioners and is provided without unnecessary delay
- **Effectiveness of care**: the degree to which the dental care provided achieves the expected improvement in dental health consistent with the current community standard
- **Safety of the care environment**: the degree to which the environment is free from hazard and danger to the patient.

Program Content and Committees

- **Quality Assurance Review**: The Quality Assurance Review process is intended to assess the structure, process and outcome of dental care provided under LIBERTY's programs. The quality assessment's goal is to identify any significant

deficient areas, so quality improvement actions may be taken to ensure the office meets professionally recognized standards.

- **Pre-Contractual Facility Review:** When required by client or regulation, a pre-contractual facility audit is conducted as a part of the initial contracting process. An applicable On-Site Assessment Structural Review audit tool will be used, and the audit will be performed by a trained and calibrated auditor. A non-passing score must be reviewed by the Dental Director, or designee, to determine whether a Corrective Action Plan (CAP) must be implemented before active provider status is received.
- **Focus Reviews:** The Dental Director or designee may determine the need for focus reviews triggered by various findings such as potential quality issues (PQIs), grievances, utilization outlier status, potential fraud, waste or abuse or other administrative reasons.

Upon identification of a potential quality issue, LIBERTY's Dental Director, or designee, may conduct or direct an on-site Quality Assurance Reviews of provider offices; and gather facts and information to support corrective action plans necessary to ensure offices are in compliance with the QM Guidelines and Standards. The offices are monitored to ensure providers attain a sufficient level of compliance, and follow up activities are undertaken at least quarterly or more frequently if warranted. If deficiencies and issues remain, LIBERTY's QMI Committee will determine additional corrective actions and may recommend the office be terminated from the network.

- **Credentialing**: LIBERTY's Credentialing Program includes initial credentialing and re-credentialing at 36-month intervals of all primary and specialty care dentists listed in the Provider Directories. Pertinent findings are reviewed quarterly or more frequently if deemed necessary during Credentialing Committee meetings. Quality-of-care issues are then referred to the Peer Review Committee for recommendations and further action.

- **Peer Review Committee (PRC)**: The Peer Review Committee is responsible for identification and resolution of quality of care issues. Potential quality issues are identified through various means, including but not limited to the review of grievance and appeal patterns, onsite audit scores, as well as provider utilization data. The PRC is focused improving care to members and minimizing potential risk cases, identifying trends of questionable care and developing corrective action plans to ensure resolutions. The PRC, identifies opportunities for improvement, with the goal of examining complex cases and options for treatment across the spectrum of care. LIBERTY's Peer Review activities routinely include the participation of providers and specialists when appropriate.

- **Potential Quality Issues (PQIs)**: As part of the QMI Program, LIBERTY has policies and procedures in place that allow us to investigate PQIs from a variety of sources, and then routinely collate quality information about providers. LIBERTY commonly investigates PQIs from grievances ruled against the dental provider, office onsite assessments with deficient critical or structural indicators, aberrant utilization patterns, significant departure from expected contractual behavior or compliance, external vendor and business partner identification, and others. The Dental Director or designee reviews each case to assess the quality of care/service provided and provides a determination for corrective action based on the severity of an individual case. Follow-up actions, including provider counseling and/or CAPs are required of all involved providers for whom a quality-of-care or service issue is confirmed.

- **Grievance:** The grievance unit investigates and resolves issues for the services or operations that are the subject of concern and ensures that issues presented by LIBERTY members are resolved in a fair and timely manner. LIBERTY's grievance and appeal program, policies and procedures are consistent with applicable program, state and/or federal requirements.

- **Utilization Data Review:** The goal of the UM Committee is to maximize the effectiveness of care provided to the member. The UM Committee monitors over and underutilization of services, identifies treatment patterns for analysis and ensures that utilization decisions are made in a timely manner which accommodate the urgency of the situation and minimizes any disruption in the provision of care.
- **Access and Availability**: LIBERTY's AA Committee has established standards for geographic access and for timeliness of preventive care appointments, routine appointments, urgent appointments, emergency care, after hours care access, wait time in the provider office, and elements of telephone service Opportunities for improvement are identified, decisions are made, and specific interventions are implemented to improve performance where needed. Compliance with access and availability standards are monitored and CAPs are developed if deficiencies occur. Activity is reviewed by the QMI Committee quarterly, or more frequently, if necessary.
- **Health Education and Promotion/Outreach**: LIBERTY's Health Education Department communicates with and educates its participating dental providers about available health education and improvement services and programs. On a regular basis, the Health Education Department communicates a summary of health education and promotion activities to the QMI Committee.

- **Dental Disease Management**: LIBERTY's innovative Disease Management Program is designed to support the clinician-patient relationship plan of care and help bridge the gap between oral health and systemic health. Our program emphasizes prevention of disease-related exacerbations and complications using evidence-based practice guidelines and patient empowerment tools. The goals of this

program include improving patient self care through education, monitoring, and communication; improving communication and coordination of services between patient, dentist, physician and plan; and improving access to care, including prevention services. As part of our quality initiative, LIBERTY works closely with our client partners to coordinate and implement this program.

- **Cultural and Linguistic Competency (CLC):** LIBERTY establishes processes and procedures for providing support, maintaining compliance and creating cultural awareness for all members, providers and associates. As part of the CLC Program, information about language (spoken and written), race and ethnicity information is gathered and analyzed. LIBERTY monitors and assures that its delegated entities provide all services, conform to regulations, and develop all reports and assessments as specified by applicable regulations and agencies.

Measurement Monitoring

LIBERTY assesses clinical and non-clinical aspects of quality activities and performance improvement. We monitor and evaluate performance using objective quality indicators which identify required measures and corresponding opportunities for improvement. LIBERTY also complies with standards developed by NCQA and the American Dental Association to ensure that measures reflect best practices of dental health care. LIBERTY conducts annual member and provider satisfaction surveys. Member satisfaction surveys assess the quality and appropriateness of care to members, while provider satisfaction surveys summarize and provide analysis of opportunities for improvement. Other opportunities to implore member and provider input include:

- Member
    - Correspondence sent to our Member Services Department
    - Grievance and appeal actions
    - Call center interaction with members
- Provider
    - Training seminars
    - Visits to provider offices
    - Local/regional meetings
    - Participation in dental associations and other dental organizations
    - Call center interaction with members

Provider Collaboration

LIBERTY's goal is to join forces with providers to actively improve the quality of care provided. Providers are contractually required to cooperate with the signed provider agreement as well as ongoing QMI goals. Timely collaboration is expected regarding the following activities:

- Completion of a Participating Provider Agreement
- Distribution of a LIBERTY Provider Reference Guide to each provider

- Each applying dentist's completion of a provider profile form, which gives us the information needed to conduct a first-level assessment of the dentist's qualifications
- A comprehensive credentialing process that adheres to NCQA standards
- Targeted structural and/or process audits of providers who have been identified through utilization analysis and grievance and satisfaction data as having potential quality issues
- Random structural reviews that assess the provider's physical facility, as well as the provider's office protocols regarding emergencies, booking appointments, sterilization and related procedures
- Chart audits that assess the provider's process of care and conformity with professional dental practice, appropriate dental management and quality of care standards
- re-credentialing of each network provider every 36 months
- A formal provider dispute resolution process
- Establishing quality improvement goals in areas where the provider does not meet LIBERTY's standards or improvement goals.

Quality assurance activities are continuously communicated to providers through our PR staff. Communication methods include:

- Initial and continuing training programs
- Provider newsletters and fax blasts
- Online notices
- Local and regional meetings to discuss and identify issues relating to claims, enrollment and any other issues that the provider can identify
- Provider satisfaction surveys
- Onsite office visits

For more information and access to LIBERTY's Network Management policies, please visit the Provider Resource Library on our website at:
https://www.libertydentalplan.com/Providers/Provider-Resource-Library.aspx

Corrective Action Plans (CAP)

The Dental Director can recommend remedial action in the form of a CAP and follow-up whenever inappropriate dental care is identified, including overutilization of services that unfavorably affect patient care, underutilization of needed services, insufficient accessibility or availability of services, inappropriate referral practices or breaches in LIBERTY policy regarding benefit applications and charges. Corrective action begins with notifying the provider of the observed deficiencies and providing an explanation of actions required or recommended to correct the deficiencies. Corrective measures may include:

- Clinical peer review
- Special claims review
- Referral to the applicable state dental board
- onsite assessments

- Mandatory prior authorization
- Member enrollment restrictions
- Termination of the provider agreement.

Utilization Management

LIBERTY's UM Program ensures access to care while maintaining quality and cost effectiveness. One of our primary responsibilities is to conduct utilization reviews to determine whether treatments meet each plan's criteria and generally accepted standards of care. We determine whether or not to authorize, modify or deny dental services based on review of radiographs, if required, and other information provided by the treating dentist.

Other UM activities include:

- Establishing dental necessity criteria
- Establishing thresholds for acceptable utilization levels
- Implementing mechanisms to evaluate overutilization and underutilization
- Determining sanctions for provider non-compliance
- Identifying potential quality issues and referrals to the QIC
- Conducting structural reviews of newly enrolled providers' offices, along with targeted onsite reviews
- Conducting peer review of UM activities by evaluating utilization data reporting, appeal requests and provider profiling
- Reporting to the QIC and dental director regarding overall UM Program effectiveness.

The process of waste, abuse and fraud detection provides an excellent example of how the UM Program operates within the QM Department. Suspected cases of waste, abuse or fraud often originate in the QM Department because, that department monitors provider and member activity to detect inconsistencies with professionally recognized standards of dental care, the potential for increased resource consumption resulting from reimbursement for unnecessary dental care, and underutilization and overutilization trends.

EDUCATIONAL ACTIVITIES

LIBERTY conveys information to providers, members and staff to help ensure their understanding of clinical and administrative issues. The Provider Relations Department coordinates and implements training and continuing education for providers.

While the QM Department has no direct responsibility for educational activities, it tracks these activities because they are an integral component of many quality improvement initiatives; such as member and provider satisfaction surveys results, which help identify topics for future educational activities.

Disciplinary Action – When LIBERTY identifies a quality issue or trend that is severe enough to be reportable, the QMI Committee acts in accordance with LIBERTY's policies and procedures. This includes the judicial review procedure, if requested by the provider. The CAP will be reported to the State Board of State Examiners and the National Practitioner Data Bank.

Credentialing / Re-credentialing
LIBERTY's Credentialing Program is designed to assure that members have access to qualified dentists who demonstrate a commitment to providing quality health services in a managed care setting. The scope of the Credentialing Program includes initial credentialing and re-credentialing at 36-month intervals of all primary and specialty care dentists listed in the Provider Directories. Pertinent findings are reviewed at least quarterly. Quality-of-care issues are then referred to the PRC for recommendations.

For a comprehensive listing of the specific Network Credentialing Qualifications and Criteria, please visit our website at https://www.libertydentalplan.com/Providers/Join-Our-Network/Credentialing.aspx

LIBERTY's Quality Management Department also oversees an extensive credentialing process for reviewing and accepting or rejecting the professional credentials of each of our applicant and contracted dental providers. Among other reviews, we perform required individual background history checks on our providers, and review information from the applicable Board of Dental Examiners and other pertinent provider sanction and licensure reports during Credentialing Committee meetings.

Provider Exclusion Screenings
LIBERTY is committed to preventing individuals and entities that are excluded, debarred, suspended, or are otherwise ineligible to participate in federal or state health care programs, procurements, or non-procurement programs, from direct or indirect affiliation with our company. Since government programs make up the vast majority of our business, we have rigorous internal protocols in place to ensure we conduct all required exclusion screenings upon initial engagement and at least monthly thereafter and, for non-contracted providers, before payment; that screenings are properly tracked and monitored; that we immediately and appropriately verify and report exclusions to required oversight agencies, and properly pursue any required recoupment; and that we maintain all relevant screening documentation for at least 10 years.

The exclusion screenings we perform include an automated, electronic review of the following databases:

- The United States Department of Health and Human Services, Office of Inspector General's ("OIG") List of Excluded Individuals/Entities ("LEIE")
- The General Service Administration's ("GSA") Excluded Parties List System ("EPLS")
- State Medicaid Inspector General's Lists of Restricted, Terminated or Excluded Individuals or Entities
- The Office of Foreign Assets Control – Specifically Designated Nationals (OFAC)

In addition, upon initial contract, and at least annually thereafter, LIBERTY requires each participating provider to disclose any person or entity with an ownership interest of five percent or more in the provider's office, including disclosure of all owner affiliates and subsidiaries. LIBERTY screens any entities/individuals the provider discloses against the required databases.

Member Grievances and Appeals

The grievance and appeals process encompasses investigation, review, and resolution of member and provider issues submitted to LIBERTY. Providers are **contractually required** to provide LIBERTY with copies of all member records requested as a result of a member grievance and/or appeal. All providers are **obligated** to respond to LIBERTY with a written response to the member's concerns and include supporting documentation; e.g., clinical notes, treatment plans, financial ledgers, radiographs, etc. Failure to cooperate/comply with the grievance and/or appeals process or resolution may lead to disciplinary actions, including termination from the LIBERTY network.

LIBERTY's grievance and/or appeals system also addresses the linguistic and cultural needs of its members as well as the needs of members with disabilities. The system is designed to ensure that all Plan members have access to and can fully participate in the grievance system. LIBERTY provides translation services for members whose primary language is not English. Grievance and/or appeals forms can be obtained from LIBERTY's Member Services Department, from a dental provider facility, or from the LIBERTY website. ***All contracted provider facilities are required to display member complaint forms.*** Nevada Medicaid members do not have a filing limitation and may file a grievance at any time.

LIBERTY resolves member and provider grievance and/or appeals within 30 calendar days of receipt. The Grievance Analyst mails notification of the receipt of the grievance and/or appeal to the member and/or provider within **five business days**.

Expedited Grievances and/or Appeals

Members and providers can file an expedited grievance and/or appeal if they feel the member's health will be harmed by waiting 30 days for treatment. Criteria for an expedited grievance/appeal include severe pain, bleeding, swelling or loss of life or bodily functions. If the Dental Director or Dental Consultant determines that the appeal does not qualify for expedited processing, the member is immediately notified by phone that the case will be reviewed under the standard guidelines; and notified in writing within two calendar days.

The timeframe for expedited case review may be extended up to 14 calendar days at the member's request. LIBERTY may also request an extension up to 14 calendar days if

there is a need for additional information that would be in the best interest of the member.

Provider Grievances and Appeals

Contracted or non-contracted providers may submit any concerns, including quality of Plan services, policy and procedure issues or any other concerns that do not involve claim disputes to LIBERTY's Quality Management Department. Grievances and/or appeals may be submitted to LIBERTY verbally or in writing, including cases from DHCFP and other sources.

Providers may also submit claim disputes challenging, appealing or requesting reconsideration of a claim (or a bundled group of substantially similar multiple claims that are individually numbered) that has been denied, adjusted or contested or seeking resolution of a billing determination or disputing a request for reimbursement of an overpayment.

Each contracted provider grievance and/or appeal must contain, at a minimum, the following information: provider's name, license number, contact information, and:

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

LIBERTY will resolve provider grievance or appeal submitted on behalf of a member through the Member Grievances and Appeals Process; however, providers may only assist a member with filing a grievance or appeal when the provider has received written consent from the member to do so.

Sending a provider grievance or appeal to LIBERTY must include the information listed above for each case/concern in question. All contracted provider disputes must be sent to the Quality Management Department at the address listed below or fax at **833.250.1817** or via email at NVGandA@libertydentalplan.com.

LIBERTY Dental Plan
6385 S. Rainbow Blvd., Ste 200
Las Vegas, NV 89118
ATTN: Quality Management Department

The Peer Review Committee reviews member/provider grievance and appeals pertaining to LIBERTY's providers and members. The Peer Review Committee monitors patterns or trends to formulate policy changes and generate recommendations as needed.

Time Period for Submission of Provider Grievance and Appeals

LIBERTY must receive provider grievances and/or appeals within **90 calendar days** from LIBERTY's action that led to the dispute (or the most recent action if there are multiple actions). In the event of LIBERTY's inaction, provider grievance and/or appeals must be received within 90 calendar days after the provider's time for contesting or denying a claim (or most recent claim if there are multiple claims) has expired.

Provider grievance and/or appeals that do not include all required information will be returned to the submitter for completion. An amended contracted provider grievance and/or appeal, which includes the missing information, may be submitted to LIBERTY within 30 business days of your receipt of a returned contracted provider dispute.

Acknowledgment of Contracted Provider Grievance and Appeals

LIBERTY will acknowledge all provider grievance and appeals within **five business days** of receipt.

Provider Grievance and Appeal Inquiries

All inquiries regarding the status of a provider grievance and/or appeal or about filing a provider grievance or appeal must be directed to the Quality Management Department at **1.866.609.0418.**

Appeals

Both providers and members may appeal any resolution made by LIBERTY. The Grievance Analyst will compile all the information used in the initial determination and any additional information received and forward it to the committee. LIBERTY personnel determining a member's or provider's appeal must have no prior involvement in the decision and no vested interest in the case.

LIBERTY abides by all state and federal regulations with respect to continuation of benefits throughout the appeal and fair hearing process. LIBERTY will continue member benefits when all the following have been met:

- The appeal is received within 10 days following LIBERTY's notice of action or the intended effective date of a proposed action
- The appeal is associated with the termination, suspension or reduction of previously authorized services
- The appealed services were ordered by an authorized LIBERTY dental provider
- The original time period covered by the initial authorization has not expired
- The member specifically requests an extension of benefits

When a member has requested and received continuation of benefits during an appeal, LIBERTY will ensure that the member benefits are continued until one of the following has been met:

- The member withdraws the appeal

- 10 days have passed since LIBERTY issued the notice of action to the member, providing the resolution of the appeal as unfavorable, unless within the 10-day timeframe, the member or provider has requested a State Fair Hearing with continuation of benefits
- A State Fair Hearing determination unfavorable to the member was made
- The original time period covered by the initial authorization has been met or has expired

Fair Hearing

All members, providers, other designees and/or legal representatives of a deceased member's estate have the right to request a State Fair Hearing. Appeals with one or more of the following will be eligible for the State Fair Hearing process:

- Denial or limited authorization of requested services
- Reduction, suspension or termination of a service previously authorized
- Denial, in whole, of in part, of payment for a service
- Failure on LIBERTY's behalf to meet specified time frames
- Denial of disenrollment for good cause

The member and provider has the right to ask for a fair hearing from the state after LIBERTY's internal appeal process has been exhausted. If LIBERTY's decision on a grievance or appeal is still unsatisfactory, a State Fair Hearing can be requested by calling the Nevada Medicaid Hearings Unit at **1.775.684.3704**, or you may send it in writing to:

Nevada Division of Health Care Financing and
Policy Hearings
1100 East William Street, Suite 204
Carson City, NV 89701

You must ask for this hearing within **<u>120 calendar days</u>** of receiving the final appeal notice from LIBERTY. If LIBERTY or a State Fair Hearing office decides to overturn a denied authorization of services and the member receives the disputed services while the appeal is pending, LIBERTY will issue payment for those services promptly and expeditiously as possible.

If you need information or help, call the State Medicaid Office at:

Las Vegas: 702.668.4200 or 1.800.992.0900
Carson City: 775.684.3651 or 1.800.992.0900

If you need legal assistance, call the Legal Services Program:

Clark County: 702.386.0404 or 1.866.432.0404
Washoe County: 775.284.3491 or 1.800.323.8666

If you need information or help, call us at:

Toll-Free: 1.866.609.0418
TTY/TTD: 1.877.855.8039

SECTION 11 - FRAUD, WASTE AND ABUSE; AND OVERPAYMENT

LIBERTY Dental Plan is committed to conducting its business in an honest and ethical manner and to operating 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 comply 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 will exercise their best independent judgment when deciding which services to order for their patients.

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 and state false claims laws which make a person liable to pay damages to the government if he or she knowingly:

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

As a provider, you are responsible to:

- Comply with all federal and state laws and LIBERTY requirements regarding fraud, waste, abuse and overpayment

- Ensure 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 you provide and bill only for services to members that are medically necessary and consistent with all applicable requirements, regulations, policies and procedures
- Ensure 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
- Notify LIBERTY immediately when you receive information about changes in a LIBERTY member's circumstances that may affect the member's eligibility including all of the following:
    - (i) Changes in the member's residence
    - (ii) A member's death

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

Fraud means knowing or intentional or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to him/her or some other person. Fraud includes any act that constitutes fraud under applicable federal or state law.

Waste means over-utilization of services or other practices that result in unnecessary costs.

Abuse means provider practices that are inconsistent with sound fiscal, business, or medical practices, and result in an unnecessary cost to government-sponsored programs, and other healthcare programs/plans; or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for healthcare. Abuse also includes recipient practices that result in unnecessary cost to federally and/or state-funded healthcare programs, and other payers.

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. 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.

Some examples of fraud, waste, abuse and overpayment include:

- Billing for services or procedures that have not been performed or have been performed by others
- Submitting false or misleading information about services performed
- Misrepresenting the services performed (e.g., up-coding to increase reimbursement)
- Not complying with regulatory documentation requirements
- Lack of documentation to support services performed
- Retaining and failing to refund and report overpayments (e.g., if your claim was overpaid, you are required to report and refund the overpayment, and unpaid overpayments also are grounds for program exclusion)
- A claim that includes items or services resulting from a violation of the Anti-Kickback Statute
- Routinely waiving patient deductibles or co-payments
- An individual provider billing multiple codes on the same day where the procedure being billed is a component of another code billed on the same day
- Routinely maxing out members' benefits or authorizations regardless of whether the services are medically necessary

Reporting Suspected Fraud, Waste, and Abuse: And 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 it to LIBERTY within 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**: compliance@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.

U.S. Mail: LIBERTY Dental Plan
Attention: Special Investigations Unit
P.O. Box 401086
Las Vegas, NV 89140

and/or

State of Nevada Office of the Attorney General

Fraud Hotline: **702.486.3420**
Email: www.ag.nv.gov
On-Line Complaint Form:
https://na2.docusign.net/Member/PowerFormSigning.aspx?PowerFormId=2409ff61-389c-4d88-87aa-dd8d070f216f

and/or

U.S. Government Recovery Board

Fraud Hotline: **877.392.3375**
U.S. Mail: Recovery Accountability and Transparency Board
Attention: Hotline Operators
P.O. Box 27545
Washington, D.C. 20038-7958

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

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.

Cooperate with LIBERTY's Audits and Investigations

LIBERTY's expectation is that you will fully cooperate and participate with its fraud, waste, abuse and overpayment audits and investigations. This includes, but is not limited to, permitting LIBERTY access to member treatment records and allowing LIBERTY to conduct onsite audits or reviews.

What to Expect During a Fraud, Waste, Abuse or Overpayment Audit or Investigation

LIBERTY's Special Investigation Unit (SIU) investigates all reports of fraud, waste, abuse and overpayment. Allegations can come from a number of different internal and external sources. SIU takes every allegation of fraud, waste, abuse and overpayment seriously and is required to investigate every allegation. The investigative process varies depending on the allegation.

SIU may choose to conduct a desk or onsite audit during the course of an audit or investigation.

During a desk audit, you will receive a request for member treatment records and other relevant documentation via certified mail, fax and/or email. You are expected to respond promptly information requests. Details on how to transmit the documentation will be provided to you in the initial record request letter.

An onsite audit can be announced or unannounced and can occur at any of your contracted service locations. Before an announced onsite audit, you will receive notice of audit via fax, e-mail or mail. The notice will provide details and instructions about the audit. You will not receive advance notice of an unannounced audit. SIU staff will provide you with proper identification as well as a written audit notice providing further details and instructions.

During onsite audits, you will be expected to provide treatment records, personnel files, scheduling documentation, and policies and procedures to SIU staff for review. If any of the information is maintained electronically, you will be expected to provide SIU staff with electronic access.

SIU may also take the following steps during an audit or investigation:

- Review your submitted claims for red flags
- Interview you and/or staff
- Review supporting documentation and conduct relevant background checks
- Interview members without provider interference

At the conclusion of an audit or investigation, SIU will report results to you in the form of a findings letter. SIU may also be required to report the findings to a customer oversight agency, or place you on a pre-payment review and/or a corrective action plan where permitted. Any overpayment identified will be referred to LIBERTY's claims department for recovery by refund check or future claims retractions in compliance with contractual and regulatory requirements.

LIBERTY's responsibility is to:

- Advise you in writing if a site visit or audit is required
- Advise you of what you need to do to prepare for the site visit or audit
- Notify you of the results of the site visit or audit in a timely manner
- Work with you to develop a corrective action plan, if required
- Perform a follow-up review of treatment records to assure corrective action has been effective in improving your record documentation, if required

Your responsibility is to:

- Comply with LIBERTY's requests for site visits or audits
- Provide information in a timely manner, including files as requested by the site visit reviewer
- Be available to answer questions from the reviewer
- Participate in developing and implementing a corrective action plan if required
- Cooperate with LIBERTY in developing and carrying out a quality improvement corrective action plan should opportunities for improvement in documentation be identified

Conduct routine self-audits

Providers are encouraged to conduct routine self-audits to measure and ensure internal compliance. During an investigation, a provider may also be asked to complete a self-audit.

LIBERTY's responsibility is to implement and regularly conduct fraud, waste, abuse and overpayment prevention activities that include:

- Extensively monitor and audit provider utilization and claims to detect fraud, waste, abuse and overpayment

- Actively investigate and pursue fraud, waste, abuse, overpayment and other alleged illegal, unethical or unprofessional conduct

- Report suspected fraud, waste, abuse, overpayment and related data to federal and state agencies, in compliance with applicable federal and state regulations and contractual obligations

- Cooperate with law enforcement authorities in the prosecution of healthcare and insurance fraud cases

- Conduct routine data mining activities to identify suspicious patterns in claims data

- Verify eligibility for members and providers

- Utilize internal controls to help ensure payments are not issued to providers who are excluded or sanctioned under Medicare/Medicaid and other federally funded healthcare programs

- Train all LIBERTY employees annually on LIBERTY's Corporate Code of Conduct and Compliance Program including, but not limited to fraud, waste, abuse and overpayment prevention, detection and reporting

- Make the LIBERTY Provider Handbook available to our providers

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 enrollees, you agree to:

- Comply with any CMS, LIBERTY or Medicaid/Medicare Advantage health plan training requirements including annual completion of Medicaid/Medicare Fraud, Waste and Abuse training, and review 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 90 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 online at: http://www.libertydentalplan.com/NVMedicaid. 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 at least 10 years – including methods of training, dates, materials, sign-in sheets, etc.

SECTION 12 – NEVADA MEDICAID SCHEDULE OF BENEFITS

Nevada Medicaid - Adult

Coverage, Limitations and Prior Authorization Requirements

PRIOR AUTHORIZATION TABLE:

01 = Prior authorization is required.

02 = Prior authorization is required. Covered services are for 1) adjacent/abutment tooth for partials and 2) for a pregnancy-related service (recipients age 21 years or older).

NC = Not Covered

Code	Description	Limitations	Prior Auth Req Adult Population	Prior Auth Req Pregnant Women	Documentation/ X-Ray Required
	Diagnostic Services				
D0120	Periodic oral evaluation	Adult Population: 1 (D0120) every 12 months – (VA) Pregnant Women: 1 (D0120) every 11 months			
D0140	Limited oral evaluation	3 (D0140) every 6 months			
D0150	Comprehensive oral evaluation	1 (D0150) every 12 months	NC		
D0160	Oral evaluation, problem focused	1 of (D0160, D0170) every 6 months			
D0170	Re-evaluation, limited, problem focused				
D0190	Screening of a patient	1 of (D0190, D0191) every 6 months			
D0191	Assessment of a patient				
D0210	Intraoral, complete series of radiographic images	1 (D0210) every 12 months. D0210 may not be billed on the same date of service as D0220 and/or D0230. Use code D0210 when providing 14 or more intraoral x-rays on the same date of service.			
D0220	Intraoral, periapical, first radiographic image	1 (D0220) every 12 months. D0220 may not be billed on the same date of service as D0210. 4 additional of (D0220, D0230) every 12 months – (VA)			
D0230	Intraoral, periapical, each add 'l radiographic image	12 (D0230) every 12 months. D0230 may not be billed on the same date of service as D0210. No more than 13 units of any combination of D0220 and /or D0230 may be billed within 12 months, 4 additional of (D0220, D0230) every 12 months – (VA)			
D0240	Intraoral, occlusal radiographic image	2 (D0240) every 12 months			
D0270	Bitewing, single radiographic image	1 of (D0270-D0277) every 6 months 1 additional (D0274) every 12 months – (VA)			
D0272	Bitewings, two radiographic images				
D0273	Bitewings, three radiographic images				
D0274	Bitewings, four radiographic images				
D0277	Vertical bitewings, 7 to 8 radiographic images				
D0322	Tomographic survey	1 (D0322) every 6 months			
D0330	Panoramic radiographic image	1 (D0330) every 36 months			
D0340	2D cephalometric radiographic image, measurement and analysis	1 (D0340) every 36 months			
D0350	2D oral/facial photographic image, intra-orally/extra-orally	1 (D0350) every 12 months			
D0364	Cone beam CT capture & interpretation, limited view, less than one whole jaw	1 of (D0364-D0367, D0380-D0383) every 36 months			Narrative Required with Claim Submission
D0365	Cone beam CT capture & interpretation, view of one full arch, mandible				
D0366	Cone beam CT capture & interpretation, view of one full arch, maxilla, cranium				
D0367	Cone beam CT capture & interpretation, view of both jaws; cranium				
D0370	Maxillofacial ultrasound capture and interpretation	1 of (D0370, D0386) every 36 months			Narrative Required with Claim Submission
D0380	Cone beam CT image capture with limited field of view, less than one whole jaw	1 of (D0364-D0367, D0380-D0383) every 36 months			Narrative Required with Claim Submission
D0381	Cone beam CT image capture with field of view of one full dental arch, mandible				
D0382	Cone beam CT image capture with field of view of one full dental arch, maxilla				
D0383	Cone beam CT image capture with field of view of both jaws				
D0386	Maxillofacial ultrasound image capture	1 of (D0370, D0386) every 36 months			Narrative Required with Claim Submission
D0415	Collection of microorganisms for culture	1 of (D0415, D0416) every 6 months			
D0416	Viral culture				
D0460	Pulp vitality tests	1 (D0460) per patient, per day, same provider			
D0502	Other oral pathology procedures, by report	1 (D0502) every 12 months			
D0600	Non-ionizing diagnostic procedure capable of quantifying, monitoring, and recording changes in structure of enamel, dentin, and cementum	1 (D0600) every 6 months			
	Preventive Services				
D1110	Prophylaxis, adult	Adult Population: 1 (D1110) every 12 months – (VA) Pregnant Women: 1 (D1110) every 6 months, 2 additional (D1110) every 12 months		02	
D1206	Topical application of fluoride varnish	1 (D1206) every 6 months	NC	02	
D1208	Topical application of fluoride, excluding varnish	1 (D1208) every 6 months	NC	02	
D1575	Distal shoe space maintainer, fixed, unilateral	4 of (D1575) in a lifetime any provider, no more than 2 units every 12 months			
	Restorative Services				
D2140	Amalgam, one surface, primary or permanent	1 of (D2140-D2335, D2391-D2394) per surface per tooth every 36 months	02	02	
D2150	Amalgam, two surfaces, primary or permanent		02	02	
D2160	Amalgam, three surfaces, primary or permanent		02	02	
D2161	Amalgam, four or more surfaces, primary or permanent		02	02	
D2330	Resin-based composite, one surface, anterior		02	02	
D2331	Resin-based composite, two surfaces, anterior		02	02	
D2332	Resin-based composite, three surfaces, anterior		02	02	
D2335	Resin-based composite, four or more surfaces, involving incisal angle		02	02	
D2390	Resin-based composite crown, anterior	1 (D2390) per tooth every 36 months	02	02	
D2391	Resin-based composite, one surface, posterior	1 of (D2140-D2335, D2391-D2394) per surface per tooth every 36 months	02	02	
D2392	Resin-based composite, two surfaces, posterior		02	02	
D2393	Resin-based composite, three surfaces, posterior		02	02	
D2394	Resin-based composite, four or more surfaces, posterior		02	02	
D2712	Crown, ¾ resin-based composite (indirect)	1 of (D2712-D2791, D2960-D2962) per tooth in a lifetime	02	02	
D2721	Crown, resin with predominantly base metal		02	02	
D2740	Crown, porcelain/ceramic		02	02	
D2751	Crown, porcelain fused to predominantly base metal		02	02	
D2781	Crown, ¾ cast predominantly base metal		02	02	
D2791	Crown, full cast predominantly base metal		02	02	
D2721	Crown, resin with predominantly base metal		02	02	
D2740	Crown, porcelain/ceramic		02	02	
D2751	Crown, porcelain fused to predominantly base metal		02	02	
D2781	Crown, ¾ cast predominantly base metal		02	02	
D2791	Crown, full cast predominantly base metal		02	02	

Code	Description	Limitations	Prior Auth Req Adult Population	Prior Auth Req Pregnant Women	Documentation/ X-Ray Required
	Restorative Services (continued)				
D2910	Re-cement or re-bond inlay, onlay, veneer, or partial coverage	1 of (D2910, D2920) per tooth every 12 months	01	01	
D2920	Re-cement or re-bond crown				
D2921	Reattachment of tooth fragment, incisal edge or cusp				
D2930	Prefabricated stainless-steel crown, primary tooth	1 of (D2930, D2932, D2933) per tooth every 36 months	02	02	
D2931	Prefabricated stainless-steel crown, permanent tooth	1 (D2931) per tooth in a lifetime	02	02	
D2932	Prefabricated resin crown	1 of (D2930, D2932, D2933) per tooth every 36 months	02	02	
D2933	Prefabricated stainless-steel crown with resin window		02	02	
D2940	Protective restoration	2 (D2940) per tooth every 6 months			
D2950	Core buildup, including any pins when required	1 (D2950) per tooth every 36 months	02	02	
D2951	Pin retention, per tooth, in addition to restoration	2 (D2951) per tooth every 36 months	02	02	
D2952	Post and core in addition to crown, indirectly fabricated	1 of (D2952, D2954) per tooth in a lifetime	02	02	
D2953	Each additional indirectly fabricated post, same tooth	1 of (D2953, D2957) per tooth in a lifetime	02	02	
D2954	Prefabricated post and core in addition to crown	1 of (D2952, D2954) per tooth in a lifetime	02	02	
D2955	Post removal	1 (D2955) per tooth in a lifetime	02	02	
D2957	Each additional prefabricated post, same tooth	1 of (D2953, D2957) per tooth in a lifetime	02	02	
D2960	Labial veneer (resin laminate), chairside	1 of (D2712-D2791, D2960-D2962) per tooth in a lifetime	02	02	
D2961	Labial veneer (resin laminate), laboratory		02	02	
D2962	Labial veneer (porcelain laminate), laboratory		02	02	
D2980	Crown repair necessitated by restorative material failure	1 (D2980) per tooth in a lifetime	02	02	
	Periodontal Services				
D4210	Gingivectomy or gingivoplasty, four or more teeth per quadrant	1 of (D4210-D4212) per site/quadrant every 60 months	NC	02	
D4211	Gingivectomy or gingivoplasty, one to three teeth per quadrant		NC	02	
D4212	Gingivectomy or gingivoplasty, restorative procedure, per tooth		NC	02	
D4341	Periodontal scaling and root planing, four or more teeth per quadrant	1 of (D4341, D4342) per site/quadrant every 12 months	NC	02	
D4342	Periodontal scaling and root planing, one to three teeth per quadrant		NC	02	
D4346	Scaling in the presence of generalized moderate or severe gingival inflammation, full mouth after oral evaluation	1 (D4346) every 12 months	NC	02	
D4355	Full mouth debridement to enable comprehensive evaluation and diagnosis, subsequent visit	1 (D4355) every 12 months			Narrative and X-rays Req with Claim Submission
D4910	Periodontal maintenance	1 (D4910) every 3 months	NC	02	
	Removable Prosthodontic Services				
D5110	Complete denture, maxillary	1 of (D5110-D5140) per arch every 60 months, unless medically necessary			Narrative and X-rays Req with Claim Submission
D5120	Complete denture, mandibular				
D5130	Immediate denture, maxillary				
D5140	Immediate denture, mandibular				
D5211	Maxillary partial denture, resin base	1 of (D5211-D5214) per arch every 60 months unless medically necessary			Narrative and X-rays Req with Claim Submission
D5212	Mandibular partial denture, resin base				
D5213	Maxillary partial denture, cast metal, resin base				
D5214	Mandibular partial denture, cast metal, resin base				
D5221	Immediate maxillary partial denture, resin base	1 of (D5221-D5222) per arch in a lifetime	01	01	
D5222	Immediate mandibular partial denture, resin base		01	01	
D5410	Adjust complete denture, maxillary	1 of (D5410-D5422) per arch every 6 months			
D5411	Adjust complete denture, mandibular				
D5421	Adjust partial denture, maxillary				
D5422	Adjust partial denture, mandibular				
D5511	Repair broken complete denture base, mandibular	1 of (D5511, D5512) per arch every 60 months			
D5512	Repair broken complete denture base, maxillary				
D5520	Replace missing or broken teeth, complete denture	1 (D5520) per arch every 60 months			
D5611	Repair cast partial framework, mandibular	Contraindicated any provider, within 91 days			
D5612	Repair cast partial framework, maxillary				
D5621	Repair cast framework, maxillary	Contraindicated any provider, within 91 days			
D5622	Repair cast framework, mandibular				
D5630	Repair or replace broken clasp, per tooth	Contraindicated any provider, within 91 days			
D5640	Replace broken teeth, per tooth	Contraindicated any provider, within 91 days			
D5650	Add tooth to existing partial denture	Contraindicated any provider, within 91 days			
D5660	Add clasp to existing partial denture, per tooth	Contraindicated any provider, within 91 days			
D5670	Replace all teeth & acrylic on cast metal frame, maxillary	1 of (D5670, D5671) per arch every 60 months	01	01	
D5671	Replace all teeth & acrylic on cast metal frame, mandibular		01	01	
D5730	Reline complete maxillary denture, chairside	1 of (D5730-D5761) per arch every 6 months, no more than 3 per arch every 60 months			
D5731	Reline complete mandibular denture, chairside				
D5740	Reline maxillary partial denture, chairside				
D5741	Reline mandibular partial denture, chairside				
D5750	Reline complete maxillary denture, laboratory				Narrative Required with Claim Submission
D5751	Reline complete mandibular denture, laboratory				
D5760	Reline maxillary partial denture, laboratory				
D5761	Reline mandibular partial denture, laboratory				
D5820	Interim partial denture, maxillary	1 of (D5820, D5821) per arch every 60 months			Narrative and X-rays Req with Claim Submission
D5821	Interim partial denture, mandibular				
D5850	Tissue conditioning, maxillary	1 of (D5850, D5851) per arch every 12 months			
D5851	Tissue conditioning, mandibular				
D5862	Precision attachment, by report	1 (D5862) every 60 months	01	01	
D5899	Unspecified removable prosthodontic procedure, by report	2 (D5899) every 60 months			
	Maxillofacial Prosthetic Services				
D5931	Obturator prosthesis, surgical	1 (D5931) in a lifetime	01	01	
D5932	Obturator prosthesis, definitive	1 (D5932) in a lifetime	01	01	
D5933	Obturator prosthesis, modification	1 (D5933) in a lifetime	01	01	
D5936	Obturator prosthesis, interim	1 (D5936) in a lifetime	01	01	
D5985	Radiation cone locator	1 (D5985) every 12 months	01	01	
D5988	Surgical splint	1 (D5988) in a lifetime	01	01	
D5992	Adjust maxillofacial prosthetic appliance, by report	1 (D5992) every 12 months	01	01	
D5993	Maintenance & cleaning, maxillofacial prosthesis, other than required adjustments, by report	1 (D5993) every 3 months	01	01	
	Fixed Prosthodontic Services				
D6930	Re-cement or re-bond fixed partial denture	Contraindicated any provider, within 91 days			
	Oral and Maxillofacial Services				
D7111	Extraction, coronal remnants, primary tooth	1 of (D7111-D7250) per tooth in a lifetime. D7111, D7140, D7210, D7220, D7230, D7240, D7241 and D7250 are contraindicated in conjunction with D9215 - same day, same recipient, any provider.			
D7140	Extraction, erupted tooth or exposed root				
D7210	Extraction, erupted tooth requiring removal of bone and/or sectioning of tooth				Narrative and X-rays Req with Claim Submission
D7220	Removal of impacted tooth, soft tissue				
D7230	Removal of impacted tooth, partially bony				
D7240	Removal of impacted tooth, completely bony				
D7241	Removal impacted tooth, complete bony, complication	1 of (D7111-D7250) per tooth in a lifetime. D7111, D7140, D7210, D7220, D7230, D7240, D7241 and D7250 are contraindicated in conjunction with D9215 - same day, same recipient, any provider. D7241 and D7261 are contraindicated against each other - within 90 days, same recipient, any provider.			Narrative and X-rays Req with Claim Submission
D7250	Removal of residual tooth roots (cutting procedure)	1 of (D7111-D7250) per tooth in a lifetime. D7111, D7140, D7210, D7220, D7230, D7240, D7241 and D7250 are contraindicated in conjunction with D9215 - same day, same recipient, any provider.			Narrative and X-rays Req with Claim Submission
D7251	Coronectomy, intentional partial tooth removal	2 (D7251) in a lifetime	01	01	

Code	Description	Limitations	Prior Auth Req Adult Population	Prior Auth Req Pregnant Women	Documentation/ X-Ray Required
	Oral and Maxillofacial Services (continued)				
D7280	Exposure of an unerupted tooth	1 (D7280) per tooth in a lifetime			Narrative and X-rays Req with Claim Submission
D7283	Placement, device to facilitate eruption, impaction				Narrative and X-rays Req with Claim Submission
D7287	Exfoliative cytological sample collection				Narrative Required with Claim Submission
D7288	Brush biopsy, transepithelial sample collection				Narrative Required with Claim Submission
D7291	Transseptal fiberotomy/supra crestal fiberotomy, by report				Narrative and X-rays Req with Claim Submission
D7292	Placement of temporary anchorage device [screw retained plate] requiring flap				Narrative and X-rays Req with Claim Submission
D7293	Placement of temporary anchorage device requiring flap; includes device removal				Narrative and X-rays Req with Claim Submission
D7294	Placement of temporary anchorage device without flap; includes device removal				Narrative and X-rays Req with Claim Submission
D7310	Alveoloplasty with extractions, four or more teeth per quadrant	1 of (D7310-D7321) per quadrant in a lifetime, contraindicated any provider within 3286 days			Narrative and X-rays Req with Claim Submission
D7311	Alveoloplasty with extractions, one to three teeth per quadrant				
D7320	Alveoloplasty, w/o extractions, four or more teeth per quadrant				
D7321	Alveoloplasty, w/o extractions, one to three teeth per quadrant		01	01	
D7412	Excision of benign lesion, complicated		01	01	
D7440	Excision of malignant tumor, up to 1.25 cm				Narrative and X-rays Req with Claim Submission
D7441	Excision of malignant tumor, greater than 1.25 cm				Narrative and X-rays Req with Claim Submission
D7472	Removal of torus palatinus	2 of (D7472, D7243) in a lifetime			Narrative and X-rays Req with Claim Submission
D7473	Removal of torus mandibularis				
D7490	Radical resection of maxilla or mandible		01	01	
D7510	Incision & drainage of abscess, intraoral soft tissue	Incidental already part of another procedure			Narrative and X-rays Req with Claim Submission
D7511	Incision & drainage of abscess, intraoral soft tissue, complicated				Narrative and X-rays Req with Claim Submission
D7520	Incision & drainage of abscess, extraoral soft tissue	Incidental already part of another procedure			Narrative and X-rays Req with Claim Submission
D7521	Incision & drainage of abscess, extraoral soft tissue, complicated				Narrative and X-rays Req with Claim Submission
D7530	Remove foreign body, mucosa, skin, tissue				Narrative Required with Claim Submission
D7540	Removal of reaction producing foreign bodies, musculoskeletal system				Narrative and X-rays Req with Claim Submission
D7550	Partial ostectomy/sequestrectomy for removal of non-vital bone				Narrative and X-rays Req with Claim Submission
D7560	Maxillary sinusotomy for removal of tooth fragment or foreign body				Narrative and X-rays Req with Claim Submission
D7610	Maxilla, open reduction (teeth immobilized, if present)				Narrative and X-rays Req with Claim Submission
D7620	Maxilla, closed reduction (teeth immobilized, if present)				Narrative and X-rays Req with Claim Submission
D7630	Mandible, open reduction (teeth immobilized, if present)				Narrative and X-rays Req with Claim Submission
D7640	Mandible, closed reduction (teeth immobilized, if present)				Narrative and X-rays Req with Claim Submission
D7650	Malar and/or zygomatic arch, open reduction	1 of (D7650, D7660, D7750, D7760) in a lifetime			Narrative and X-rays Req with Claim Submission
D7660	Malar and/or zygomatic arch, closed reduction				
D7670	Alveolus, closed reduction, may include stabilization of teeth				Narrative and X-rays Req with Claim Submission
D7671	Alveolus, open reduction, may include stabilization of teeth				Narrative and X-rays Req with Claim Submission
D7680	Facial bones, complicated reduction with fixation, multiple surgical approaches				Narrative and X-rays Req with Claim Submission
D7710	Maxilla, open reduction				Narrative and X-rays Req with Claim Submission
D7720	Maxilla, closed reduction				Narrative and X-rays Req with Claim Submission
D7730	Mandible, open reduction				Narrative and X-rays Req with Claim Submission
D7740	Mandible, closed reduction				Narrative and X-rays Req with Claim Submission
D7750	Malar and/or zygomatic arch, open reduction	1 of (D7650, D7660, D7750, D7760) in a lifetime			Narrative and X-rays Req with Claim Submission
D7760	Malar and/or zygomatic arch, closed reduction				
D7770	Alveolus, open reduction stabilization of teeth				Narrative and X-rays Req with Claim Submission
D7771	Alveolus, closed reduction stabilization of teeth				Narrative and X-rays Req with Claim Submission
D7780	Facial bones, complicated reduction with fixation and multiple approaches				Narrative and X-rays Req with Claim Submission
D7810	Open reduction of dislocation		01	01	
D7820	Closed reduction of dislocation			NC	Narrative Required with Claim Submission
D7840	Condylectomy			NC	Narrative and X-rays Req with Claim Submission
D7850	Surgical discectomy, with/without implant			NC	Narrative and X-rays Req with Claim Submission
D7852	Disc repair			NC	Narrative and X-rays Req with Claim Submission
D7854	Synovectomy			NC	Narrative and X-rays Req with Claim Submission
D7858	Joint reconstruction		01	NC	
D7860	Arthrotomy			NC	Narrative and X-rays Req with Claim Submission
D7865	Arthroplasty			NC	Narrative and X-rays Req with Claim Submission
D7870	Arthrocentesis			NC	Narrative and X-rays Req with Claim Submission
D7872	Arthroscopy, diagnosis, with or without biopsy			NC	Narrative and X-rays Req with Claim Submission
D7873	Arthroscopy: lavage and lysis of adhesions			NC	Narrative and X-rays Req with Claim Submission
D7874	Arthroscopy: disc repositioning and stabilization			NC	Narrative and X-rays Req with Claim Submission
D7875	Arthroscopy: synovectomy			NC	Narrative and X-rays Req with Claim Submission
D7876	Arthroscopy: discectomy			NC	Narrative and X-rays Req with Claim Submission

Code	Description	Limitations	Prior Auth Req Adult Population	Prior Auth Req Pregnant Women	Documentation/ X-Ray Required
	Oral and Maxillofacial Services (continued)				
D7877	Arthroscopy: debridement			NC	Narrative and X-rays Req with Claim Submission
D7880	Occlusal orthotic device, by report			NC	Narrative Required with Claim Submission
D7910	Suture of recent small wounds up to 5 cm				
D7911	Complicated suture, up to 5 cm				Narrative Required with Claim Submission
D7912	Complicated suture, greater than 5 cm				Narrative Required with Claim Submission
D7940	Osteoplasty, for orthognathic deformities	1 (D7940) in a lifetime	01	01	
D7941	Osteotomy, mandibular rami	1 of (D7941-D7945) in a lifetime	01	01	
D7943	Osteotomy, mandibular rami with bone graft; includes obtaining the graft		01	01	
D7944	Osteotomy, segmented or subapical		01	01	
D7945	Osteotomy, body of mandible		01	01	
D7946	LeFort I (maxilla, total)	1 of (D7946-D7949) in a lifetime	01	01	
D7947	LeFort I (maxilla, segmented)		01	01	
D7948	LeFort II or LeFort III, without bone graft		01	01	
D7949	LeFort II or LeFort III, with bone graft		01	01	
D7951	Sinus augmentation with bone or bone substitutes via a lateral open approach				Narrative and X-rays Req with Claim Submission
D7953	Bone replacement graft for ridge preservation, per site		01	01	
D7955	Repair of maxillofacial soft and/or hard tissue defect	1 (D7955) every 24 months	01	01	
D7960	Frenulectomy (frenectomy or frenotomy), separate procedure	3 (D7960) in a lifetime			Narrative Required with Claim Submission
D7970	Excision of hyperplastic tissue, per arch				Narrative Required with Claim Submission
D7971	Excision of pericoronal gingiva				Narrative Required with Claim Submission
D7980	Surgical Sialolithotomy				Narrative Required with Claim Submission
D7981	Excision of salivary gland, by report				Narrative Required with Claim Submission
D7982	Sialodochoplasty				Narrative Required with Claim Submission
D7983	Closure of salivary fistula				Narrative Required with Claim Submission
D7990	Emergency tracheotomy				Narrative Required with Claim Submission
D7991	Coronoidectomy	1 (D7991) in a lifetime			Narrative Required with Claim Submission
D7996	Implant – mandible for augmentation purposes, by report		01	01	
D7998	Intraoral placement of a fixation device not in conjunction with a fracture				Narrative Required with Claim Submission
	Adjunctive General Services				
D9110	Palliative (emergency) treatment, minor procedure	1 (D9110) per day same provider, 2 every 6 months			
D9120	Fixed partial denture sectioning	1 (D9120) every 60 months			
D9210	Local anesthesia not in conjunction, operative or surgical procedures				Narrative Required with Claim Submission
D9212	Trigeminal division block anesthesia				Narrative Required with Claim Submission
D9215	Local anesthesia in conjunction with operative or surgical procedures				
D9222	Deep sedation/general anesthesia, first 15-minute increment	5 of (D9222, D9223) per day, not to be completed on same date of service with D9239, D9243. Anesthesia must show actual beginning and ending times. Anesthesia time begins when the provider starts to physically prepare the recipient for induction of anesthesia in the operating area and ends when the provider is no longer in constant attendance (i.e., when the recipient can be safe placed under postoperative supervision)			Narrative and X-rays Required with Claim Submission
D9223	Deep sedation/general anesthesia, each subsequent 15-minute increment				
D9230	Inhalation of nitrous oxide/analgesia, anxiolysis				Narrative Required with Claim Submission
D9239	Intravenous moderate (conscious) sedation/analgesia, first 15-minute increment	5 of (D9239, D9243) per day, not to be completed on same date of service with D9222, D9223. Anesthesia must show actual beginning and ending times. Anesthesia time begins when the provider starts to physically prepare the recipient for induction of anesthesia in the operating area and ends when the provider is no longer in constant attendance (i.e., when the recipient can be safe placed under postoperative supervision)			Narrative and X-rays Required with Claim Submission
D9243	Intravenous moderate (conscious) sedation/analgesia, each subsequent 15-minute increment				
D9248	Non-intravenous (conscious) sedation, includes non-IV minimal and moderate sedation				Narrative and X-rays Req with Claim Submission
D9310	Consultation, other than requesting dentist				
D9311	Consultation with a medical health care professional	1 (D9311) every 6 months			Narrative and X-rays Req with Claim Submission
D9410	House/extended care facility call				
D9420	Hospital or ambulatory surgical center call				
D9610	Therapeutic parenteral drug, single administration	1 (D9610) every 12 months			Narrative Required with Claim Submission
D9612	Therapeutic parenteral drugs, two or more administrations, different meds.	1 (D9612) every 12 months			Narrative Required with Claim Submission
D9630	Drugs or medicaments dispensed in the office for home use				Narrative Required with Claim Submission
D9930	Treatment of complications, post-surgical, unusual, by report	1 (D9930) every 12 months			Narrative Required with Claim Submission
D9991	Dental case management, addressing appointment compliance barriers	1 of (D9991-D9994) every 6 months			
D9992	Dental case management, care coordination				
D9993	Dental case management, motivational interviewing				
D9994	Dental case management, patient education to improve oral health literacy				

(This concludes the Nevada Medicaid – Adult Schedule of Benefits)

Nevada Medicaid – Child Services

Coverage, Limitations and Prior Authorization Requirements

PRIOR AUTHORIZATION TABLE:

01 = Prior authorization is required.

02 = Prior authorization is required. Covered services are for 1) adjacent/abutment tooth for partials and 2) for a pregnancy-related service (recipients age 21 years or older).

NC = Not Covered

Code	Description	Limitations	Prior Auth Req	Documentation/ X-Ray Required
	Diagnostic Services			
D0120	Periodic oral evaluation	1 (D0120) every 11 months		
D0140	Limited oral evaluation	3 (D0140) every 6 months		
D0145	Oral evaluation under age 3	1 (D0145) every 6 months, up to age 3		
D0150	Comprehensive oral evaluation	1 (D0150) every 12 months		
D0160	Oral evaluation, problem focused	1 of (D0160, D0170) every 6 months		
D0170	Re-evaluation, limited, problem focused			
D0190	Screening of a patient	1 of (D0190, D0191) every 6 months. 1 additional of (D0190, D0191) every 12 months by a PCP or their clinical staff, or by mobile based providers, to facilitate PCP Fluoride Varnish – (VA)		
D0191	Assessment of a patient			
D0210	Intraoral, complete series of radiographic images	1 (D0210) every 12 months. D0210 may not be billed on the same date of service as D0220 and/or D0230. Use code D0210 when providing 14 or more intraoral x-rays on the same date of service.		
D0220	Intraoral, periapical, first radiographic image	1 (D0220) every 12 months. D0220 may not be billed on the same date of service as D0210.		
D0230	Intraoral, periapical, each add 'l radiographic image	12 (D0230) every 12 months. D0230 may not be billed on the same date of service as D0210. No more than 13 units of any combination of D0220 and /or D0230 may be billed within 12 months		
D0240	Intraoral, occlusal radiographic image	2 (D0240) every 12 months		
D0270	Bitewing, single radiographic image	1 of (D0270-D0277) every 6 months		
D0272	Bitewings, two radiographic images			
D0273	Bitewings, three radiographic images			
D0274	Bitewings, four radiographic images			
D0277	Vertical bitewings, 7 to 8 radiographic images			
D0322	Tomographic survey	1 (D0322) every 6 months		
D0330	Panoramic radiographic image	1 (D0330) every 36 months		
D0340	2D cephalometric radiographic image, measurement and analysis	1 (D0340) every 36 months		
D0350	2D oral/facial photographic image, intra-orally/extra-orally	1 (D0350) every 12 months		
D0364	Cone beam CT capture & interpretation, limited view, less than one whole	1 of (D0364-D0367, D0380-D0383) every 36 months		Narrative Required with Claim Submission
D0365	Cone beam CT capture & interpretation, view of one full arch, mandible			
D0366	Cone beam CT capture & interpretation, view of one full arch, maxilla,			
D0367	Cone beam CT capture & interpretation, view of both jaws; cranium			
D0370	Maxillofacial ultrasound capture and interpretation	1 of (D0370, D0386) every 36 months		Narrative Required with Claim Submission
D0380	Cone beam CT image capture with limited field of view, less than one whole	1 of (D0364-D0367, D0380-D0383) every 36 months		Narrative Required with Claim Submission
D0381	Cone beam CT image capture with field of view of one full dental arch,			
D0382	Cone beam CT image capture with field of view of one full dental arch,			
D0383	Cone beam CT image capture with field of view of both jaws			
D0386	Maxillofacial ultrasound image capture	1 of (D0370, D0386) every 36 months		Narrative Required with Claim Submission
D0415	Collection of microorganisms for culture	1 of (D0415, D0416) every 6 months		
D0416	Viral culture			
D0460	Pulp vitality tests	1 (D0460) per patient, per day, same provider		
D0470	Diagnostic casts	1 (D0470) every 12 months		Narrative Required with Claim Submission
D0502	Other oral pathology procedures, by report	1 (D0502) every 12 months		
D0600	Non-ionizing diagnostic procedure capable of quantifying, monitoring, and recording changes in structure of enamel, dentin, and cementum	1 (D0600) every 6 months		
D0601	Caries risk assessment and documentation, low risk	1 of (D0601-D0603) every 12 months – (VA)		The Caries Risk Assessment (D0601, D0602, D0603) must be performed at the same visit as an evaluation (D0120, D0140, D0145, D0150)
D0602	Caries risk assessment and documentation, moderate risk			
D0603	Caries risk assessment and documentation, high risk			
	Preventive Services			
D1120	Prophylaxis, child	1 (D1120) every 6 months		
D1206	Topical application of fluoride varnish	1 (D1206) every 6 months. 1 additional (D1206) every 12 months at Primary Care Physician or their clinical staff, or by mobile based providers, to facilitate PCP Fluoride Varnish – (VA)		
D1208	Topical application of fluoride, excluding varnish	1 (D1208) every 6 months		
D1351	Sealant, per tooth	1 of (D1351, D1352) per tooth in a lifetime		Premolar Sealants Only; Narrative or photo of tooth Required with Claim Submission
D1352	Preventive resin restoration, permanent tooth			
D1353	Sealant repair, per tooth	1 (D1353) per tooth in a lifetime		
D1354	Interim caries arresting medicament application, per tooth	1 (D1354) per tooth every 6 months		X-ray, Clinical Photo, or Narrative Required on first application to a tooth
D1510	Space maintainer, fixed, unilateral	4 of (D1510-D1525, D1575) in a lifetime any provider, no more than 2 units every 12 months		
D1515	Space maintainer, fixed, bilateral			

Code	Description	Limitations	Prior Auth Req	Documentation/ X-Ray Required
	Preventive Services (continued)			
D1520	Space maintainer, removable, unilateral	4 of (D1510-D1525, D1575) in a lifetime any provider, no more than 2 units every 12 months		
D1525	Space maintainer, removable, bilateral			
D1550	Re-cement or re-bond space maintainer	2 (D1550) per tooth in a lifetime		
D1555	Removal of fixed space maintainer	1 (D1555) per tooth in a lifetime		
D1575	Distal shoe space maintainer, fixed, unilateral	4 of (D1510-D1525, D1575) in a lifetime any provider, no more than 2 units every 12 months		
	Restorative Services			
D2140	Amalgam, one surface, primary or permanent	1 of (D2140-D2335, D2391-D2394) per surface per tooth every 36 months		Narrative and X-rays Required with Claim Submission
D2150	Amalgam, two surfaces, primary or permanent			
D2160	Amalgam, three surfaces, primary or permanent			
D2161	Amalgam, four or more surfaces, primary or permanent			
D2330	Resin-based composite, one surface, anterior			
D2331	Resin-based composite, two surfaces, anterior			
D2332	Resin-based composite, three surfaces, anterior			
D2335	Resin-based composite, four or more surfaces, involving incisal angle			
D2390	Resin-based composite crown, anterior	1 (D2390) per tooth every 36 months		Narrative and X-rays Required with Claim Submission
D2391	Resin-based composite, one surface, posterior	1 of (D2140-D2335, D2391-D2394) per surface per tooth every 36 months		Narrative and X-rays Required with Claim Submission
D2392	Resin-based composite, two surfaces, posterior			
D2393	Resin-based composite, three surfaces, posterior			
D2394	Resin-based composite, four or more surfaces, posterior			
D2712	Crown, ¾ resin-based composite (indirect)	1 of (D2712-D2791, D2960-D2962) per tooth in a lifetime		Narrative and X-rays Required with Claim Submission
D2721	Crown, resin with predominantly base metal			
D2740	Crown, porcelain/ceramic			
D2751	Crown, porcelain fused to predominantly base metal			
D2781	Crown, ¾ cast predominantly base metal			
D2791	Crown, full cast predominantly base metal			
D2910	Re-cement or re-bond inlay, onlay, veneer, or partial coverage	1 of (D2910, D2920) per tooth every 12 months		
D2915	Re-cement or re-bond indirectly fabricated/prefabricated post & core	1 (D2915) per tooth in a lifetime		
D2920	Re-cement or re-bond crown	1 of (D2910, D2920) per tooth every 12 months		
D2921	Reattachment of tooth fragment, incisal edge or cusp			
D2930	Prefabricated stainless-steel crown, primary tooth	1 of (D2930, D2932, D2933) per tooth every 36 months		Narrative and X-rays Required with Claim Submission
D2931	Prefabricated stainless-steel crown, permanent tooth	1 (D2931) per tooth in a lifetime		Narrative and X-rays Required with Claim Submission
D2932	Prefabricated resin crown	1 of (D2930, D2932, D2933) per tooth every 36 months		Narrative and X-rays Required with Claim Submission
D2933	Prefabricated stainless-steel crown with resin window			
D2940	Protective restoration	2 (D2940) per tooth every 6 months		
D2950	Core buildup, including any pins when required	1 (D2950) per tooth every 36 months		Narrative and X-rays Required with Claim Submission
D2951	Pin retention, per tooth, in addition to restoration	2 (D2951) per tooth every 36 months		
D2952	Post and core in addition to crown, indirectly fabricated	1 of (D2952, D2954) per tooth in a lifetime		Narrative and X-rays Required with Claim Submission
D2953	Each additional indirectly fabricated post, same tooth	1 of (D2953, D2957) per tooth in a lifetime		
D2954	Prefabricated post and core in addition to crown	1 of (D2952, D2954) per tooth in a lifetime		Narrative and X-rays Required with Claim Submission
D2955	Post removal	1 (D2955) per tooth in a lifetime		X-rays Required with Claim Submission
D2957	Each additional prefabricated post, same tooth	1 of (D2953, D2957) per tooth in a lifetime		
D2960	Labial veneer (resin laminate), chairside	1 of (D2712-D2791, D2960-D2962) per tooth in a lifetime	Y	
D2961	Labial veneer (resin laminate), laboratory		Y	
D2962	Labial veneer (porcelain laminate), laboratory		Y	
D2975	Coping	1 (D2975) per tooth in a lifetime		
D2980	Crown repair necessitated by restorative material failure	1 (D2980) per tooth in a lifetime		Narrative and X-rays Required with Claim Submission
	Endodontic Services			
D3110	Pulp cap, direct (excluding final restoration)	1 of (D3110, D3120) per tooth every 36 months		
D3120	Pulp cap, indirect (excluding final restoration)			
D3220	Therapeutic pulpotomy (excluding final restoration)	1 (D3220) per tooth every 36 months		
D3222	Partial pulpotomy, apexogenesis, permanent tooth, incomplete root	1 (D3222) per tooth in a lifetime		
D3230	Pulpal therapy, anterior, primary tooth (excluding final restoration)	1 of (D3230, D3240) per tooth in a lifetime		
D3240	Pulpal therapy, posterior, primary tooth (excluding finale restoration)			
D3310	Endodontic therapy, anterior tooth (excluding final restoration)	1 of (D3310-D3330) per tooth in a lifetime		X-rays Required with Claim Submission
D3320	Endodontic therapy, premolar tooth (excluding final restoration)			
D3330	Endodontic therapy, molar tooth (excluding final restoration)			
D3351	Apexification/recalcification, initial visit	1 (D3351) per tooth in a lifetime		X-rays Required with Claim Submission
D3352	Apexification/recalcification, interim medication replacement	1 (D3352) per tooth in a lifetime		X-rays Required with Claim Submission
D3353	Apexification/recalcification, final visit	1 (D3353) per tooth in a lifetime		X-rays Required with Claim Submission
D3410	Apicoectomy, anterior	1 of (D3410-D3425) per tooth in a lifetime		X-rays Required with Claim Submission
D3421	Apicoectomy, premolar (first root)			
D3425	Apicoectomy, molar (first root)			
D3426	Apicoectomy, (each additional root)	1 (D3426) per tooth in a lifetime		X-rays Required with Claim Submission
D3430	Retrograde filling, per root	1 (D3430) per tooth in a lifetime - multiple roots may be claimed		X-rays Required with Claim Submission
D3450	Root amputation, per root	1 (D3450) per tooth in a lifetime		X-rays Required with Claim Submission
D3460	Endodontic endosseous implant	1 (D3460) per tooth in a lifetime		X-rays Required with Claim Submission
D3920	Hemisection, not including root canal therapy	1 (D3920) per tooth in a lifetime		X-rays Required with Claim Submission
D3950	Canal preparation and fitting of preformed dowel or post	1 (D3950) per tooth in a lifetime		
	Periodontal Services			
D4210	Gingivectomy or gingivoplasty, four or more teeth per quadrant	1 of (D4210-D4278) per site/quadrant every 60 months		Narrative and X-rays Required with Claim Submission
D4211	Gingivectomy or gingivoplasty, one to three teeth per quadrant			

Code	Description	Limitations	Prior Auth Req	Documentation/ X-Ray Required
	Endodontic Services (continued)			
D4212	Gingivectomy or gingivoplasty, restorative procedure, per tooth	1 of (D4210-D4278) per site/quadrant every 60 months		Narrative and X-rays Required with Claim Submission
D4230	Anatomical crown exposure, one to three teeth per quadrant			
D4231	Anatomical crown exposure, four or more teeth per quadrant			
D4240	Gingival flap procedure, four or more teeth per quadrant			
D4241	Gingival flap procedure, one to three teeth per quadrant			
D4249	Clinical crown lengthening, hard tissue			
D4260	Osseous surgery, four or more teeth per quadrant			
D4261	Osseous surgery, one to three teeth per quadrant			
D4263	Bone replacement graft, retained natural tooth, first site, quadrant			
D4264	Bone replacement graft, retained natural tooth, each additional site			
D4265	Biologic materials to aid in soft and osseous tissue regeneration			
D4266	Guided tissue regeneration, resorbable barrier, per site			
D4267	Guided tissue regeneration, non-resorbable barrier, per site			
D4270	Pedicle soft tissue graft procedure			
D4273	Autogenous connective tissue graft procedure, first tooth			
D4274	Mesial/distal wedge procedure, single tooth			
D4277	Free soft tissue graft, first tooth		Y	
D4278	Free soft tissue graft, each additional tooth		Y	
D4320	Provisional splinting, intracoronal	1 of (D4320, D4321) per quadrant every 60 months		Narrative and X-rays Required with Claim Submission
D4321	Provisional splinting, extracoronal			
D4341	Periodontal scaling and root planing, four or more teeth per quadrant	1 of (D4341, D4342) per site/quadrant every 12 months		X-Rays Required with Claim Submission
D4342	Periodontal scaling and root planing, one to three teeth per quadrant			
D4346	Scaling in the presence of generalized moderate or severe gingival inflammation, full mouth after oral	1 (D4346) every 12 months		Narrative and X-rays Required with Claim Submission
D4355	Full mouth debridement to enable comprehensive evaluation and diagnosis, subsequent visit	1 (D4355) every 12 months		Narrative and X-rays Required with Claim Submission
D4381	Localized delivery of antimicrobial agent/per tooth	1 (D4381) per tooth every 12 months		
D4910	Periodontal maintenance	1 (D4910) every 3 months		
	Removable Prosthodontic Services			
D5110	Complete denture, maxillary	1 of (D5110-D5140) per arch every 60 months, unless medically necessary		Narrative and X-rays Required with Claim Submission
D5120	Complete denture, mandibular			
D5130	Immediate denture, maxillary			
D5140	Immediate denture, mandibular			
D5211	Maxillary partial denture, resin base	1 of (D5211-D5214) per arch every 60 months unless medically necessary		Narrative and X-rays Required with Claim Submission
D5212	Mandibular partial denture, resin base			
D5213	Maxillary partial denture, cast metal, resin base			
	Removable Prosthodontic Services			
D5214	Mandibular partial denture, cast metal, resin base	1 of (D5211-D5214) per arch every 60 months unless medically necessary		Narrative and X-rays Required with Claim Submission
D5221	Immediate maxillary partial denture, resin base	1 of (D5221-D5222) per arch every 12 months		Narrative and X-rays Required with Claim Submission
D5222	Immediate mandibular partial denture, resin base			
D5410	Adjust complete denture, maxillary	1 of (D5410-D5422) per arch every 6 months		
D5411	Adjust complete denture, mandibular			
D5421	Adjust partial denture, maxillary			
D5422	Adjust partial denture, mandibular			
D5511	Repair broken complete denture base, mandibular	1 of (D5511, D5512) per arch every 60 months		
D5512	Repair broken complete denture base, maxillary			
D5520	Replace missing or broken teeth, complete denture	1 (D5520) per arch every 60 months		
D5611	Repair cast partial framework, mandibular	Contraindicated any provider, within 91 days		
D5612	Repair cast partial framework, maxillary			
D5621	Repair cast framework, maxillary	Contraindicated any provider, within 91 days		
D5622	Repair cast framework, mandibular			
D5630	Repair or replace broken clasp, per tooth	Contraindicated any provider, within 91 days		
D5640	Replace broken teeth, per tooth	Contraindicated any provider, within 91 days		
D5650	Add tooth to existing partial denture	Contraindicated any provider, within 91 days		
D5660	Add clasp to existing partial denture, per tooth	Contraindicated any provider, within 91 days		
D5670	Replace all teeth & acrylic on cast metal frame, maxillary	1 of (D5670, D5671) per arch every 60 months	Y	
D5671	Replace all teeth & acrylic on cast metal frame, mandibular		Y	
D5730	Reline complete maxillary denture, chairside	1 of (D5730-D5761) per arch every 6 months, no more than 3 per arch every 60 months		
D5731	Reline complete mandibular denture, chairside			
D5740	Reline maxillary partial denture, chairside			
D5741	Reline mandibular partial denture, chairside			
D5750	Reline complete maxillary denture, laboratory			Narrative Required with Claim Submission
D5751	Reline complete mandibular denture, laboratory			
D5760	Reline maxillary partial denture, laboratory			
D5761	Reline mandibular partial denture, laboratory			
D5820	Interim partial denture, maxillary	1 of (D5820, D5821) per arch every 60 months		Narrative and X-rays Required with Claim Submission
D5821	Interim partial denture, mandibular			
D5850	Tissue conditioning, maxillary	1 of (D5850, D5851) per arch every 12 months		
D5851	Tissue conditioning, mandibular			
D5862	Precision attachment, by report	1 (D5862) every 60 months	Y	
D5899	Unspecified removable prosthodontic procedure, by report	2 (D5899) every 60 months		
	Maxillofacial Prosthetic Services			
D5931	Obturator prosthesis, surgical	1 (D5931) in a lifetime	Y	
D5932	Obturator prosthesis, definitive	1 (D5932) in a lifetime	Y	
D5933	Obturator prosthesis, modification	1 (D5933) in a lifetime	Y	

Code	Description	Limitations	Prior Auth Req	Documentation/ X-Ray Required
	Maxillofacial Prosthetic Services (continued)			
D5936	Obturator prosthesis, interim	1 (D5936) in a lifetime	Y	
D5985	Radiation cone locator	1 (D5985) every 12 months	Y	
D5988	Surgical splint	1 (D5988) in a lifetime	Y	
D5992	Adjust maxillofacial prosthetic appliance, by report	1 (D5992) every 12 months		Narrative Required with Claim Submission
D5993	Maintenance & cleaning, maxillofacial prosthesis, other than required adjustments, by report	1 (D5993) every 3 months		Narrative Required with Claim Submission
	Fixed Prosthodontic Services			
D6930	Re-cement or re-bond fixed partial denture	Contraindicated any provider, within 91 days		
	Oral and Maxillofacial Services			
D7111	Extraction, coronal remnants, primary tooth	1 of (D7111-D7250) per tooth in a lifetime. D7111, D7140, D7210, D7220, D7230, D7240, D7241 and D7250 are contraindicated in conjunction with D9215 - same day, same recipient, any provider.		
D7140	Extraction, erupted tooth or exposed root			
D7210	Extraction, erupted tooth requiring removal of bone and/or sectioning of tooth			Narrative and X-rays Required with Claim Submission
D7220	Removal of impacted tooth, soft tissue			
D7230	Removal of impacted tooth, partially bony	1 of (D7111-D7250) per tooth in a lifetime. D7111, D7140, D7210, D7220, D7230, D7240, D7241 and D7250 are contraindicated in conjunction with D9215 - same day, same recipient, any provider. D7241 and D7261 are contraindicated against each other - within 90 days, same recipient, any provider.		Narrative and X-rays Required with Claim Submission
D7240	Removal of impacted tooth, completely bony			
D7241	Removal impacted tooth, complete bony, complication			Narrative and X-rays Required with Claim Submission
D7250	Removal of residual tooth roots (cutting procedure)	1 of (D7111-D7250) per tooth in a lifetime. D7111, D7140, D7210, D7220, D7230, D7240, D7241 and D7250 are contraindicated in conjunction with D9215 - same day, same recipient, any provider.		Narrative and X-rays Required with Claim Submission
D7251	Coronectomy, intentional partial tooth removal	2 (D7251) in a lifetime		Narrative and X-rays Required with Claim Submission
D7260	Oroantral fistula closure	Contraindicated any provider, within 91 days		Narrative and X-rays Required with Claim Submission
D7261	Primary closure of a sinus perforation	Contraindicated any provider, within 91 days. D7241 and D7261 are contraindicated against each other - within 90 days, same recipient, any provider.		Narrative and X-rays Required with Claim Submission
D7270	Tooth reimplantation and/or stabilization, accident	Contraindicated any provider, within 91 days		Narrative and X-rays Required with Claim Submission
D7280	Exposure of an unerupted tooth	1 (D7280) per tooth in a lifetime		Narrative and X-rays Required with Claim Submission
D7283	Placement, device to facilitate eruption, impaction			Narrative and X-rays Required with Claim Submission
D7285	Incisional biopsy of oral tissue, hard (bone, tooth)			Narrative and X-rays Required with Claim Submission
D7286	Incisional biopsy of oral tissue, soft			Narrative Required with Claim Submission
D7287	Exfoliative cytological sample collection			Narrative Required with Claim Submission
D7288	Brush biopsy, transepithelial sample collection			Narrative Required with Claim Submission
D7290	Surgical repositioning of teeth			Narrative and X-rays Required with Claim Submission
D7291	Transseptal fiberotomy/supra crestal fiberotomy, by report			Narrative and X-rays Required with Claim Submission
D7292	Placement of temporary anchorage device [screw retained plate] requiring flap			Narrative and X-rays Required with Claim Submission
D7293	Placement of temporary anchorage device requiring flap; includes device removal			Narrative and X-rays Required with Claim Submission
D7294	Placement of temporary anchorage device without flap; includes device removal			Narrative and X-rays Required with Claim Submission
D7310	Alveoloplasty with extractions, four or more teeth per quadrant	1 of (D7310-D7321) per quadrant in a lifetime, contraindicated any provider within 3286 days		
D7311	Alveoloplasty with extractions, one to three teeth per quadrant			
D7320	Alveoloplasty, w/o extractions, four or more teeth per quadrant			
D7321	Alveoloplasty, w/o extractions, one to three teeth per quadrant			
D7410	Excision of benign lesion, up to 1.25 cm			Narrative and X-rays Required with Claim Submission
D7411	Excision of benign lesion, greater than 1.25 cm			Narrative and X-rays Required with Claim Submission
D7412	Excision of benign lesion, complicated			Narrative and X-rays Required with Claim Submission
D7440	Excision of malignant tumor, up to 1.25 cm			Narrative and X-rays Required with Claim Submission
D7441	Excision of malignant tumor, greater than 1.25 cm			Narrative and X-rays Required with Claim Submission
D7450	Removal, benign odontogenic cyst/tumor, up to 1.25 cm			Narrative and X-rays Required with Claim Submission
D7451	Removal, benign odontogenic cyst/tumor, greater than 1.25 cm			Narrative and X-rays Required with Claim Submission
D7460	Removal, benign nonodontogenic cyst/tumor, up to 1.25 cm			Narrative and X-rays Required with Claim Submission
D7461	Removal, benign nonodontogenic cyst/tumor, greater than 1.25 cm			Narrative and X-rays Required with Claim Submission
D7465	Destruction of lesion(s) by physical or chemical method, by report			Narrative and X-rays Required with Claim Submission
D7472	Removal of torus palatinus	2 of (D7472, D7243) in a lifetime		Narrative and X-rays Required with Claim Submission
D7473	Removal of torus mandibularis			
D7490	Radical resection of maxilla or mandible		Y	
D7510	Incision & drainage of abscess, intraoral soft tissue	Incidental already part of another procedure		Narrative and X-rays Required with Claim Submission
D7511	Incision & drainage of abscess, intraoral soft tissue, complicated			Narrative and X-rays Required with Claim Submission
D7520	Incision & drainage of abscess, extraoral soft tissue	Incidental already part of another procedure		Narrative and X-rays Required with Claim Submission
D7521	Incision & drainage of abscess, extraoral soft tissue, complicated			Narrative and X-rays Required with Claim Submission
D7530	Remove foreign body, mucosa, skin, tissue			Narrative Required with Claim Submission
D7540	Removal of reaction producing foreign bodies, musculoskeletal system			Narrative and X-rays Required with Claim Submission
D7550	Partial ostectomy/sequestrectomy for removal of non-vital bone	1 of (D7650, D7660, D7750, D7760) in a lifetime		Narrative and X-rays Required with Claim Submission
D7560	Maxillary sinusotomy for removal of tooth fragment or foreign body			Narrative and X-rays Required with Claim Submission

Code	Description	Limitations	Prior Auth Req	Documentation/ X-Ray Required
	Oral and Maxillofacial Services (continued)			
D7610	Maxilla, open reduction (teeth immobilized, if present)			Narrative and X-rays Required with Claim Submission
D7620	Maxilla, closed reduction (teeth immobilized, if present)			Narrative and X-rays Required with Claim Submission
D7630	Mandible, open reduction (teeth immobilized, if present)			Narrative and X-rays Required with Claim Submission
D7640	Mandible, closed reduction (teeth immobilized, if present)			Narrative and X-rays Required with Claim Submission
D7650	Malar and/or zygomatic arch, open reduction	1 of (D7650, D7660, D7750, D7760) in a lifetime		Narrative and X-rays Required with Claim Submission
D7660	Malar and/or zygomatic arch, closed reduction			
D7670	Alveolus, closed reduction, may include stabilization of teeth			Narrative and X-rays Required with Claim Submission
D7671	Alveolus, open reduction, may include stabilization of teeth			Narrative and X-rays Required with Claim Submission
D7680	Facial bones, complicated reduction with fixation, multiple surgical approaches			Narrative and X-rays Required with Claim Submission
D7710	Maxilla, open reduction			Narrative and X-rays Required with Claim Submission
D7720	Maxilla, closed reduction			Narrative and X-rays Required with Claim Submission
D7730	Mandible, open reduction			Narrative and X-rays Required with Claim Submission
D7740	Mandible, closed reduction			Narrative and X-rays Required with Claim Submission
D7750	Malar and/or zygomatic arch, open reduction	1 of (D7650, D7660, D7750, D7760) in a lifetime		Narrative and X-rays Required with Claim Submission
D7760	Malar and/or zygomatic arch, closed reduction			
D7770	Alveolus, open reduction stabilization of teeth			Narrative and X-rays Required with Claim Submission
D7771	Alveolus, closed reduction stabilization of teeth			Narrative and X-rays Required with Claim Submission
D7780	Facial bones, complicated reduction with fixation and multiple approaches			Narrative and X-rays Required with Claim Submission
D7810	Open reduction of dislocation		Y	
D7820	Closed reduction of dislocation			Narrative Required with Claim Submission
D7840	Condylectomy			Narrative and X-rays Required with Claim Submission
D7850	Surgical discectomy, with/without implant			Narrative and X-rays Required with Claim Submission
D7852	Disc repair			Narrative and X-rays Required with Claim Submission
D7854	Synovectomy			Narrative and X-rays Required with Claim Submission
D7858	Joint reconstruction		Y	
D7860	Arthrotomy			Narrative and X-rays Required with Claim Submission
D7865	Arthroplasty			Narrative and X-rays Required with Claim Submission
D7870	Arthrocentesis			Narrative and X-rays Required with Claim Submission
D7872	Arthroscopy, diagnosis, with or without biopsy			Narrative and X-rays Required with Claim Submission
D7873	Arthroscopy: lavage and lysis of adhesions			Narrative and X-rays Required with Claim Submission
D7874	Arthroscopy: disc repositioning and stabilization			Narrative and X-rays Required with Claim Submission
D7875	Arthroscopy: synovectomy			Narrative and X-rays Required with Claim Submission
D7876	Arthroscopy: discectomy			Narrative and X-rays Required with Claim Submission
D7877	Arthroscopy: debridement			Narrative and X-rays Required with Claim Submission
D7880	Occlusal orthotic device, by report			Narrative Required with Claim Submission
D7910	Suture of recent small wounds up to 5 cm			
D7911	Complicated suture, up to 5 cm			Narrative Required with Claim Submission
D7912	Complicated suture, greater than 5 cm			Narrative Required with Claim Submission
D7940	Osteoplasty, for orthognathic deformities	1 (D7940) in a lifetime	Y	
D7941	Osteotomy, mandibular rami	1 of (D7941-D7945) in a lifetime	Y	
D7943	Osteotomy, mandibular rami with bone graft; includes obtaining the graft		Y	
D7944	Osteotomy, segmented or subapical		Y	
D7945	Osteotomy, body of mandible		Y	
D7946	LeFort I (maxilla, total)	1 of (D7946-D7949) in a lifetime	Y	
D7947	LeFort I (maxilla, segmented)		Y	
D7948	LeFort II or LeFort III, without bone graft		Y	
D7949	LeFort II or LeFort III, with bone graft		Y	
D7951	Sinus augmentation with bone or bone substitutes via a lateral open approach			Narrative and X-rays Required with Claim Submission
D7953	Bone replacement graft for ridge preservation, per site			Narrative and X-rays Required with Claim Submission
D7955	Repair of maxillofacial soft and/or hard tissue defect	1 (D7955) every 24 months	Y	Narrative Required with Claim Submission
D7960	Frenulectomy (frenectomy or frenotomy), separate procedure	3 (D7960) in a lifetime		Narrative Required with Claim Submission
D7963	Frenuloplasty			Narrative Required with Claim Submission
D7970	Excision of hyperplastic tissue, per arch			Narrative Required with Claim Submission
D7971	Excision of pericoronal gingiva			Narrative Required with Claim Submission
D7980	Surgical Sialolithotomy			Narrative Required with Claim Submission
D7981	Excision of salivary gland, by report			Narrative Required with Claim Submission
D7982	Sialodochoplasty			Narrative Required with Claim Submission
D7983	Closure of salivary fistula			Narrative Required with Claim Submission

Code	Description	Limitations	Prior Auth Req	Documentation/ X-Ray Required
	Oral and Maxillofacial Services (continued)			
D7990	Emergency tracheotomy			Narrative Required with Claim Submission
D7991	Coronoidectomy	1 (D7991) in a lifetime		Narrative Required with Claim Submission
D7998	Intraoral placement of a fixation device not in conjunction with a fracture			Narrative Required with Claim Submission
D9110	Palliative (emergency) treatment, minor procedure	1 (D9110) per day same provider, 2 every 6 months		
D9120	Fixed partial denture sectioning	1 (D9120) every 60 months	Y	
D9210	Local anesthesia not in conjunction, operative or surgical procedures			Narrative Required with Claim Submission
D9212	Trigeminal division block anesthesia			Narrative Required with Claim Submission
D9215	Local anesthesia in conjunction with operative or surgical procedures			
D9222	Deep sedation/general anesthesia, first 15-minute increment	5 of (D9222, D9223) per day, not to be completed on same date of service with D9239, D9243. Anesthesia must show actual beginning and ending times. Anesthesia time begins when the provider starts to physically prepare the recipient for induction of anesthesia in the operating area and ends when the provider is no longer in constant attendance (i.e., when the recipient can be safe placed under postoperative supervision)		Narrative and X-rays Required with Claim Submission
D9223	Deep sedation/general anesthesia, each subsequent 15-minute increment			
D9230	Inhalation of nitrous oxide/analgesia, anxiolysis			Narrative Required with Claim Submission
D9239	Intravenous moderate (conscious) sedation/analgesia, first 15-minute increment	5 of (D9239, D9243) per day, not to be completed on same date of service with D9222, D9223. Anesthesia must show actual beginning and ending times. Anesthesia time begins when the provider starts to physically prepare the recipient for induction of anesthesia in the operating area and ends when the provider is no longer in constant attendance (i.e., when the recipient can be safe placed under postoperative supervision)		Narrative and X-rays Required with Claim Submission
D9243	Intravenous moderate (conscious) sedation/analgesia, each subsequent 15-minute increment			
D9248	Non-intravenous (conscious) sedation, includes non-IV minimal and moderate sedation			Narrative and X-rays Required with Claim Submission
D9310	Consultation, other than requesting dentist			
D9311	Consultation with a medical health care professional	1 (D9311) every 6 months		Narrative Required with Claim Submission
D9410	House/extended care facility call			
D9420	Hospital or ambulatory surgical center call			
D9440	Office visit, after regularly scheduled hours	1 (D9440) every 12 months		Narrative Required with Claim Submission
D9610	Therapeutic parenteral drug, single administration	1 (D9610) every 12 months		Narrative Required with Claim Submission
D9612	Therapeutic parenteral drugs, two or more administrations, different meds.	1 (D9612) every 12 months		Narrative Required with Claim Submission
D9630	Drugs or medicaments dispensed in the office for home use			Narrative Required with Claim Submission
D9930	Treatment of complications, post-surgical, unusual, by report	1 (D9930) every 12 months		Narrative Required with Claim Submission
D9940	Occlusal guard, by report	1 (D9940) every 36 months	Y	
D9942	Repair and/or reline of occlusal guard	1 (D9942) in a lifetime		Narrative Required with Claim Submission
D9950	Occlusion analysis, mounted case	1 (D9950) in a lifetime		Narrative Required with Claim Submission
D9951	Occlusal adjustment, limited	1 (D9951) in a lifetime		
D9952	Occlusal adjustment, complete	1 (D9952) in a lifetime		
D9991	Dental case management, addressing appointment compliance barriers	1 of (D9991-D9994) every 6 months		
D9992	Dental case management, care coordination			
D9993	Dental case management, motivational interviewing			
D9994	Dental case management, patient education to improve oral health literacy			

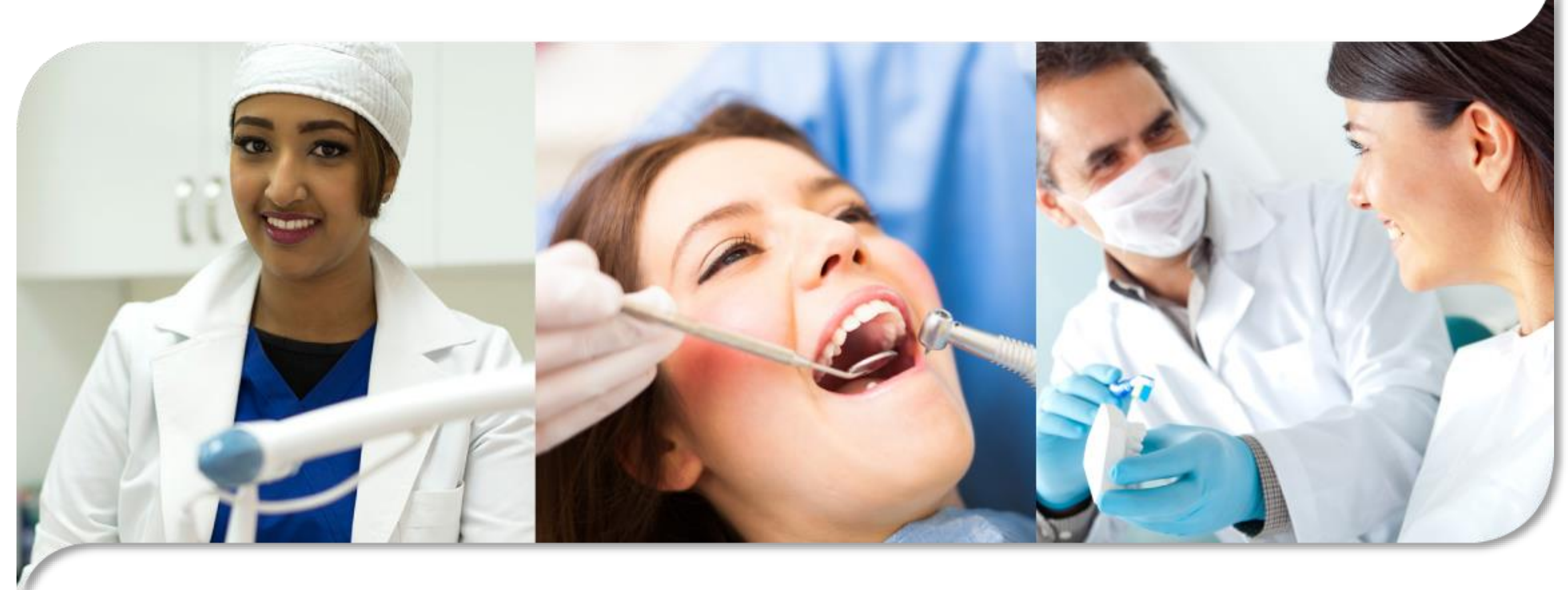
(This concludes the Nevada Medicaid – Child Schedule of Benefits)

SECTION 13 – ATTACHMENTS

Attachment A – Medicaid Service Manual (MSM 1000)

Nevada Medicaid

Revisions to Medicaid Services Manual (MSM) Chapter 1000



www.libertydentalplan.com/NVMedicaid

MEDICAID SERVICES MANUAL
TRANSMITTAL LETTER

June 28, 2017

TO: CUSTODIANS OF MEDICAID SERVICES MANUAL

FROM: LYNNE FOSTER, CHIEF OF DIVISION COMPLIANCE

SUBJECT: MEDICAID SERVICES MANUAL CHANGES
CHAPTER 1000 – DENTAL

BACKGROUND AND EXPLANATION

Revisions to Medicaid Services Manual (MSM) Chapter 1000 – Dental are being proposed to strengthen policy and to provide clarity to the Medicaid policy. The proposed revision is in Section 1003.8 – Orthodontics, where authorization for orthodontics will be changed from the Handicapping Labio-lingual Deviation Index scoring to Medically Necessary Orthodontic Automatic Qualifying Conditions. Additional revisions in this section include: Coverage and Limitations, Provider Responsibilities and a new section for Recipient Responsibilities. The prior authorization process is revised to reflect the above changes in qualifying conditions and the required documentation to be submitted for prior authorization.

Throughout the chapter, grammar, punctuation and capitalization changes were made, duplications removed, acronyms used and standardized and language reworded for clarity. Renumbering and re-arranging of sections was necessary.

Entities Financially Affected: Provider Type 22 – Dentists enrolled with Nevada Medicaid as a Provider Type 22 with Specialty Code 079 – Orthodontists.

Financial Impact on Local Government: None known.

These changes are effective June 29, 2017.

MATERIAL TRANSMITTED	MATERIAL SUPERSEDED
MTL 16/17 MSM CHAPTER 1000 – DENTAL	MTL 14/15, 02/17 MSM CHAPTER 1000 – DENTAL

Manual Section	Section Title	Background and Explanation of Policy Changes, Clarifications and Updates
1003.8.A.1	Orthodontics – Coverage and Limitations	Removed Panoramic films paragraph, not applicable to the Orthodontic section. Referenced Medically

Manual Section	Section Title	Background and Explanation of Policy Changes, Clarifications and Updates
		Necessary Orthodontic Automatic Qualifying Conditions.
1003.8.A.2	**Orthodontics – Coverage and Limitations**	New Section. Defines Medically Necessary Orthodontic Qualifying Conditions.
1003.8.A.3	**Orthodontics – Coverage and Limitations**	New Section. Provides policy related to attending dental appointments and dental history for orthodontic Prior Authorization (PA).
1003.8.A.4	**Orthodontics – Coverage and Limitations**	New Section. Defines service limitations for orthodontic services.
1003.8.A.5	**Orthodontics – Coverage and Limitations**	New Section. Defines the provider type and specialty type allowed for orthodontic services.
1003.8.B.1	**Orthodontics – Provider Responsibility**	Removed redundant language for clarity and replaced with the provider type and specialty type authorized for orthodontic services.
1003.8.B.2	**Orthodontics – Provider Responsibility**	New Section. Provides policy regarding Client Treatment History Form and who may complete the form.
1003.8.B.3	**Orthodontics – Provider Responsibility**	New Section. Provides policy related to the Client Treatment History Form, regarding appointment attendance, not complying with dental treatment plans and conditions that will deny orthodontic treatment PA requests.
1003.8.B.4	**Orthodontics – Provider Responsibility**	New Section. Provides policy related to appointment attendance and the amount of data required for PA submission.
1003.8.B.5	**Orthodontics – Provider Responsibility**	Moved from Section1003.8.B.11 for continuity.
1003.8.B.5.a	**Orthodontics – Provider Responsibility**	New Section. Provides policy related to routine cleanings and examinations during orthodontic treatment.

Manual Section	Section Title	Background and Explanation of Policy Changes, Clarifications and Updates
1003.8.B.6	**Orthodontics – Provider Responsibility**	New Section. Provides policy regarding transfer of orthodontic care for dissatisfaction with a provider, relocation and changing providers.
1003.8.B.7	**Orthodontics – Provider Responsibility**	New Section. Provides policy regarding conditions that an Orthodontist may discontinue treatment.
1003.8.B.8	**Orthodontics – Provider responsibilities**	New Section. Provides policy regarding refunding of unused funds if orthodontic treatment is discontinued.
1003.8.B.9	**Orthodontics – Provider Responsibility**	New Section. Policy clarification related to not assessing or billing a recipient for additional services related to approved orthodontic treatment.
1003.8.B.10	**Orthodontics – Provider responsibility**	New Section. Policy regarding dental records in orthodontic treatment.
1003.8.C	**Orthodontics – Recipient Responsibilities**	New Section. Provides policy regarding recipient's responsibilities regarding appointments, oral hygiene, follow-up and missed appointments. Policy regarding the recipient contacting the Orthodontic provider immediately when missing scheduled appointments, provider changes, eligibility status changes or relocating.
1003.8.D	**Orthodontics – Authorization Process**	Renamed and re-numbered from Section 1003.8.C to Section 1003.8.D due to addition of Recipient Responsibilities Section.
1003.8.D.1	**Orthodontics – Authorization Process**	Removed redundant language related to which providers are authorized to review orthodontic PAs. Provided policy clarification related to the Orthodontic Medical Necessity Form, documentation requirements and conditions that qualify as Medically Necessary Orthodontic conditions.
1003.8.D.2.a	**Orthodontics – Authorization Process**	Provided policy clarification related to conditions that are not considered medically necessary for orthodontics.
1003.8.D.2.b	**Orthodontics – Authorization Process**	Provided policy clarification related to the psychological need for orthodontics.

Manual Section	Section Title	Background and Explanation of Policy Changes, Clarifications and Updates
1003.8.D.2.e	**Orthodontics – Authorization Process**	Removed section. Handicapping Labiolingual Deviation (HLD) form will no longer be used for orthodontic PAs.
1003.8.D.3	**Orthodontics – Authorization Process**	Provided policy clarification. Removed redundant language. New language is: PA requests must be submitted on an American Dental Association (ADA) claim form. Remove dental consultant.
1003.8.D.3.a	**Orthodontics – Authorization Process**	Removed reference to HLD form, added Orthodontic Medical Necessity Form.
1003.8.D.3.c	**Orthodontics – Authorization Process**	New Section regarding materials and measurement requirements of x-rays and other diagnostic materials regarding PAs for orthodontics.
1003.8.D.3.d	**Orthodontics – Authorization Process**	New Section. Policy regarding the level of documentation required for PA submission for orthodontics.
1003.8.D.3.e	**Orthodontics – Authorization Process**	Renumbered from Section 1003.8.D.3.c and language added regarding documentation for orthodontic treatment plans for PA submission.
1003.8.D.3.f	**Orthodontics – Authorization Process**	Renumbered from Section 1003.8.D.3.d regarding any other documentation to substantiate the PA decision.
1003.8.D.4	**Orthodontics – Authorization Process**	Removed language – not part of the authorization process.
1003.8.D.4	**Orthodontics – Authorization Process**	Renumbered from Section 1003.8.D.5. Defines provider type and specialty type authorized to request PA for orthodontic services.
1003.8.D.4.a	**Orthodontics – Authorization Process**	Removed redundant language referring to Coverage, Limitations and PA website.
1003.8.D.4.b	**Orthodontics – Authorization Process**	Section removed – not part of the authorization process.

Manual Section	Section Title	Background and Explanation of Policy Changes, Clarifications and Updates
1003.8.D.4.b	**Orthodontics – Authorization Process**	Renumbered from 1003.8.D.4.c. Provides policy clarification regarding extension for orthodontic services.
1003.8.D.4.c	**Orthodontics – Authorization Process**	Provided policy clarification for PA submission.
1003.8.D.4.d	**Orthodontics – Authorization Process**	New Section. Provided policy for QIO-like vendor to shorten orthodontic treatment plans.
1003.8.D.5	**Orthodontics – Authorization Process**	Renumbered from Section 1003.8.D.6. Provide policy clarification for processing an approved PA for orthodontics and denied PA requests.
1003.8.D.6	**Orthodontics – Authorization Process**	Renumbered from Section 1003.8.D.7. Provides policy related to claims submission for approved orthodontic treatment.
1003.8.D.8	**Orthodontics – Authorization Process**	Removed – not applicable to this section. Rewritten for clarity in Section 1003.8.B.7.b.
1003.8.D.9	**Orthodontics – Authorization Process**	Removed – not applicable to this section. Rewritten for clarity in Section 1003.8.B.7.b.
1003.8.D.10	**Orthodontics – Authorization Process**	Removed – not applicable to this section. Rewritten for clarity in Section 1003.8.B.7.c.
1003.8.D.11	**Orthodontics – Authorization Process**	Removed – not applicable to this section. Rewritten for clarity in Section 1003.8.B.9.
1003.8.D.12	**Orthodontics – Authorization Process**	Removed – not applicable to this section. Rewritten for clarity in Section 1003.8.B.10.

DIVISION OF HEALTH CARE FINANCING AND POLICY

MEDICAID SERVICES MANUAL
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1000 DENTAL

INTRODUCTION

The Nevada Medicaid Dental Services Program is designed to provide dental care under the supervision of a licensed provider. Dental services provided shall maintain a high standard of quality and shall be provided within the coverage and limitation guidelines outlined in this Chapter and the Quality Improvement Organization-Like (QIO-Like) Vendor's Billing Guide. All Medicaid policies and requirements, (such as prior authorization, etc.) except for those listed in the Nevada Check Up (NCU) Manual Chapter 1000 are the same for NCU.

Dentists participating in Nevada Medicaid shall provide services in accordance with the rules and regulations of the Nevada Medicaid program. Dental care provided in the Nevada Medicaid program must meet prevailing professional standards for the community-at-large. Any dental provider, who undertakes dental treatment, as covered by Nevada Medicaid, must be qualified by training and experience in accordance with the Nevada State Board of Dental Examiners rules and regulations.

All materials and therapeutic agents used or prescribed must meet the minimum specifications of the American Dental Association (ADA). All dental services, including without limitation, examinations, radiographs, restorative and surgical treatment, as well as record keeping are to be provided in accordance with current ADA guidelines and the ADA Code of Ethics, and are to be coded according to the definitions and descriptions in the current ADA Code on Dental Procedures and Nomenclature (CDT Code) manual. All dental services must conform to the statutes, regulations and rules governing the practice of dentistry in the state in which the treatment takes place.

Nevada Medicaid provides dental services for most Medicaid-eligible individuals under the age of 21 as a mandated service, a required component of the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) benefit. For Medicaid-eligible adults age 21 years and older, dental services are an optional service as identified in this chapter and the Billing Guide documents located at www.medicaid.nv.gov in Provider Type (PT) 22 Dentist.

Individuals under Age 21

Through the EPSDT benefits, individuals under the age of 21 receive comprehensive dental care such as periodic and routine dental services needed for restoration of teeth, prevention of oral disease and maintenance of dental health. The EPSDT program assures children receive the full range of necessary dental services, including orthodontia when medically necessary and pre-approved by the Nevada Medicaid QIO-like vendor. The EPSDT screening provider may refer children for dental services. However, such a referral is not necessary if the parent otherwise elects to contact a Medicaid dental provider. The local Medicaid District Office can direct the parent/guardian to local dental providers.

Individuals age 21 and older

Dental services for Medicaid-eligible adults who qualify for full Medicaid benefits receive emergency extractions, palliative care and may also be eligible to receive prosthetic care (dentures/partials) under certain guidelines and limitations.

Pregnancy Related Services

Nevada Medicaid offers expanded dental services in addition to the adult dental services for Medicaid-eligible pregnant women. These expanded pregnancy related services require prior authorization. Medical providers and/or Managed Care Organization should provide a dental referral when it is discovered that a recipient is pregnant. Dental providers should attach a copy of the referral or provide a statement of pregnancy in the comment section of the ADA claim form to any Prior Authorization (PA) requests for pregnancy related dental services. Pregnancy related dental services are discontinued on the date of delivery. Except for services that were authorized but not completed prior to the end of the pregnancy.

1001 AUTHORITY

Nevada Revised Statute (NRS) 631 – Dentistry and Dental Hygiene.

The State Plan of Nevada describes the amount, duration and scope of dental care and services provided to the categorically needy in Attachments 3.1-A 10 and 3.1-A 12b.

The Centers for Medicare and Medicaid Services (CMS) state that necessary and essential dental services are mandatory for all eligible Medicaid children under the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) under the Social Security Act (SSA) 1905(r)(3). The Nevada EPSDT program provides children with services that are in addition to those available to adult recipients as cited in the Code of Federal Regulations (CFR) Title 42 Section 441.56.

1002 RESERVED

1003 NEVADA MEDICAID POLICY

Reference the Coverage, Limitations and Prior Authorization Requirements document located in the QIO-like vendor's web portal at www.medicaid.nv.gov in PT 22 Dentist Billing Guide for a list of CDT codes detailing prior authorization requirements and service limitations.

1003.1 DIAGNOSTIC AND PREVENTIVE SERVICES (D0100 – D1999)

The branch of dentistry used to identify and prevent dental disorders and disease.

The United States Preventive Services Task Force (USPSTF) is an independent, volunteer panel of national experts in prevention and evidence-based medicine. Nevada Medicaid lists these recommendations in the Medicaid Services Manual (MSM) Chapter 600, Attachment A.

The USPSTF recommends application of fluoride varnish to primary teeth of all infants, children, starting at the age of primary tooth eruption, and oral fluoride supplementation starting at six months of age for children whose water supply is fluoride deficient.

Nevada Medicaid promotes oral health by providing coverage for routine, periodic oral examinations and preventive treatment, fluoride treatment and sealant application for children, in accordance with the recommendations of the American Dental Association (ADA) and the American Academy of Pediatric Dentists (AAPD) for the prevention of tooth decay and the promotion of good oral health. Medicaid's coverage for preventive services, for children, is guided by the recommendations of the ADA and AAPD. Periodic dental examinations and routine preventive treatment should begin with eruption of the first tooth and before the first birthday, and should continue every six months or as recommended by the dentist. The examination includes assessment of pathology and injuries, growth and development and caries risk assessment. Anticipatory guidance/counseling should be an integral part of each dental visit. Counseling on oral hygiene, nutrition/dietary practices, injury prevention and non-nutritive oral habits should be included.

Nevada Medicaid authorizes payment of diagnostic and preventive dental services for qualified recipients.

A. COVERAGE AND LIMITATIONS

Coverage is limited to EPSDT for persons less than 21 years of age. Coverage for persons over 21 years of age is limited to diagnostic services needed for emergency extractions or palliative care.

B. AUTHORIZATION REQUIREMENTS

No PA is necessary for these services covered under EPSDT.

1003.2 RESTORATIVE DENTISTRY SERVICES (D2000 – D2999)

The branch of dentistry used to restore the integrity of the teeth through the use of fillings or crowns.

Nevada Medicaid authorizes payment of restorative dentistry for qualified recipients.

A. COVERAGE AND LIMITATIONS

Restorative services are limited to EPSDT, for persons less than 21 years of age.

For recipients age 21 years and older, with a PA, Nevada Medicaid reimburses for certain fillings and crowns on teeth that are an abutment (anchor) tooth for that partial denture. The ADA defines an abutment tooth as “a tooth used as a support for a prosthesis” (i.e. partial denture). Nevada Medicaid also reimburses for palliative treatment for persons 21 years of age and older. Pregnancy related services as defined in the MSM Addendum for persons 21 years of age and older are listed in the QIO-like vendor’s web portal at www.medicaid.nv.gov in the Provider Type 22 Dentist Billing Guide.

Fillings are limited to the use of amalgam or tooth colored restorations.

Tooth preparation, acid etching, all adhesives (including bonding agents) liners and bases, polishing and curing and occlusal adjustment of either the restored tooth or the opposing tooth, is part of the amalgam restoration and must be included in the fee for the restoration. If pins are used, they should be reported under the appropriate code.

Tooth colored restorations refers to a broad category of materials including, but not limited to, self-curing composite, light-cured composite and glass ionomers. Tooth preparation, acid etching, adhesives, bonding agents, liners, bases and curing are included as part of the resin based composite restoration. If pins are used, they should be reported under the appropriate code.

The ADA defines an Indirect Pulp Cap as a nearly exposed pulp that is covered with a protective dressing to protect the pulp from additional injury and to promote healing. If the pulp is exposed and the provider attempts to cover it in the hopes of avoiding further injury to the nerve, that would be a Direct Pulp Cap (D3110). Placing a protective covering under a deep filling to help avoid sensitivity or pulpal irritation is not a billable service and is included in the restoration as a “liner.”

Crowns are limited to stainless steel and composite resin repairs.

Reference the Coverage, Limitations and Prior Authorization Requirements document located in the QIO-like vendor’s web portal at www.medicaid.nv.gov in PT 22 - Dentist Billing Guide.

B. AUTHORIZATION REQUIREMENTS

No PA is necessary under EPSDT.

1003.3 ENDODONTIC SERVICES (D3000 – D3999)

The branch of dentistry specializing in disease or injury that affects the root tips or nerves in the teeth through the use of root canals.

Nevada Medicaid authorizes payment of endodontics for qualified recipients.

A. COVERAGE AND LIMITATIONS

Coverage is limited to EPSDT for persons less than 21 years of age.

B. AUTHORIZATION REQUIREMENTS

No PA is necessary under EPSDT.

Reference the Coverage, Limitations and Prior Authorization Requirements document located in the QIO-like vendor's web portal at www.medicaid.nv.gov in PT 22 - Dentist Billing Guide.

1003.4 PERIODONTIC SERVICES (D4000 – D4999)

The branch of dentistry used to treat and prevent disease affecting supporting bones, ligaments and gums of the teeth.

Nevada Medicaid authorizes payment of periodontics for qualified recipients.

A. COVERAGE AND LIMITATION

1. Coverage is limited to EPSDT, for persons less than 21 years of age. Periodontal services for persons less than 21 years of age are limited to either four quadrants of scaling and root planing every two years with a maximum of four periodontal maintenance treatments annually or a maximum of two dental prophylaxis treatments annually.

2. Medicaid carefully monitors for the appropriate use of Codes D4341 and D4342. These codes are generally limited to recipients who are at least 14 years old. Providers' in-office records must verify x-rays, periodontal charting and diagnoses documenting the need for these procedures.

3. Periodontal scaling and root planing for pregnant recipients is a covered service.

Due to the risk of pregnancy gingivitis, Medicaid will cover a second cleaning during pregnancy as well as 100% coverage of the treatment of inflamed gums around wisdom teeth during pregnancy. Medical providers and/or Managed Care Organizations should provide a dental referral when a recipient becomes pregnant. Dental providers should attach a copy of the referral or provide a statement of pregnancy in the comment section of the ADA claim form to any PA requests for pregnancy related dental services. Pregnancy related dental services are discontinued on the date of delivery, except for services that were authorized but not completed prior to the end of the pregnancy.

4. Palliative treatment (CDT Codes D4355 and D4999) are covered for persons 21 years of age and older.

Additionally, Medicaid also monitors for the appropriate use of Code D4355 – Full Mouth Debridement. This code is typically reserved for severe cases in which the licensed dental provider is unable to complete a comprehensive oral evaluation because the tooth surfaces are covered by thick deposits of plaque and calculus. The full mouth debridement involves gross removal of the prominent plaque and calculus deposits making it possible for a licensed dental provider to inspect the oral cavity for signs of decay, infection or gum disease. CDT Code D4355 is a preliminary treatment that should be completed before the comprehensive exam and should not occur on the same day.

B. AUTHORIZATION REQUIREMENTS

1. No PA is necessary under EPSDT.

2. Some codes require a PA for pregnancy related services for persons age 21 and older.

Reference the Coverage, Limitations and Prior Authorization Requirements document located in the QIO-like vendor's web portal at www.medicaid.nv.gov in PT 22 Dentist Billing Guide.

1003.5 PROSTHODONTICS SERVICES (D5000 – D6999)

The branch of dentistry used to replace missing teeth or restore oral structure through the use of partials, dentures, etc.

Nevada Medicaid provides payment benefits of certain prosthodontics for qualified recipients. Emergency prosthetic repair refers to dental prosthetics that are rendered completely unserviceable. Loose dentures or dentures with broken/missing teeth do not meet the intent of the definition unless irritation is present and sufficiently documented. The dentist's in-office records must substantiate the emergency for the purposes of Medicaid post-payment utilization review and control.

A. COVERAGE AND LIMITATIONS

1. Partial dentures and full dentures may be provided when medically necessary to prevent the progression of weight loss and promote adequate mastication. Medicaid limits reimbursement of services to one new full or partial denture per five years. Given reasonable care and maintenance, prostheses should last five years. Education given by the dentist on the proper care of the prostheses is expected and included in the purchase of any prosthetic service.

2. Medicaid will pay for necessary emergency x-rays required to diagnose Medicaid covered removable prostheses. No PA is necessary for the initial emergency examination and x-rays. The dentist's office records must substantiate the recipient's medical necessity (e.g., x-ray evidence, reported significant loss of weight, sore and bleeding gums, painful mastication, etc.). Payment for the examination and x-rays may be withdrawn if post-payment reviews of in-office records do not substantiate the medical necessity. Payment for dentures or partials includes any adjustments or relines necessary for six months after the date of delivery.

3. A person qualifies for a partial denture with four or more missing teeth, if anterior to the second molar in the same arch, or the four or more missing teeth are unilaterally (on one side only) in sequence as in, "2, 3, 4 & 5." Medicaid does not allow unilateral partials except in the immediately preceding and following examples. In the following examples the person would be eligible for a partial because four teeth would be missing and the person would be expected to have difficulty with mastication: missing 18, 19, 20 and 28 or 29; or 18, 19, 20 and 21 (four teeth in a row). However, a person would not be eligible for a partial if missing 19, 20, and 31 or 32 because there are not enough teeth missing for significant difficulty with mastication.

4. Third molars are not replaceable as missing teeth nor are they considered in the qualification for payment of partial dentures. Second molars are replaceable as missing teeth with missing posteriors in the same quadrant as explained in the above examples. A flipper may be used as a temporary replacement for employment purposes when an anterior tooth is extracted. For healing purposes, a flipper may be used temporarily when the partial for an anterior tooth will not be available for greater than three months.

5. A person may also qualify for a partial when missing any one of the six upper or lower anterior teeth (6, 7, 8, 9, 10, 11, 22, 23, 24, 25, 26 or 27) when necessary for employment. A supportive written Division of Welfare and Supportive Services (DWSS), New Employees of Nevada (NEON) report meets the employment

verification requirement. The NEON report must be maintained in the recipient's dental record for retrospective review.

6. Requests to override the 5-year limitation on full and partial dentures will require a PA and will only be considered for the following exceptional circumstances:

   a. Dentures were stolen (requires a copy of the police report). Also, under consideration is if the theft is a repeatedly occurring event. The recipient must exercise reasonable care in maintaining the denture.

   b. Dentures were lost in a house fire (requires a copy of the fire report or other notification documenting the fire such as a newspaper article).

   c. Dentures were lost in a natural disaster (requires a copy of documentation from Federal Emergency Management Agency (FEMA), the American Red Cross or any other documentation indicating that the recipient's residence was in the area affected by the natural disaster).

   d. Dentures no longer fit due to a significant medical condition. Requires one letter from each of the recipient's physician/surgeon and dentist. Physician/surgeon documenting the supporting medical condition. The dentist stating that the existing denture cannot be made functional by adjusting or relining it and that new dentures will be functional. Providers and recipients cannot expect to receive approval for replacement prosthesis without adequate justification and documentation.

   e. Dentures could not be made functional by issuing dentist. Requires a letter from the recipient's new dentist, the recipient's physician/surgeon and the recipient. The physician/surgeon stating the medical necessity for the denture. The dentist stating that the existing denture cannot be made functional by adjusting or relining it and that the new denture will be functional. The recipient stating that they returned to the issuing dentist requesting the denture be made functional and the issuing dentist was unable to comply. Providers and recipients cannot expect to receive approval for replacement prosthesis without adequate justification and documentation.

   Process to request an override based on the above exceptional circumstances requires PA, the provider must submit the following:

   f. A properly completed ADA claim form clearly marked "Request for Denture Override".

g. Copies of current radiographs when requesting an override for a partial denture to a full denture.

h. Any supporting documentation listed in this section, as applicable.

i. A cover letter that clearly describes the circumstances of the case.

j. These requests must be mailed to Medicaid's QIO-like vendor.

7. Medicaid will pay for a maximum of one emergency denture reline and/or maximum of six adjustments done not more often than every six months, beginning six months after the date of partial/denture purchase. No prior approval is required for relines. The provider's in-office records must substantially document the medical emergency need. Denture/partial relines and adjustments required within the first six months are considered prepaid with Medicaid's payment for the prosthetic. Dentists should call or write to the fiscal agent to insure the reline is not being done within six months of the date of the last reline or new denture purchase. A claim submitted for a reline or adjustment sooner than six months since the last payment for a reline or adjustment will deny for payment. Post payment review will be done to assure that medical necessity of the service has been substantially documented.

8. If the recipient is unable to wear the denture, the recipient must schedule an appointment with the issuing dentist to have the denture/partial made functional. Factors which would cause the denture to not be functional would include improper fit, sore or bleeding gums and painful mastication. If the issuing dentist is unable to make the denture functional, resulting in the recipient requiring services from another dentist, a full or partial recoupment of payment may occur less the cost of the laboratory services. When the issuing dentist receives a recoupment notice the dentist must provide a copy of the invoice detailing the laboratory charges so that it may be deducted from the recoupment amount. The requirements in Section 1003.6 are applicable if a dentist requests a new denture within a five year period.

B. PROVIDER RESPONSIBILITY

1. New dentures or partials (or their replacements every five years) must be evaluated for medical necessity. Medicaid will not pay for routine examinations (Code D0150) in connection with new dentures or denture replacements. For new dentures, dentists may bill Code D0140 for the initial dental emergency and another Code D0140 for the evaluation/provision of the dentures. Dentists may bill one examination charge at the time of the first visit. They may bill the other examination on the same service date used to bill the denture or partial. For replacement of full

dentures, the provider may not bill Code D0140 a second time with the date of service used to bill the denture(s).

2. Keep diagnosable, panoramic or full mouth x-rays as part of the dentist's record for all removable prosthetics. The x-rays and dentists office notes must substantiate all missing teeth.

3. The recipient must sign and date a delivery receipt to verify that the dentures/partials were received and are accepted and/or acceptable. The date of the signature on the delivery receipt must be the date the dentures/partials were received by the recipient. The delivery receipt must include the recipient's name, quantity, detailed description of the time(s) delivered and the date and time of delivery, and be maintained in the recipient's dental record.

C. AUTHORIZATION REQUIREMENTS

1. PA is required for partials and/or full dentures for all recipients residing in Nursing Facilities or receiving Hospice services. There are additional codes for denture repairs that also require a PA. Refer to the Coverage, Limitations and Prior Authorization Requirements document located in the QIO-like vendor's web portal at www.medicaid.nv.gov in PT 22 – Dentist Billing Guide.

2. Requests for partials and/or full dentures for all recipients residing in Nursing facilities or receiving Hospice services must explain the significance of all of the following qualifications of medical need:

   a. The recipient's medical need for the service in considering his/her total medical condition. Requires one letter each from the recipient's primary care physician and dentist documenting the supporting medical condition.

   b. Factors relating to conditions that hinder effective functioning, including but not limited to, impaired mastication, muscular dysfunction, type of diet, current weight compared to the previous year, diagnosis, ability to swallow and reason for poor nutrition. When documenting reason for poor nutrition, specify whether this is related to dental structures, or related to the recipients physical or medical condition and will not be improved with dentures.

   c. Mental status relating to the recipients ability to understand the use and care of the partials and/or full dentures.

3. No PA is required for partials and/or full dentures for all other recipients. Post payment review will be completed at the discretion of the fiscal agent with

recoupment of payment for any partials or full dentures not meeting the above policy for qualification of coverage.

1003.6 DENTURE IDENTIFICATION EMBEDDING

Nevada Medicaid provides payment of denture identification embedding for qualified recipients.

A. COVERAGE AND LIMITATIONS

Any removable prosthetic appliance paid for by the Nevada Medicaid program must have permanent identification labeling embedded in it as defined in NRS 631.375.

B. PROVIDER RESPONSIBILITY

Medicaid requires embedding of the recipient's first initial, last name or the last four digits of the social security number for complete dentures, partial dentures with acrylic saddles and when relining unmarked appliances. In cases of insufficient room, you may reduce the person's name and identifiers to the first and second initials or the last four digits of the social security number.

Code D5899 and descriptor "ID Embedding" must be completed by delivery unless the prosthetics already show such markings and the provider so states.

C. AUTHORIZATION REQUIREMENTS

Nevada Medicaid does not require PA for ID embedding.

1003.7 ORAL SURGERY (D7000 – D7999)

The branch of dentistry using surgery to treat disorders/diseases of the mouth.

Nevada Medicaid authorizes payment of oral surgery for qualified recipients.

A. COVERAGE AND LIMITATIONS

1. Coverage is limited to EPSDT, for persons less than 21 years of age, pregnant persons 21 years of age and older, and as palliative treatment for persons 21 years of age and older.

2. Tooth extraction coverage is limited to cases involving symptomatic teeth with clinical symptoms and/or signs of pathology, including acute or chronic pain, inflammation, infection or peri-radicular radiographic evidence of defect.

3. Elective tooth extractions are not covered by Medicaid. "Elective Tooth Extraction" is the extraction of asymptomatic teeth, that is, teeth without symptoms and/or signs of pathology. It includes the extraction of other asymptomatic teeth without clinical evidence of pathology, including third molars (tooth numbers 1, 16, 17 and 32). The exception is extractions that are deemed medically necessary as part of Prior Authorized orthodontic treatment plan.

B. AUTHORIZATION REQUIREMENTS

No PA is necessary under EPSDT and for some pregnancy related services, or for persons 21 years of age and older, if the service is considered an emergency extraction or palliative care.

Reference the Coverage, Limitations and Prior Authorization Requirements document located in the QIO-like vendor's web portal at www.medicaid.nv.gov in PT 22 Dentist Billing Guide.

1003.8 ORTHODONTICS (D8000 – D8999)

The branch of dentistry used to correct malocclusions (the "bite") of the mouth and restore it to proper alignment and function.

Nevada Medicaid authorizes payment for orthodontics for qualified recipients under 21 years of age.

The Diagnostic Codes D0330, D0350 and D0470 are considered to be "Orthodontia" services only when required for Orthodontia treatment prior authorization.

A. COVERAGE AND LIMITATIONS

1. Medicaid excludes orthodontic work, except that which is authorized by the Children with Special Health Care Needs Program and reimbursed by Medicaid, or when specifically authorized by Medicaid's QIO-like vendor as medically necessary under EPSDT, based on Medically Necessary Orthodontic Automatic Qualifying Conditions.

2. Medically Necessary Orthodontic Automatic Qualifying Conditions are deemed medically necessary and are qualified for reimbursement when it is part of a case involving treatment of cranio-facial anomalies, malocclusions caused by trauma or a severe malocclusion or cranio-facial disharmony that include, but are not limited to:

   a. Overjet equal to or greater than 9 millimeters.

b. Reverse overjet equal to or greater than 3.5 millimeters.

c. Posterior crossbite with no functional occlusal contact.

d. Lateral or anterior open bite equal to or greater than 4 millimeters.

e. Impinging overbite with either palatal trauma or mandibular anterior gingival trauma.

f. One or more impacted teeth when eruption is impeded (excluding third molars).

g. Defects of cleft lip or palate, or other craniofacial anomalies or trauma.

h. Congenitally missing teeth (extensive hypodontia) of at least one tooth per quadrant (excluding third molars).

i. Anterior crossbite with soft tissue destruction.

Note: For conditions not listed above, providers may request orthodontic treatment under the EPSDT "Healthy Kids Exception" by demonstrating "Medical Need."

3. Prior to the Orthodontist requesting a Prior Authorization (PA) for Orthodontic services, the following criteria must be met:

   a. the recipient must have received dental services by a referring dentist on at least two occasions, on separate days; and

   b. missed no more than 30 percent of any scheduled appointments, for any reason on all Client Treatment History forms submitted.

   c. The referring provider must provide the applicable dental appointment history and not submit more than three years of dental appointment history.

   When a recipient is unable to attend dental appointments for any reason, the treatment plan could be jeopardized, or could cause the treatment plan to extend beyond the anticipated time to complete the treatment, for which the Orthodontist is not reimbursed.

4. Orthodontia treatment is limited to once per a recipient's lifetime for limited transitional treatment (Dental Codes D8010, D8020 and D8040), and once per lifetime for comprehensive orthodontic treatment (Dental Codes D8080 and

D8090). If treatment is discontinued for any reason, including the recipient's non-compliance, Medicaid will not authorize a second orthodontia treatment.

5. Medicaid reimburses for orthodontia services only to those providers enrolled with Nevada Medicaid with the orthodontia specialty (PT 22 with Specialty Code 079).

B. PROVIDER RESPONSIBILITY

1. Only Dentists with a specialty of Orthodontia: PT 22 with the Specialty Code 079 will be reimbursed for orthodontic services.

2. A copy of the Client Treatment History form must be completed by the recipient's treating general or pediatric dentist and is to be in the orthodontic PA request. The treating orthodontist must complete a new Client Treatment History form when requesting a PA for a second phase of orthodontic treatment.

3. Medicaid shall deny any orthodontic prior authorization requests when the attached Client Treatment History form report does not show the recipient has a good history of keeping dental appointments, which is defined as: missing no more than 30 percent of scheduled appointments for any reason within a 24 month period or not complying with dental care treatment plans, as evidenced by active carious lesions, acute gingivitis, acute periodontitis, poor oral hygiene or other unresolved dental factors that could result in poor orthodontic case success.

4. Prior to the Orthodontist requesting a PA for Orthodontic services, the following criteria must be met:

   a. the recipient must have received dental services by a referring dentist on at least two occasions, on separate days; and

   b. missed no more than 30 percent of any scheduled appointments, for any reason on all Client Treatment History forms submitted.

   c. The referring provider must provide the applicable dental appointment history and not submit more than three years of dental appointment history.

   When a recipient is unable to attend dental appointments for any reason, the treatment plan could be jeopardized, or could cause the treatment plan to extend beyond the anticipated time to complete the treatment, for which the Orthodontist is not reimbursed.

5. Coordination with Ancillary Dentists: The orthodontist and any ancillary dentists must coordinate with each other to assure Medicaid will pay for the ancillary dental

services. For example, the orthodontist's proposed treatment plan should show he/she will be referring the child for extractions or other services. The ancillary dentist need not obtain separate approval for his/her services.

a. Additionally, the treating orthodontist must coordinate with the recipient's general dentist or provide in their own orthodontic practice routine cleanings and examinations according to the AAPD periodicity schedule.

6. A recipient may select a new Orthodontist if the recipient becomes dissatisfied with the original Orthodontist or must geographically move before completion of the treatment plan. When a recipient changes providers during active treatment, the provider must comply with the following:

   a. Acceptance of reimbursement by the Orthodontist is considered their agreement to prorate and forward any unused portion of the reimbursement to a Nevada Medicaid contracted Orthodontist, selected by the recipient, to complete the treatment.

   b. The originating provider must not release Medicaid funds to anyone other than another Medicaid orthodontic provider who agrees to use the funds to complete the approved treatment plan. No additional funds will be allocated or approved to the new Orthodontist for the completion of the treatment. Without such an agreement, the originating provider must return the unused fund (see Section 8 below) to the Medicaid fiscal agent at the address listed in Section 1005.1 of this chapter.

   c. Medicaid holds the Orthodontist responsible for removing any banding and providing retainers at no additional cost to the recipient. The Orthodontist accepts this responsibility as part of providing Medicaid services.

7. Circumstances in which an Orthodontist may discontinue treatment:

   a. Due to the recipients' poor oral hygiene compliance, when identified and documented by the Orthodontist;

   b. The recipient fails to contact the Orthodontist's office within a four-month period; and/or

   c. When the recipient has not kept at least one appointment within a six-month period.

8. When treatment is discontinued due to any of the reasons listed above, the provider must refund any unused portion of the reimbursement to the Medicaid Fiscal Agent

(address listed in Section 1005.1 of this chapter). The provider must contact the Fiscal Agent to request a balance of the remaining funds which should be refunded. It will be based on the approved treatment plan, the services already rendered and the residual amount that will be refunded to the Fiscal Agent. Any refunded unused funds are not available to be used for further or future orthodontic treatment for that recipient.

9. The Orthodontist may not assess the recipient or bill Medicaid for additional charges on broken bands, or other necessary services, even if the recipient's poor compliance or carelessness caused the need for additional services.

10. Providers must maintain a detailed, comprehensive, legible dental record of all orthodontia treatment and care. Legible electronic dental records are acceptable.

C. RECIPIENT'S RESPONSIBILITIES

1. Prior to the Orthodontist requesting a PA for Orthodontic services, the following criteria must be met:

   a. the recipient must have received dental services by a referring dentist on at least two occasions, on separate days; and

   b. missed no more than 30 percent of any scheduled appointments, for any reason.

   c. The recipient's referring provider must provide the applicable dental appointment history and not submit more than three years of dental appointment history.

2. The recipient is responsible for maintaining good oral hygiene on a regular basis, as instructed by the Orthodontist, to maintain the orthodontia treatment plan or orthodontic appliances received.

3. The recipient is responsible to attend all scheduled and follow-up appointments as scheduled as part of the treatment plan.

4. The recipient is responsible for contacting the Orthodontic provider immediately when they are going to miss any scheduled appointments, change providers, or when they have a change in their eligibility status, or when they are moving out of the area.

D. AUTHORIZATION PROCESS

1. Request for orthodontic treatment must be Prior Authorized. The PA request must include a completed Orthodontic Medical Necessity (OMN) form. To qualify for authorization, the form must explain the significance of at least one of the following Medically Necessary Orthodontic Automatic Qualifying Conditions, in the OMN form (form found at www.medicaid.nv.gov) or Medical Necessity under EPSDT "Healthy Kids" exception. Clinical documentation must be submitted that substantiates and validates the condition(s) with diagnostic panoramic radiographs, diagnostic photos or photographs of diagnostic models with the automatic qualifying condition.

   Medically Necessary Orthodontics are deemed necessary and qualified when it is part of a case involving treatment of cranio-facial anomalies, malocclusions caused as a result of trauma or a severe malocclusion or cranio-facial disharmony that includes, but not limited to:

   a. Overjet equal to or greater than 9 millimeters.

   b. Reverse overjet equal to or greater than 3.5 millimeters.

   c. Posterior crossbite with no functional occlusal contact.

   d. Lateral or anterior open bite equal to or greater than 4 millimeters.

   e. Impinging overbite with either palatal trauma or mandibular anterior gingival trauma.

   f. One or more impacted teeth when eruption is impeded (excluding third molars).

   g. Defects of cleft lip or palate or other craniofacial anomalies or trauma.

   h. Congenitally missing (extensive hypodontia) of at least one tooth per quadrant (excluding third molars).

   i. Anterior crossbite with soft tissue destruction.

   Note: For conditions not listed above, providers may request orthodontic treatment under the EPSDT "Healthy Kids Exception" by demonstrating "Medical Need."

2. Requests for orthodontia must explain the significance of one or more of the following considerations of "medical need."

a. Functional factors relating to conditions that hinder effective functioning, including, but not limited to, impaired mastication and muscular dysfunction. Orthodontic treatment is not authorized under medical necessity for the following, but not limited to: a possibility of risk of a future condition, ease of hygiene or esthetic improvement.

b. Factors related to the degree of deformity and malformation which produce a psychological need for the procedure. The psychological need must be based on objective evidence provided by a Qualified Mental Health Practitioner (QMHP) within the scope of their practice and reviewed by the QIO-like vendor.

c. The recipient's overall medical need for the service in light of his/her total medical condition. For example, an orthodontia need which might be slight in an otherwise healthy child may become quite severe for a child suffering from complicating ailments such as cerebral palsy or epilepsy.

d. The medical appropriateness of an orthodontic treatment plan as opposed to other available dental treatment. Appropriate consideration may be given, for example, to a child's inability to understand and follow a treatment plan where failure to follow the plan would result in medical complications of the child's condition.

3. PA requests must be submitted on an American Dental Association (ADA) claim form.

The following documents are required to be attached with the prior authorization request to the QIO-like vendor:

a. Orthodontic Medical Necessity (OMN) Form.

b. Client Treatment History Form.

c. A copy of the oral examination record(s), including diagnostic photographs or photos of diagnostic models demonstrating measurements and a copy of a panoramic x-ray. Diagnostic photographs and/or photographs of diagnostic models and panoramic x-rays must be of sufficient quality to confirm the diagnosis, and must include any other documentation or measurements as required in the Orthodontic Medical Necessity Form, to confirm the diagnosis.

d. The provider must submit the appropriate level of documentation to support the diagnosis. Providers are encouraged to use the recommendations for

diagnostic records encompassed in the most current edition of the American Association of Orthodontists "Clinical Practice Guidelines for Orthodontics and Dentofacial Orthopedics" which includes the recommendations for the use of panoramic radiographs, cephalometric radiographs and Intraoral and Extraoral photographs to confirm a diagnosis.

e. A statement addressing the diagnosis/treatment plan and prognosis to include the following:

1. Principal diagnosis and any significant associated diagnoses.

2. Prognosis.

3. Date of onset of the illness or condition and etiology if known.

4. Clinical significance or functional impairment caused by the illness or condition.

5. Specific services to be rendered by each discipline and anticipated time for achievement of treatment goals.

6. Therapeutic goals to be achieved by each discipline and anticipated time for achievement of the therapeutic goals.

7. A description of previous services that were provided to address the illness/condition and the result of the prior care.

f. Any other documentation that may be required to substantiate prior authorization decision.

The Orthodontic Medical Necessity Form and the Client Treatment History Form are located on the QIO-like vendor's web portal at www.medicaid.nv.gov.

4. Medicaid's QIO-like vendor will accept PA requests ONLY from those providers with a specialty in Orthodontia (PT 22 with Specialty Code 079).

a. Orthodontists must use one of the codes for "limited" or "comprehensive" orthodontic treatment for bills and payment PA requests.

b. Medicaid will deny an extension of orthodontic treatment if the results are poor or the recipient has failed to keep appointments or comply with treatment.

c. PA requests submitted must show all proposed orthodontic procedures, and list the following at a minimum: initial banding, months of treatment including retention treatments and any retainers. Medicaid expects the provider to render unlisted but necessary treatment components at no additional charge. The provider's usual and customary charge must show for each service. Stating a total fee for all services is not acceptable.

d. The QIO-like vendor may require the Orthodontists to shorten their treatment plan after reviewing the submitted PA materials and documentation.

5. The QIO-like vendor inputs the disposition for the requested orthodontic service directly in to the current system. No forms are submitted for signature for indication of approved reimbursement amount. The fiscal agent does not return denied orthodontic requests to providers.

6. When the provider completes the initial banding, he/she must enter the date of service and the usual and customary charges amount on the claim form, and return it to the fiscal agent. The fiscal agent will make payment for the total specified on the approved treatment plan.

1003.9 ADJUNCTIVE GENERAL SERVICES (D9000 – D9999)

The branch of dentistry for unclassified treatment including palliative care and anesthesia.

Nevada Medicaid authorizes payment of adjunctive general services for qualified recipients under 21 years of age and for palliative care and anesthesia for persons 21 years of age and older.

A. COVERAGE AND LIMITATIONS

Coverage is limited to EPSDT, for persons less than 21 years of age, and for palliative care for persons 21 years of age and older.

For dental codes related to General or IV anesthesia, the provider must show the actual beginning and end times in the recipient's dental record. Anesthesia time begins when the provider physically prepares the recipient for the induction of anesthesia in the operating area, and ends when the provider is no longer in constant attendance (i.e., when the recipient can be safely placed under postoperative supervision).

B. AUTHORIZATION REQUIREMENTS

No PA is necessary under EPSDT. Persons 21 years of age and older require PA unless the service is for emergency extractions or palliative care.

Reference the Coverage, Limitations and Prior Authorization Requirements document located in the QIO-like vendor's web portal at www.medicaid.nv.gov in Provider Type 22 Dentist Billing Guide.

1003.10 PERSONS 21 YEARS OF AGE AND OLDER

Nevada Medicaid authorizes payment for qualified persons 21 years of age and older for partials, dentures, emergency extractions and palliative care only.

A. COVERAGE AND LIMITATIONS

Reference Nevada Medicaid Fee Schedule, Coverage and Limitations and Prior Authorization document for PT 22, can be found on the QIO-like vendor's web portal at www.medicaid.nv.gov.

B. PROVIDER RESPONSIBILITY

1. Providers must keep all substantiating x-rays on file for a minimum of six years following the date of service. Providers must keep the x-rays, related charting and other case documentation easily available to Medicaid reviewers during this period.

2. The Medicaid program considers emergency extractions a program benefit without prior or post approval. This includes the use of in-office sedation or anesthesia. The program never covers extractions for cosmetic purposes. Dentists need not routinely submit substantiating x-rays to the Medicaid fiscal agent. However, Medicaid will periodically request copies of x-rays substantiating third molar extractions (teeth 1, 16, 17 and 32 for adults and children) related to tissue impaction, partial and full bony and surgical verses simple extractions. The dentists on-file x-rays must reveal sufficient bone and root complications for difficult surgical removal procedures.

3. For treatment necessary to avoid life-threatening health complications, providers perform services necessary to prevent life-threatening deterioration of a person's physical health without PA even though the services do not immediately qualify as Medicaid covered emergency services. The dentist must certify the services were medically necessary due to health complicating conditions such as HIV, AIDS, cancer, bone marrow transplantation or post kidney transplant. The dentist's certification must be part of a note explaining why the treatment was necessary to avoid life-threatening problems. For example, the dentist may explain successful cancer treatment or organ transplantation depended on extractions or treatment of caries to protect the recipient's compromised immune system from the stress of oral infection.

C. AUTHORIZATION REQUIREMENTS

No authorization is needed if the service is for emergency extraction or palliative care.

1003.11 SERVICES NOT COVERED BY MEDICAID

A. COVERAGE AND LIMITATIONS

Nevada Medicaid does not cover the following services:

1. Cosmetic services, unless prior approved by the QIO-like vendor's Dental Consultant to return the recipient to work.

2. Routine and preventive dental care, such as periodic prophylaxis, restoration of incipient or minor decay, treatment of sensitivity to hot and cold or other minor pain is not covered for persons 21 years of age and older. (Prophylaxes and restorative dental services under pregnancy related services require PA and reviewed on an individual basis based on medical necessity).

3. Crowns are not allowed for persons 21 years of age and older, except where required on an anchor or abutment tooth for a partial denture. Gold crowns are not a covered benefit for any age.

4. For persons 21 years of age and older, Temporal Mandibular Disease (TMD) services are not covered by Nevada Medicaid except for adult emergency services.

5. No show appointments or charges for missed appointments are not allowed.

1003.12 PHARMACY SERVICES

Nevada Medicaid authorizes payment of pharmacy services for qualified recipients.

A. COVERAGE AND LIMITATIONS

Fluoride supplements are covered only for recipients less than 21 years old.

B. PROVIDER RESPONSIBILITY

Supplements need no PA when ordered by a dentist. The dentist should write, “Result of Healthy Kids” or “Result of EPSDT” on the prescription. The recipient must present the prescription with a Nevada Medicaid card to a Medicaid participating pharmacy provider. Providers must verify eligibility prior to service.

C. AUTHORIZATION PROCESS

These guidelines do not change any Medicaid policy regarding non-covered medications or medications which always require PA.

1003.13 RESIDENTS OF INTERMEDIATE CARE FACILITIES FOR INDIVIDUALS WITH INTELLECTUAL DISABILITIES (ICF/IID)

Nevada Medicaid authorizes payment for services provided in an ICF/IID to full Medicaid-eligible recipients.

All dental services provided to recipients in an ICF/IID are administered under the same policy coverage and limitations provided throughout this dental chapter.

A. COVERAGE AND LIMITATIONS

Under Federal regulations, the ICF/IID is required to include comprehensive dental services to their resident. Specifically, the ICF/IID's are responsible for:

1. A comprehensive diagnostic dental examination within one month of admission to the facility unless the recipient has had a dental examination within 12 months before admission.

2. Periodic examination and diagnosis done at least annually for each recipient.

3. Comprehensive dental treatment including dental care needed for relief of pain and infections, restoration of teeth and maintenance of dental health. Necessary access to the services, excluding sealants, orthodontia, pharmacy services, fluoride treatments and fluoride treatments with prophylaxis.

4. Emergency dental treatment on a 24-hour-a-day basis by a qualified dentist.

5. If appropriate, the dentist's/hygienist's participation in development, review and updating of the individual program plan as part of the Interdisciplinary Team (IDT) process, either in person or through written reports to the IDT.

For dental services beyond the Medicaid coverage benefit the facility must provide or make arrangements for each client from qualified personnel, including licensed dentists and dental hygienists to establish a relationship with the ICF/IID.

B. PROVIDER RESPONSIBILITY

For dental services beyond the Medicaid coverage benefit, the dentist must establish a

relationship with the ICF/IID facility staff to assure verification of the recipient's ICF/IID residency, and payment source for dental services prior to service.

1003.14 PROVIDERS OUTSIDE NEVADA

Nevada Medicaid authorizes payment for out-of-state providers under Medicaid guidelines.

A. COVERAGE AND LIMITATIONS

Out-of-state providers are subject to the coverage and limitations of dental services under Nevada Medicaid.

B. PROVIDER RESPONSIBILITY

Out-of-state providers are subject to all Medicaid rules and guidelines.

C. AUTHORIZATION REQUIREMENTS

Out-of-state providers must use the same PA process as in-state dental providers.

1003.15 PAYMENT OF NON-COVERED SERVICES

A. COVERAGE AND LIMITATIONS

Nevada Medicaid does not authorize payment for non-covered services.

B. PROVIDER RESPONSIBILITY

Dental providers must inform the recipient of his/her financial responsibility before rendering any uncovered service. Consider this done when the recipient or a responsible designee signs a written document acknowledging acceptance of financial responsibility for each specific itemized service. The signed document must state, "I understand Medicaid will not cover the above itemized service cost(s). I agree to pay for the services."

If Medicaid covers a procedure, the provider cannot charge the recipient for the balance after Medicaid's payment. Also, providers cannot charge Medicaid for one covered service and provide a different service. For example, since Medicaid does not cover restorations or prosthetics made of gold, Medicaid's payment on a covered restoration or prosthesis cannot be used to offset one made of gold. The recipient would need to pay the complete charge for the gold restoration or prosthesis, or the recipient must accept the Medicaid benefit service only.

C. RECIPIENT RESPONSIBILITY

Services exceeding program limitations are not considered Medicaid benefits. These services are the financial responsibility of the recipient.

D. AUTHORIZATION REQUIREMENTS

Nevada Medicaid does not authorize payment for non-covered services.

1003.16 SERVICES PROVIDED IN NURSING FACILITIES

Nevada Medicaid authorizes payment for services provided in nursing facilities to qualified recipients eligible with full Medicaid benefits.

A. COVERAGE AND LIMITATIONS

All dental services provided to recipients in a nursing facility are administered under the same policy coverage and limitations provided throughout this Dental Chapter.

B. PROVIDER RESPONSIBILITY

Medicaid advises dentists to confirm the recipient's eligibility through the Eligibility Verification System (EVS) for the month the service will be provided and retain a copy prior to service. Medicaid advises dentists to develop procedures with nursing facility staff to screen for ineligible recipients. Medicaid recommends dentists become users of EVS by making arrangements with Medicaid's QIO-like vendor.

C. NURSING FACILITY RESPONSIBILITY

Nursing facility staff must screen for Medicaid eligibility.

D. AUTHORIZATION REQUIREMENTS

NOTE: If the recipient is covered under Managed Care and has been an in-patient over 45 days, the recipient is then covered by Fee-for-Service from the 46th day forward.

PA is required for partials and/or full dentures for all recipients residing in nursing facilities or receiving Hospice services.

1003.17 HOSPITAL/SURGICAL CENTERS

A. COVERAGE AND LIMITATIONS

Nevada Medicaid authorizes payment for certain dental services in hospital or surgical centers for qualified recipients with PA unless it is an emergency.

B. AUTHORIZATION REQUIREMENTS

1. Two authorizations for inpatient hospitalization for a dental procedure are necessary for Medicaid reimbursement.

   a. The dental consultant must prior authorize the dental procedure.

   b. The Medicaid's QIO-like vendor or the Managed Care Organization (MCO) must certify the necessity for the recipient to be hospitalized for the performance of the inpatient dental procedure. The certification must be done before or on the date of the admission.

      The provider must write, "Hospital Admission" at the top of the Examination and Treatment Plan box of the claim form.

2. Procedures done as outpatient services for recipients less than 21 years of age in a hospital or surgical center must be identified. The provider must write, "Outpatient Facility Services" at the top of the Examination and Treatment Plan box of the claim form.

   a. Specific authorization is not required for the anesthesiologist and/or outpatient facility for recipients less than 21 years of age.

   b. All dentists providing surgical center services to Medicaid recipients must retain in-office copies of x-rays, intra-oral preoperative photographs (when necessary) and documentation necessary to substantiate service need. The substantiating evidence must be retained and remain readily available for no less than six years. Medicaid holds the provider responsible for assuring the evidence is sufficient for the Medicaid agency's post utilization review/control purposes.

   c. In situations where the dentist believes his treatment plan to have weak support from x-rays, intra-oral photographs, etc., the dentist should submit the evidence with a request for PA. Without PA, Medicaid will reclaim payment for the services if post service review findings do not support the dentist's treatment plan and medical necessity.

   d. All outpatient facility services for Medicaid recipients 21 years of age and older must be prior authorized.

e. Medicaid does not reimburse providers for travel and hospital call related costs for services done in an outpatient surgical center.

1003.18 MAXILLOFACIAL SURGERY AND OTHER PHYSICIAN SERVICES

Nevada Medicaid authorizes payment for maxillofacial surgery and other physician services for qualified recipients.

Temporomandibular Disorders (TMDs) encompasses a variety of conditions. For recipients, age 20 years and younger, TMD services may be provided by a dentist or medical doctor. Adult dental services continue to be restricted to palliative treatment, emergency extractions and dentures/partials with PA.

A. COVERAGE AND LIMITATIONS

Coverage is limited to EPSDT, for persons less than 21 years of age.

Coverage for the medical management of TMD related disease for recipients, age 20 years and younger will be limited to appropriate current TMD related diagnosis codes.

The following CPT codes are covered for TMD services for recipient's age 20 years and younger:

99241 - 99245	Office and Other Outpatient Consultations
21089	Prepare face/oral prosthesis
70328	X-ray exam of jaw joint
70330	X-ray exam of jaw joints
70336	Magnetic image, jaw joint
70355	Panoramic x-ray of jaws
76100	X-ray exam of body section

B. PROVIDER RESPONSIBILITY

Program utilization control requires that each type of provider (dentist, physician, pharmacist, etc.) be delineated with the use of a specific PT number. For example, dentists are a PT 22 while physicians are a PT 20. All dental related services must be billed/requested with the most appropriate dental code found on the QIO-like vendor's web portal at www.medicaid.nv.gov. When the list of accepted dental codes provides only a "By Report" code, the provider must use the most appropriate "By Report" code. When an appropriate dental code is not available, a CPT Code from range 10000 through 69999 and 99241 through 99245 may be used. A dentist, PT 22, who is a dually boarded Maxillofacial Surgeon, may bill the following CPT Codes in addition to those previously listed: 00190, 21085, 70250, 70300, 70328, 70330, 70350, 70355, 70380 and 99281 through 99285.

Fluoride varnish application which can be administered by PT 17, 20, 24 and 77 should be billed on a CMS 1500 form using the most appropriate and available ICD diagnosis code.

C. AUTHORIZATION REQUIREMENTS

See B. Provider Responsibility.

1003.19 CONDITIONS FOR PARTICIPATION

All dental providers must have a current license issued by the Nevada State Board of Dental Examiners to practice dentistry. Dental specialists must be dental specialties that are recognized and approved by the American Dental Association and the Nevada State Board of Dental Examiners, or dental hygiene which has been issued by the Nevada State Board of Dental Examiners and be enrolled as a Nevada Medicaid provider. Out of state dentists must meet the licensing requirements of the state in which they practice and be enrolled as a Nevada Medicaid provider.

Dental services may also be performed in a clinic setting as long as the care is furnished by or under the direction of a dentist. The clinic must have a dental administrator and all professional staff, dentists, hygienists, etc. must have a current Nevada license and/or certification from the appropriate state licensing board.

1003.20 IMPROPER BILLING PRACTICE

Provider must bill only for the dates when services were actually provided, in accordance with this MSM Chapter and the PT 22 Billing Guide.

Any provider found by the State or its agent(s) to have engaged in improper billing practices, without limitations, may be subject to sanctions including recoupment, denial or termination from participation in Nevada Medicaid.

The findings and conclusions of any investigation or audit by the DHCFP shall not be construed as prohibiting any criminal or civil investigations, actions or other claims for relief that may be available to any party under applicable federal, state or local laws.

Improper billing practices may include but are not limited to:

A. Submitting claims for unauthorized procedures or treatments.

B. Submitting claims for services not provided.

C. Submitting false or exaggerated claim of the level of functional impairment or medical necessity to secure approval for treatment and reimbursement.

D. Submitting claims for treatment or procedures without documentation to support the claims.

E. Submitting claims for unnecessary procedures or treatments that are in excess of amount, scope and duration necessary to reasonably achieve its purpose.

F. Submitting claims for dental services provided by unqualified personnel.

Any Dental provider who improperly bills the DHCFP for services rendered is subject to all administrative and corrective sanctions and recoupment in the MSM Chapter 3300. All Medicaid overpayments are subject to recoupment.

Any such action taken against a dental provider by the DHCFP has no bearing on any criminal liability of the provider.

1004 HEARINGS

Please reference Nevada MSM Chapter 3100 for Medicaid Hearing process.

1005 REFERENCES AND CROSS REFERENCES/FORMS

Other sources which may impact the provision of Dental services include, but are not limited to the following:

Chapter 100: Eligibility Coverage and Limitations
Chapter 200: Hospital Services Program
Chapter 300: Diagnostic Testing and Radiology Services
Chapter 500: Nursing Facility
Chapter 600: Physician Services
Chapter 1200: Prescription Services (Rx)
Chapter 1500: Healthy Kids (EPSDT)
Chapter 1600: Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID)
Chapter 2100: Home and Community-Based Services Waiver (MR)
Chapter 3100: Fair Hearing Process
Chapter 3300: Program Integrity

1005.1 CONTACTS

A. Nevada Medicaid Provider Support
Division of Health Care Financing and Policy
1100 East Williams Street
Carson City, NV 89701
(775) 684-3705
https://dhcfp.nv.gov

B. Hewlett Packard Enterprise Services
Customer Services Center
(For claim inquiries and general information)
(877) 638-3472
www.medicaid.nv.gov

C. Prior Authorization for Dental
Attn: Dental PA
PO Box 30042
Reno, NV 89520-3042
(800) 525-2395 (Phone)
(855) 709-6848 (Fax)

D. Mail all paper claims (CMS 1500, UB-92, ADA, and Medicare Crossover) to the following address:

Quality Improvement Organization (QIO) – Claims
(Include claims type e.g. CMS 1500, UB-92)
P. O. Box 30042
Reno, NV 89520-3042

1005.2 FORMS

A. The ADA 2012 version is required for all prior authorization requests, claims, adjustments and voids.

1005.3 DENTAL PERIODICITY SCHEDULE

The recommended periodicity schedule can be found at http://www.aapd.org/.