Ohio Medicaid Managed Care Program

Provider Resource Guide
Effective January 1, 2025

LIBERTY DENTAL PLAN®

Making members shine, one smile at a time™

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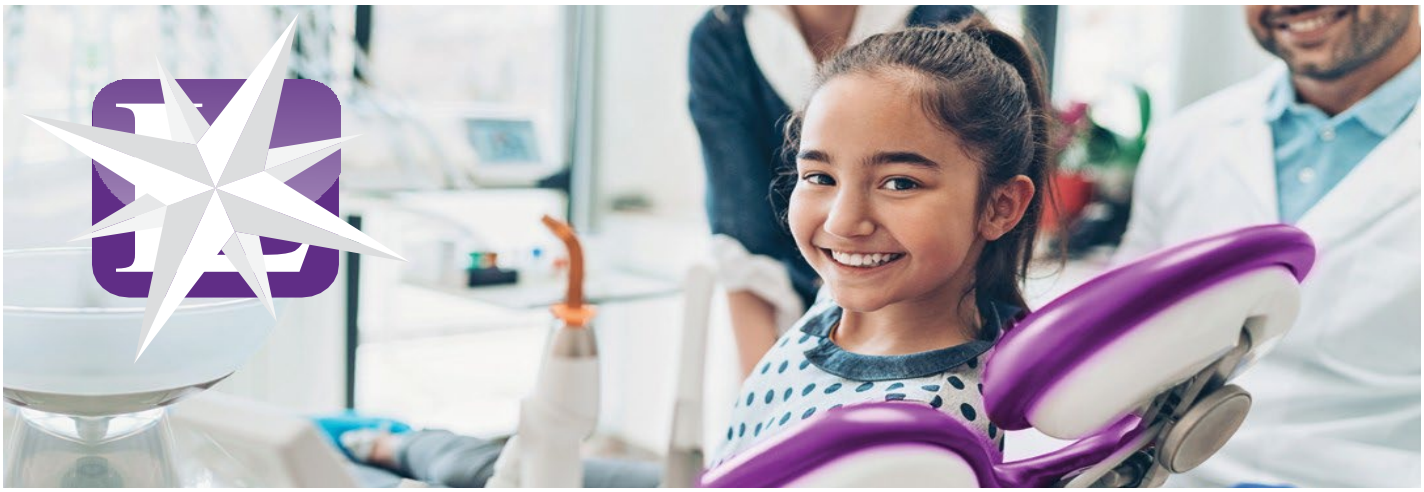
SECTION 1. LIBERTY DENTAL PLAN INFORMATION



INTRODUCTION

Welcome to LIBERTY Dental Plan's ("LIBERTY's") Medicaid network of Participating Providers for the State of Ohio. We are proud to maintain a broad network of qualified dental providers who offer both general and specialized treatment, guaranteeing widespread access to our Members.

As an organization founded by a dentist, we understand the importance of ensuring excellent customer service and engagement of our providers in retaining the dentists in our network. LIBERTY's provider network has been developed to provide access to Dental Covered Services for Medicaid Members statewide.

Our mission is to ensure access to high-quality primary and specialty dental care to all Members, regardless of where they reside in Ohio. Our tenured Provider Relations Department engages in continuous provider education, assistance, and training. A provider-centric portal allows our providers to always be in touch with specific member information related to your practice.

This Provider Manual serves only as a summary of certain terms of the Provider Agreement between you (or the contracting dental office/facility) and LIBERTY, and additional terms and conditions of the Provider Agreement may apply. In the event of a conflict between a term in this Provider Manual and a term in the Provider Agreement, the term in the Provider Agreement shall control. You received a copy of the fully executed Provider Agreement when you joined LIBERTY's network or during orientation.

You may also obtain a copy of the Provider Agreement at any time by submitting a request to **OHprinquiries@libertydentalplan.com,** or by contacting the Provider Relations Department at 888-352-7924.

Approved Dental Service Organizations (DSOs) may submit requests to **dsoupdates@libertydentalplan.com**. If your organization has not already been recognized as an approved LIBERTY DSO partner, please contact Provider Relations at 888-352-7924 prior to using this method of communication.

OUR MISSION FOR THE MEDICAID PROGRAM AND MEDICAID MEMBERS

LIBERTY's mission is to be the industry leader in improving access to quality oral health care services for the Ohio Medicaid population. LIBERTY seeks to increase annual patient visits and improve the overall health of the Medicaid population through Member outreach and education. Our continued expansion is an outgrowth of our commitment to exceptional service and expertise in our industry while providing a positive, rewarding, and enjoyable professional relationship with our network providers, Medicaid Members and LIBERTY staff members.

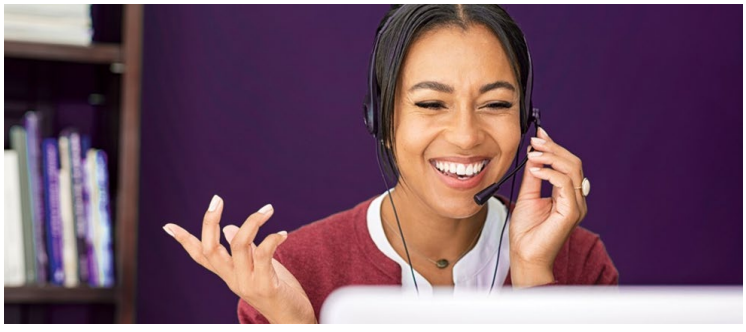
OHIO PROVIDER CONTACT AND INFORMATION GUIDE

LIBERTY provides a twenty-four (24) hour helpline to respond to requests for prior authorization. In addition, LIBERTY staff is available from 8:00 a.m. to 5:00 p.m. EST Monday through Friday to answer provider questions and respond to provider complaints, emergencies, and notifications.

After regular business hours the provider service line is answered by an automated system with the capability to provide callers with information about operating hours and instructions about how to verify enrollment for a member with an emergency or urgent medical condition. The requirement that LIBERTY provides information to providers about how to verify enrollment shall not be construed to mean that the provider must obtain verification before providing emergency services and care.

Please reference the LIBERTY contact information guide on the following page.

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



IMPORTANT PHONE NUMBERS	GENERAL INFORMATION
CALL: 888-352-7924 **877-855-8039(TDD/TTY)** • **Eligibility & Benefits**: • **Claims**: • **Prior Authorizations:** • **Referrals**: • **Request Materials:** • **General Info.**:	**HOURS**: Monday-Friday 8:00 a.m.- 5:00 p.m. (EST) **ONLINE**: **www.libertydentalplan.com** **MAILING ADDRESS:** LIBERTY Dental Plan P.O. Box 15149 Tampa, FL 33684-5149
PROVIDER PORTAL (I-Transact)	**ELIGIBILITY & BENEFITS**
Go to the following to create an account **https://www.libertydentalplan.com/Providers/Office-Vendor-Portal.aspx** **i-transact allows you:** • Electronic Claims Submission • Claim Status & Inquiries • Real-time Eligibility Verification • Member Benefits • Referral Submission & Status	Use i-transact for real-time status at **https://www.libertydentalplan.com/Providers/Office-Vendor-Portal.aspx** **Phone:** 888-352-7924 **PROFESSIONAL RELATIONS** **Email: prinquiries@libertydentalplan.com** **Phone:** 888-352-7924, 877-855-8039(TDD/TTY) **Fax:** 800-268-0154
REFERRAL SUBMISSIONS & INQUIRIES	**CLAIM SUBMISSIONS AND INQUIRIES**
Use **i-transact** for submissions & to check the status at: **https://www.libertydentalplan.com/Providers/Office-Vendor-Portal.aspx** • **EMERGENCY REFERRALS**: 888-352-7924, 877-855-8039(TDD/TTY) • **Mail:** use our mailing address **ATTN: REFERRALS DEPARTMENT**	Use **i-transact** for submissions & to check the status at: **https://www.libertydentalplan.com/Providers/Office-Vendor-Portal.aspx** • **EDI PAYOR ID#:** CX083 • **Phone:** 888-352-7924, 877-855-8039(TDD/TTY) • **Mail:** use our mailing address **ATTN: CLAIMS DEPARTMENT**

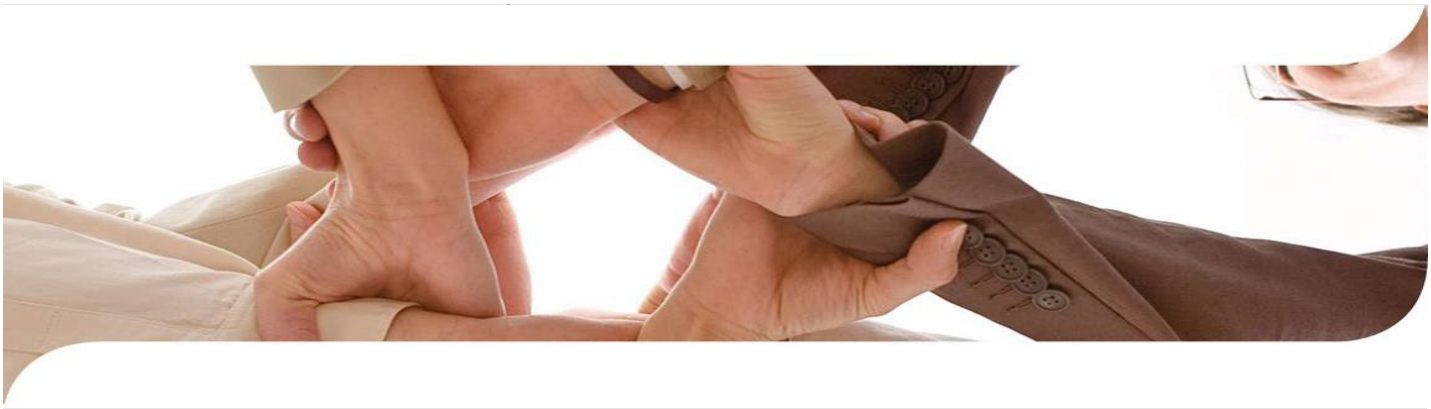
PROVIDER DISPUTE RESOLUTION (PDR)	MEMBER GRIEVANCES & APPEALS (G&A)
LIBERTY Dental Plan Use i-transact for PDR submissions at **www.libertydentalplan.com** PDR Forms available online through Provider Resource Library at **www.libertydentalplan.com** Mail PDR forms to our mailing address **Attention: Grievances & Appeals Department**	**Anthem Blue Cross Blue Shield** Members G&A form and online submission are available at: **https://www.anthem.com/content/dam/digital/docs/medicaid/oh/forms/abcbs-oh-membergrievance-eng.pdf.** **Phone**: 888.352.7924 **Fax:** 866-587-3316 **Email:** ohioga@anthem.com **Mailing address:** Medicaid Appeals Anthem Blue Cross Blue Shield PO Box 62509 Virginia Beach, VA 23466

ADVERSE INCIDENTS

Providers are responsible to report adverse incidents to LIBERTY within forty-eight (48) hours of the incident. Adverse incidents include Members who show self-harm, threat to another person, threat to LIBERTY and those listed below.

- Is associated in whole or in part with service provision rather than the condition for which such service provision occurred; and
- Is not consistent with or expected to be a consequence of service provision; or
- Occurs as a result of service provision to which the patient has not given his informed consent; or
- Occurs as the result of any other action or lack thereof on the part of the staff of the provider.

SECTION 2. PROVIDER RELATIONS AND TRAINING



LIBERTY's team of Network Managers is responsible for recruiting, contracting, servicing, and maintaining our network of Providers. All office demographic changes must be made through the State PNM. We encourage our Providers to communicate directly with their designated Network Manager to assist with the following:

- Plan contracting
- Escalated claim payment issues
- Education on LIBERTY Policies and Member Benefits
- Provider Trainings and Orientations
- Directory Validation

PROVIDER COMPLIANCE TRAINING

LIBERTY provides initial orientation and training to all new offices within thirty (30) days of executing an agreement. Additional training is provided for new staff, when changes in the program occur, or when there is a change in provider utilization and/or other activity. Further, LIBERTY provides regular training through webinars, as well as telephonic and in-person meetings, as requested.

All trainings regarding the requirements of the Medicaid Contract, including any Contract amendments and special needs of Members are available to providers and their staff. LIBERTY works with providers treating the Individuals with Intellectual and Developmental Disabilities (IDD) population to ensure best practices are met Provider are trained on identifying adverse incidents and requirements to report adverse incidents to LIBERTY within forty-eight (48) hours of the incident.

Training modules are available online at:
https://www.libertydentalplan.com/Providers/Provider-Training-1.aspx

Training Programs include:

- **Critical Incident Awareness**
- **Code of Business Ethics & Conduct**

- **Cultural Competency**
- **Fraud, Waste & Abuse Training**
- **General Compliance**
- **HIPAA**

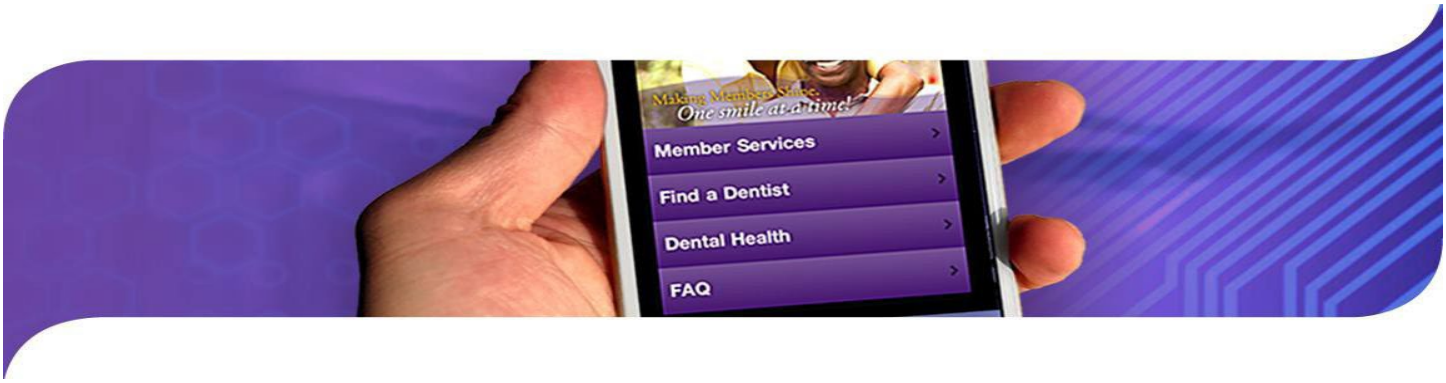
To ensure that your information is displayed accurately in our provider directory, and claims are processed efficiently, please submit all changes within thirty (30) days to **OHprinquiries@libertydentalplan.com** for Dental Service Organizations, submit an email to **dsoupdates@libertydentalplan.com,** or in writing. Provider Relations will address your inquiry within three (3) business days of receipt.

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

Provider Relations Team
M — F from 8 am – 5 pm (EST)
833.352.7924

Email at **OHprinquiries@libertydentalplan.com** or
Dental Service Organizations at **dsoupdates@libertydentalplan.com**

SECTION 3. ONLINE SELF-SERVICE TOOLS



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

We offer free, real-time access twenty-four (24) hours a day, seven (7) days a week to important information and tools through our secure online Provider Portal. Registered users will be able to:

- Submit electronic claims
- Request prior authorizations
- Check claim status
- Review prior authorizations
- Verify Member eligibility and benefits
- View office and contract information
- Submit referrals and check status
- Access benefit plans
- Perform a provider search

ON-LINE ACCOUNT ACCESS

To register and obtain immediate access to your office's Provider Portal account, visit: https://providerportal.libertydentalplan.com.

All contracted network dental offices are issued a unique Office Number and Access Code. These numbers can be found on your LIBERTY Welcome Letter. The designated Office Administrator should set up the account on behalf of all providers/staff. The Office Administrator will be responsible for adding, editing, and terminating additional users within the office.

- View the benefits of using the Provider Portal at: https://www.libertydentalplan.com/Resources/Documents/ma_Provider_Portal_benefits.pdf

- Detailed instructions on how to utilize our online services can be found in the Online Provider Portal User Guide by visiting by visiting: https://www.libertydentalplan.com/Resources/Documents/ma_Office_Portal_User_Guide.pdf

SYSTEM REQUIREMENTS

- Internet Connection compatible with Microsoft Edge, Google Chrome, and Mozilla Firefox
- Adobe Acrobat Reader

iTRANSACT Provider Portal

DIRECTORY INFORMATION VERIFICATION (DIV) ONLINE

LIBERTY actively works to verify and maintain the accuracy of our provider directories which are available to members and the public. It is required that we maintain current office information to ensure the information provided to our members reflects both your current office demographic information and associate dentists that are available to LIBERTY Members. It is required that providers ensure our provider directories are up to date.

Anytime you have changes, including, but not limited to appointment times, office hours, address, phone number, fax number, associate dentist, etc., your office must update your information. This will reduce calls to your office and ensure accurate office information. **Changes must be submitted to the Ohio Department of Medicaid to be reflected on the State PNM file.**

SECTION 4. ELIGIBILITY

Anti-Discrimination Notice: LIBERTY complies with Federal civil rights laws, which prohibits discrimination based on race, religion, color, national origin, sex, disability, political affiliation, or beliefs. Any person who is enrolled in a Plan's program is eligible for benefits under the Plan certificate.

Providers are responsible for verifying Member eligibility prior to providing dental services. The Member's ID card does not guarantee eligibility. Checking eligibility will allow providers to complete medically necessary procedures and reduce the risk of denied claims. Members must seek treatment at their **assigned dental home** otherwise claims may be denied. Members assigned to a General Dentist as a Primary Dental Provider ("PDP") that need to be seen by a Pediatric Dentist should be referred to the LIBERTY Member Services to request a transfer to a Pediatric "PDP."

HOW TO VERIFY ELIGIBILITY

There are several options to verify eligibility:

1. **Provider Portal:** https://providerportal.libertydentalplan.com
   The Member's last name, first name, and any combination of the Member twelve digit Medicaid ID, or date of birth is required (Member's Last Name, First Name, and Date of Birth is recommended for best results).
2. **Calling Member Services Department:** In the event a Member does not appear on the monthly roster, speak with a live representative, Monday through Friday, from 8:00 a.m. to 8:00 p.m. EST.

Verification of network participation: Offices may be linked to child and/or adult programs. If you are unsure which program you are currently linked to, please contact your local Network Manager or Provider Relations at 888.352.7924.

State Eligibility System
Ohio Department of Job and Family Services
800.686.1516

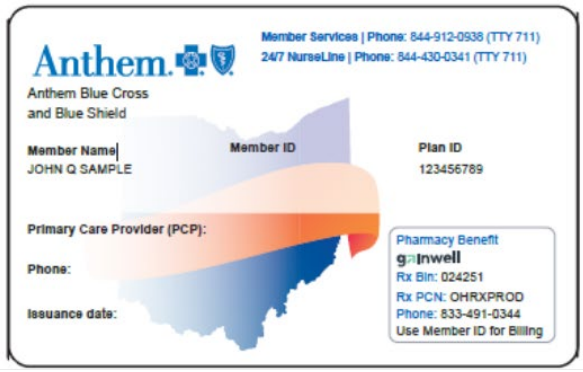
MEMBER IDENTIFICATION CARDS
Members should present their ID card at each appointment. Providers are encouraged to validate the identity of the person presenting an ID card by requesting some form of photo identification. Presentation of an ID card does not guarantee eligibility and/or payment of benefits.

Members receive identification cards from their Plan. Participating Providers are responsible for verifying that Members are eligible at the time services are rendered and to determine if recipients have other health insurance.

Please note that due to possible eligibility status changes, this information does not guarantee payment and is subject to change without notice.

Sample of the Anthem plan I.D. Cards

Front



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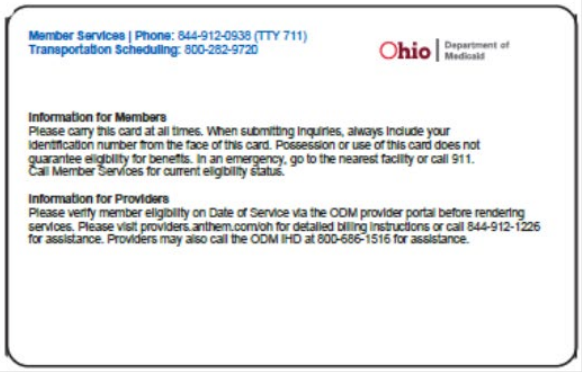

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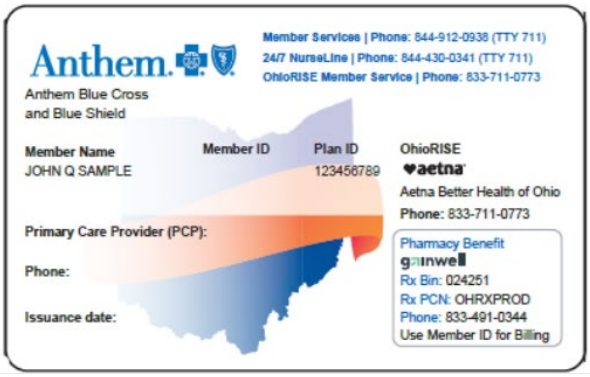

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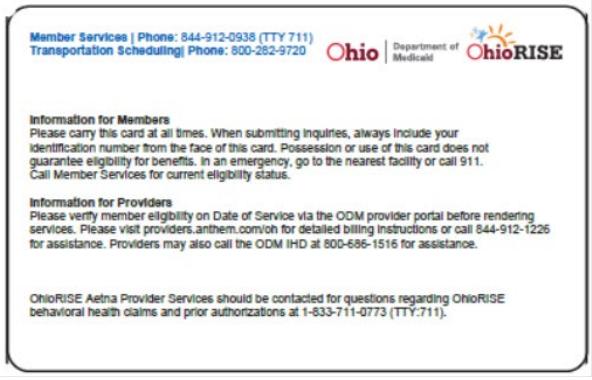
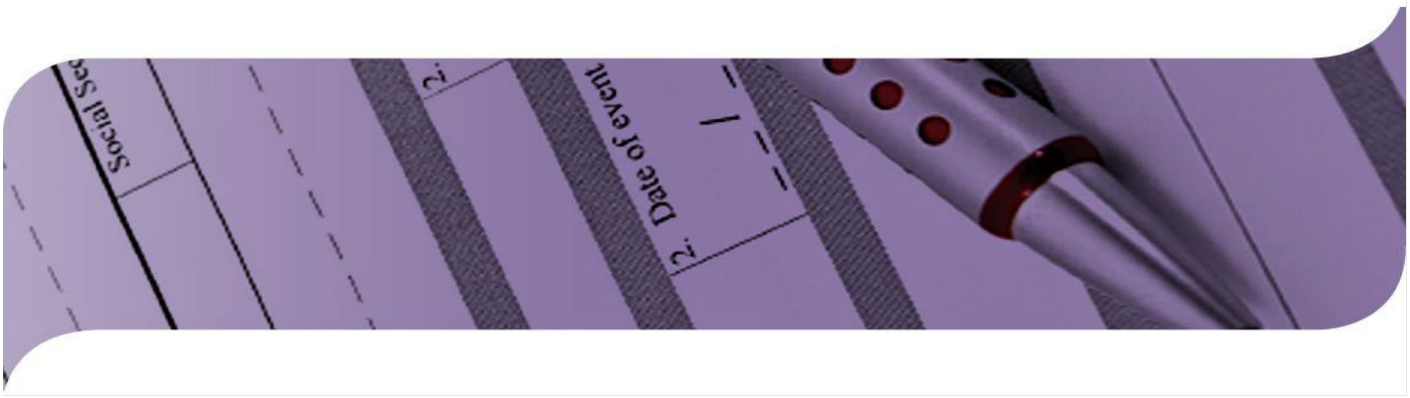


SPECIALTY CARE REFERRAL AND AUTHORIZATION GUIDELINES

A patient requiring a referral to a dental specialist can be referred directly to any specialist contracted with LIBERTY without authorization from LIBERTY. The dental specialist is responsible for obtaining prior authorization for services according to Appendix B of this manual. If you are unfamiliar with the LIBERTY contracted specialty network or need assistance locating a certain specialty, please contact LIBERTY's Member Service Department at 888-352-7924/TTY 877-855-8039.

SECTION 5. CLAIMS AND BILLING



At LIBERTY, we are committed to accurate and efficient claims processing. It is imperative that all information be accurate and submitted in the correct format.

Network dentists are encouraged to submit clean claims within forty-five (45) days of completion of treatment. Payment will be denied for claims submitted more than three-hundred-sixty-five (365) days for from the date of service.

LIBERTY receives dental claims in four possible formats. These formats include the following:

- HIPPA Complaint "873D" file
- Electronic submissions via LIBERTY's Provider Portal at: **https://www.libertydentalplan.com/Providers/Office-Vendor-Portal.aspx**
- Electronic submissions via clearinghouse

HIPPA COMPLIANT 873D FILE

LIBERTY currently accepts HIPAA Compliant 837D files. If you want to set up or ask about this option, contact our IT Department at (833) 276-0851.

ELECTRONIC SUBMISSION

LIBERTY strongly encourages the electronic submission of claims. This convenient feature assists in reducing costs, streamlining administrative tasks, and expediting claim payment turnaround time for providers.

There are two options to submit electronically:

- Provider Portal: https://www.libertydentalplan.com/Providers/Office-Vendor-Portal.aspx
- Third-Party Clearing House

LIBERTY currently accepts electronic claims/encounters from providers through the clearinghouses listed below. If you do not have an existing relationship with a clearinghouse, please contact any one of the choices listed below to begin electronic claims submission.

The EDI vendors accepted by LIBERTY are:

LIBERTY EDI VENDOR	PHONE NUMBER	WEBSITE	PAYER ID
DentalXchange	800-576-5641	www.dentalxchang.com	CX083
Vyne Dental	463-218-6519	www.vynedental.com	CX083

All electronic submissions should be submitted in compliance with state and federal laws, as well as LIBERTY's policies and procedures. National Electronic Attachment, Inc. (NEA) is recommended for electronic attachment submission. For additional information regarding NEA and to register your office, please visit www.nea-fast.com, select FASTATTACHTM, and then select Providers.

ELECTRONIC ATTACHMENTS

LIBERTY accepts dental radiographs electronically via FastAttach™ for authorization requests. LIBERTY, in conjunction with National Electronic Attachment, Inc. (NEA), allows Participating Providers the opportunity to submit all claims electronically, even those that require attachments. This program allows transmissions via secure Internet lines for radiographs, periodontic charts, intraoral pictures, narratives and explanation of benefits.

FastAttach™ is inexpensive and easy to use, reduces administrative costs, eliminates lost or damaged attachments, and accelerates claims and prior authorization processing. It is compatible with most claims clearinghouse or practice management systems. For more information or to sign up for FastAttach, go to **http://www.nea-fast.com** or call NEA at 800.782.5150.

SUBMITTING AUTHORIZATION OR CLAIMS WITH X-RAYS

Electronic submission using National Electronic Attachment (NEA) is recommended. For more information, please visit www.nea-fast.com and click the "Learn More" button. To register, click the "Provider Registration" button in the middle of the home page.

Submission of duplicate radiographs (which we will recycle and not return) Submission of original radiographs with a self-addressed stamped envelope (SASE) so that we may return the original radiographs. **Note:** determinations will be sent separately, and any radiographs received without a SASE will not be returned to the sender.

Please note we also require radiographs to be mounted when there are five (5) or more radiographs submitted at one time. If five (5) or more radiographs are submitted and not mounted, they will be returned to you and your request for prior authorization and/or claims will not be processed.

You will need to resubmit a copy of the 2024 or newer ADA form that was originally submitted, along with mounted radiographs so that we may process the claim correctly. You can find a copy of the ADA claim form on our website at:
https://www.libertydentalplan.com/Resources/Documents/ADA-Claim-Form.pdf

CLAIMS SUBMISSION PROTOCOLS AND STANDARDS

LIBERTY requires the following claims documentation:

- All claims must be submitted to LIBERTY for payment for services with the Member twelve (12) digit Medicaid ID number, first and last name and pre or post-treatment documentation, if required.
    - Your National Provider Identifier (NPI) number and tax ID are required on all claims. Claims submitted without these numbers will be rejected. All health care providers, health plans and clearinghouses are required to use the National Provider Identifier number (NPI) as the ONLY identifier in electronic health care claims and other transactions.
    - If you do not have an NPI number, you must register for one at the following website: http://nppes.cms.hhd.gov
- All claims must include the name of the program (such as Ohio Medicaid) under which the Member is covered and all the information and documentation necessary to adjudicate the claim.

A **"clean claim"** means one that can be processed without obtaining additional information from the provider of the service or from a third party. It includes a claim with errors originating in a State's claims system. It does not include a claim from a provider who is under investigation for fraud or abuse, or a claim under review for medical necessity.

- For emergency services, please submit a standard claim form which must include all the appropriate information, including pre-operative x-rays and a detailed explanation of the emergency circumstances.
- For children under the age of eighteen (18) years old, and those who have special health care needs, inclusive of behavioral and/or complex medical conditions, who are under the age of twenty-one (21) years, a letter of medical necessity must accompany the claim form.

CLAIMS STATUS INQUIRY

There are two (2) options to check the status of a claim:

	**Provider Portal:** https://www.libertydentalplan.com/Providers/Office-Vendor-Portal.aspx
	**Phone: 888-352-7924,** Select Option 2

CLAIMS STATUS EXPLANATIONS

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

CLAIMS RESUBMISSION

Providers have ninety (90) days from the date of service to request a resubmission or reconsideration of a claim that was previously denied for:

- Missing documentation
- Incorrect coding
- Processing errors

CLAIMS OVERPAYMENT

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

NOTICE OF OVERPAYMENT OF A CLAIM

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

CONTESTED NOTICE

If the provider contests LIBERTY's notice of overpayment of a claim, the provider may dispute the notice of overpayment within ninety (90) working days of the receipt of the notice of overpayment of a claim. Any such dispute must be received by LIBERTY in writing stating the basis upon which the provider believes that the claim was not overpaid. LIBERTY will process the contested notice following LIBERTY's Provider Complaint Resolution Process described in Section 9.

NO CONTEST

If the provider does not contest LIBERTY's notice of overpayment of a claim, the provider must reimburse LIBERTY within sixty (60) working days of the provider's receipt of the notice of overpayment. If the provider fails to reimburse LIBERTY within sixty (60) 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. In accordance with the LIBERTY provider agreement, which specifically authorizes LIBERTY to offset an uncontested notice of overpayment of a claim from the provider's current claims submissions. In the event that an overpayment of a claim or claims is offset against the provider's current claim or claims pursuant to this section, LIBERTY will provide the provider with a detailed written explanation identifying the specific overpayment or payments that have been offset against the specific current claim or claims.

PROMPT PAYMENT OF CLAIMS

LIBERTY's processing policies, payments, procedures, and guidelines follow applicable State and Federal requirements.

Following federal regulations (42 CFR 447.46) and this Agreement, except if LIBERTY and its network provider have established an alternative payment schedule mutually agreed upon and described in the provider contract, the LIBERTY must:

- Pay or deny 90% of all submitted clean claims within twenty-one (21) calendar days of the date of receipt of the claim.
- Pay or deny 99% of clean claims within sixty (60) calendar days of the date of receipt of the claim.
- Pay or deny 100% of all claims within ninety (90) calendar days of receipt of the claim.

ELECTRONIC FUNDS TRANSFER

LIBERTY's Electronic Funds Transform Form can be located on our Provider Portal at **https://www.libertydentalplan.com/Resources/Documents/ma_EFT_transfer_Form.pdf**

ENCOUNTER/CLAIMS DATA REPORTING REQUIRED ON ALL MEDICAID PLANS

All contracted LIBERTY general dentistry providers must submit encounter/claims data for all services rendered, regardless of reimbursement methodology, regularly. The information should be submitted on a current standard ADA Dental Claims Form for all services provided to the Member. LIBERTY strongly recommends that you provide claims following each visit.

PEER-TO-PEER COMMUNICATION

If you have questions or concerns about a referral, prior authorization and/or claim determination and would like to speak with a LIBERTY Dental Director, or the clinical designee, licensed dentists, responsible for the determination, you may contact:

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

Provider Relations
M — F from 8 am – 5 pm (EST)
888.442.3514

Email
umpeertopeer@libertydentalplan.com

Please note that when calling the phone number listed above, your call will be transferred to the voicemail of the Dental Director or clinical designee, licensed dentists, responsible for the determination. Please leave a detailed message including the Member ID and claim number and your call will be returned. For more information on Peer-to-Peer consultations associated with the provider clinical appeal process, please see section 9.

PRIOR AUTHORIZATION, RETROSPECTIVE REVIEW & DOCUMENTATION REQUIREMENTS

PRIOR-AUTHORIZATION OR CLAIM DOCUMENTATION REVIEW OF DENTAL SERVICES

For Adult Dental and Child Services, if the code requires documentation with claim submission or prior authorization, there will be a notation as to the type of documentation that is required within the list of covered dental services. For Children under (twenty-one) 21 if documentation is not sent in with the request, the case will be reviewed based on information that is received. You could receive a medical denial for not meeting criteria.

Dentists can obtain prior authorization for dental procedures performed in a hospital outpatient setting or an Ambulatory Surgical Center (ASC). Providers seeking information on this process can contact the Members Medical Plan carrier for specific details on how to obtain prior authorization for services to be done in a hospital outpatient setting or an Ambulatory Surgical Center (ASC).

For all prior authorization requests, medical necessity will be determined based on radiographic and/or other documented rationale. For the Ohio Medicaid definition of medical necessity please see section 9.

Prior-Authorization requires that the provider obtain written authorization to perform the procedure prior to performing the service. Prior-Authorization requires specific documentation to establish medical necessity or justification for the procedure. Additionally, Ohio Medicaid Dental members have the right to request the submission of a prior authorization for large, complex treatment plans, and for non-covered services.

A provider and/or dental office cannot refuse to submit a prior authorization for an Ohio Medicaid Dental member on the basis that the service is not covered. Please see Section 10. for more information.

To establish medical necessity or justification for a procedure documentation with claim submission may be required. For procedures that require documentation providers have the option to submit a Prior-Authorization request prior to performing the procedure. If LIBERTY approves the Prior-Authorization there is no need to submit documentation with claim submission.

PRIOR AUTHORIZATION FOR TREATMENT

LIBERTY must make a decision on a request for prior authorization within five (5) business days from the date LIBERTY receives this request. The initial five (5) days may be extended up to an additional seven (7) days upon request of the member or provider or if LIBERTY justifies to the ODM in advance and in writing that the member would benefit from such an extension.

If LIBERTY denies the approval for some or all of the services requested, LIBERTY will send the member and provider a written notice of the reasons for the denial(s) that will include information on rights to the appeal process. Providers can also access copies of the written notice of the status of the prior authorization through the provider portal.

PROCEDURES REQUIRING PRIOR AUTHORIZATION

LIBERTY has specific dental utilization criteria as well as a prior authorization and retrospective review process to manage the utilization of services. Consequently, LIBERTY operational focus is on assuring compliance with its dental utilization criteria.

One method used on a limited basis to assure compliance is to require providers to supply specified documentation prior to authorizing payment for certain procedures. Services that require prior authorization should not be started prior to the determination of coverage (approval or denial of the prior authorization) for non-emergency services.

Non-emergency treatment started prior to the determination of coverage will be performed at the financial risk of the dental office. If coverage is denied, the treating dentist will be financially responsible and may not balance bill the Member, the State of Ohio and or any agents, and/or LIBERTY.

Prior authorizations will be honored for one-hundred-eighty (180) days from the date they are issued. An approval does not guarantee payment. The Member must be eligible at the time the services are provided. The provider must verify member eligibility at the time of service.
Requests for prior authorization must be sent with the appropriate documentation through

LIBERTY's secure email , the web portal, or mail. LIBERTY cannot accept x-rays submitted with prior authorization requests through fax. Any claims or prior authorizations submitted without the required documentation will be denied and must be resubmitted to obtain reimbursement.

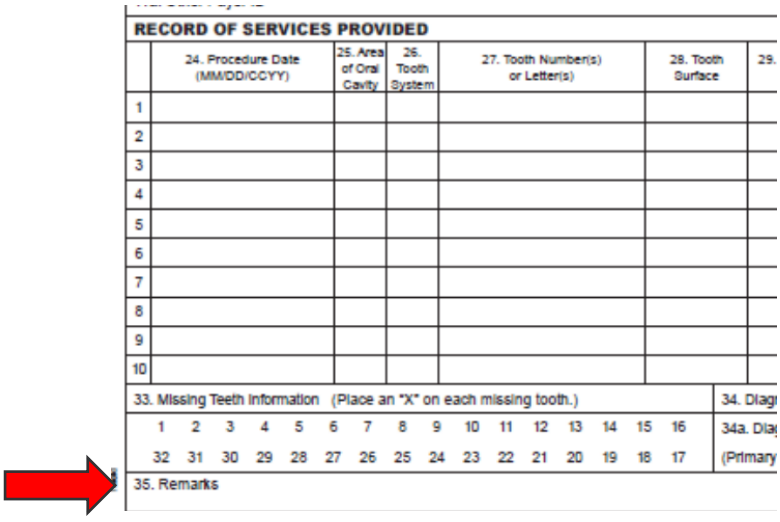
The basis for granting or denying approval shall be whether the item or service is medically necessary, whether a less expensive service would adequately meet the Member's needs, and whether the proposed item or service conforms to commonly accepted standards in the dental community.

During the prior authorization process, it may become necessary to have your patient clinically evaluated. If this is the case, the provider will be notified that addition documentation is required. The provider is responsible for ensuring the member is seen for any recall examinations, if necessary, for the submission of the additional documentation required for LIBERTY to make a decision based on medical necessity.

EMERGENCY TREATMENTS AND AUTHORIZATIONS

If a patient presents with an emergency condition that requires immediate treatment or intervention, you should always take necessary clinical steps to mitigate pain, swelling, or other symptoms that might put the members overall health at risk and completely document your findings.

After treatment, please complete the appropriate authorization request, and enter EMERGENCY/ URGENT in box 35, remarks, and the appropriate narrative or descriptor of the patient's conditions, including all supporting documentation.



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.
1						
2						
3						
4						
5						
6						
7						
8						
9						
10						

33. Missing Teeth Information (Place an "X" on each missing tooth.) 34. Diag

1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 34a. Dia

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

35. Remarks

LIBERTY will process emergency authorization requests as high priority. After you receive the

authorization number, then and only then should you submit the claim. Our system will link the authorization number and the claim, and payment should be processed.

RETROSPECTIVE REVIEW

Services that would normally require prior authorization but are performed in an emergency situation due to retroactive Medicaid eligibility. Retrospective review is available for Medicaid members in instances where it is in the dental practitioner's opinion that a procedure may subject the member to unnecessary or duplicative service if delivery of the service is delayed until prior authorization is granted.

LIBERTY will not retroactively deny a claim for an emergency screening examination because the condition, which appeared to be an emergency medical condition under the prudent layperson standard turned out to be non- emergency in nature.

Retrospective review needs to be submitted with the appropriate documentation by the provider within three hundred-sixty-five (365) business days of the date the service is performed.

Types of documentation required, including but not limited to:

- Radiographs (pre-op, post-op or opposing arch x-rays as indicated in the exhibits)
- Narrative of medical necessity
- Periodontal charting

Any claims for retrospective review submitted without the required documents will be denied and must be resubmitted for reimbursement. If the procedure(s) does not meet medical necessity criteria upon review by Utilization Management, the prior authorization request will be denied, and the provider will not be reimbursed for the service by LIBERTY or the member.

A LIBERTY clinical designee, a licensed dentist, will review the documentation to ensure the services rendered meet the clinical criteria requirements as outlined in this manual. Once the clinical review is completed, the claim is either paid or denied within twenty (20) calendar days for clean claims and notification will be sent to the provider via the provider remittance statement.

PARTICIPATING HOSPITALS

Upon approval, Participating Providers are required to administer services at Plan's participating hospitals. Provider should submit services for dental care to LIBERTY for authorization. Upon receipt of approval from LIBERTY, Provider should use the information below for facility authorization if applicable.

The navigation breakdown on the portal, https://providerportal.libertydentalplan.com, **Claims section**.

Approval will be available on the provider portal and faxed to the provider. For Medical Prior Authorizations, please visit the Anthem website for OH Providers at **https://providers.anthem.com/ohio-provider/home** for assistance. The prior authorization requirements, toolkit, contact information, and forms are available under 'Resources', as follows:

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 one-hundred (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.

IDENTIFYING THE PRIMARY CARRIER

When determining the order of benefits (making payment) between two coordinating plans, the effective date refers to the first date the plan actively covers a Member. When there is a break in coverage, LIBERTY will be primary based on the LIBERTY effective date versus the new group effective date.

The table below is a guide to assist your office in determining the primary carrier:

PATIENT IS THE MEMBER	PRIMARY
Member has a government-funded plan and individual or supplemental coverage through another carrier.	Individual/Supplemental coverage is primary.
Member has two government-funded plans: Federal (Medicare) and State (Medicaid, or Medicare Advantage Value Add).	Federal coverage is primary.
Member has dental coverage through a group plan and a government-funded plan.	Group plan is primary.

NOTE: Medicaid is always the payor of last resort. If the Member has any other plan, it will always be the primary coverage.

SCENARIOS OF COBS

- When LIBERTY is the Primary Carrier: LIBERTY will only be considered the primary carrier

for Medicaid when the Member has no other dental coverage. Medicaid is always considered the payor of last resort.

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

WHEN LIBERTY IS A SECONDAR CARRIER

A claim should always be sent to the primary carrier first. Following the primary carrier's payment, the primary carrier's Explanation of Benefits (EOBs) should be sent showing payments and member responsibility, or denial information with the claim to LIBERTY. LIBERTY will consider the dentist's participation status with the primary carrier and coordinate the claim with the EOB provided.

When LIBERTY is secondary, payment is based on the lesser of either the amount that it would have paid in the absence of any other dental benefit coverage, or the member's total out-of-pocket cost payable under the primary carrier for benefits covered under the secondary carrier following Ohio laws.

That means whatever amount remains on the member's bill that was not paid by the member's primary carrier is now the responsibility of the secondary carrier to pay with the following conditions:

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

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

LIBERTY will not refuse to pay a dental office solely because a dental office has in good faith communicated with a prospective, current, or former member regarding the method by which the dental office is compensated by LIBERTY.

SECTION 7. PROFESSIONAL GUIDELINES AND STANDARDS OF CARE

PRIMARY DENTAL PROVIDER RESPONSIBILITIES AND RIGHTS

LIBERTY Ohio Medicaid Participating Providers have the following Responsibilities and Rights:

- Communicate with patients, including Members regarding dental treatment options.
- Recommend a course of treatment to a Member, even if the course of treatment is not a covered benefit or approved by Plan/LIBERTY.
- File an appeal or complaint pursuant to the procedures of Plan/LIBERTY.
- Supply accurate, relevant, factual information to a member in connection with an appeal or complaint filed by the Member.
- Object to policies, procedures, or decisions made by Plan/LIBERTY.
- If a recommended course of treatment is not covered, e.g., not approved by Plan/LIBERTY, the participating Provider must notify the Member in writing and obtain a signature of waiver if the Provider intends to charge the Member for such a non-compensable service.
- To be informed of the status of their credentialing or recredentialing application, upon request.
- Provide and/or coordinate all dental care for Member.
- Perform an initial dental assessment including a risk assessment.
- Provider has the right to dismiss a member in writing to LIBERTY and stating reasons why.
- Provide a written treatment plan to Members that identifies covered services, non-covered services, and clearly identifies any costs associated with each treatment plan that is understandable by a prudent layperson with general knowledge of oral health issues.
- Provide supporting materials for dental services and procedures which document their medical necessity.
- Treatment plans and informed consent documents must be signed by the Member or responsible party showing understanding of the treatment plan.
- A financial agreement for any non-covered service will be documented separately from any treatment plan or informed consent.

- Work closely with specialty care and primary dental providers to promote continuity of care.
- Cooperate with, and adhere to the LIBERTY Quality Management and Improvement Program
- Identify dependent children with special health care needs and notify LIBERTY of these needs.
- Notify LIBERTY of the following:
    - An employee death
    - The performance of a surgical procedure on the wrong patient
    - Brain or spinal damage
    - The performance of a wrong surgical procedure
    - The performance of a wrong-site surgical procedure
    - The performance of a surgical procedure that is medically unnecessary or otherwise unrelated to the patient's diagnosis or medical condition.
    - The surgical repair of damage resulting to a patient from a planned surgical procedure, where the damage was not a recognized specific risk, as disclosed to the patient and documented through the informed-consent process.
    - The performance of procedures to remove unplanned foreign objects remaining from a surgical procedure.
- Arrange coverage by another provider when away from dental facility.
- Ensure that emergency dental services and/or information are available and accessible for patients of record twenty-four (24) hours a day, seven (7) days a week.
- Maintain after-hours telephone coverage (such as via an answering service, machine referral to an on-call provider) with reasonable and timely call back.
- Maintain scheduled office hours.
- Maintain dental records for a period of ten (10) years.
- Provide updated credentialing information when requested, upon renewal dates.
- Provide requested information upon receipt of a standard patient grievance/complaint within three (3) business days of receiving a notice letter.
- Coordinate and provide language assistance services, which includes telephonic and onsite interpretation services for Members when necessary and when requested.
- Document the member's preferred language and any requests/refusal of interpreting services in the dental chart.
- Submit encounter data on EDI or standard ADA claims.
- Notify LIBERTY of any changes regarding the provider's practice, including location, name, telephone number, address, associate additions/terminations, change of ownership, plan terminations, etc.
- Notify LIBERTY If a Member chooses to transfer to another participating dental office; there will be no charge to the Member for copies of records maintained in chart. All copies of records must be provided to Member within fifteen (15) days of request.

- Provide dental services in accordance with peer reviewed clinical principals, criteria, guidelines and any evidence-based parameters of care.
- Providers will not discriminate or retaliate against a Member or attempt to disenroll a Member for filing a grievance and/or appeal.
- Provider requested information upon receipt of a member grievance/appeal within three (3) business days of the notice from LIBERTY.
- Provider understands and agrees that assignment or delegation by Provider of services under its agreement with LIBERTY is null and void unless prior written approval is obtained from LIBERTY and, to the extent required, by LIBERTY from relevant Health Plan clients.

SPECIALTY CARE PROVIDER RESPONSIBILITIES AND RIGHTS

LIBERTY Ohio Medicaid Specialty Care Providers have the following Responsibilities and Rights:

- All of the responsibilities and rights of the PDP listed above.
- Provide necessary and appropriate specialty consultation and care to Members.
- Inform primary dental provider when treatment is complete.
- Bill LIBERTY timely for all dental services that are authorized.
- Prior Authorize any necessary treatment, not previously approved.

MEMBER'S BILL OF RIGHTS AND RESPONSIBILITIES

LIBERTY aims to broaden access to high-quality, compassionate healthcare services within the resources available. We are dedicated to treating all Members with respect, upholding their rights, and recognizing the responsibilities expected of them.

MEMBER RIGHTS

LIBERTY Ohio Medicaid are entitled to the **following rights**:

- To exercise these rights without any adverse effects.
- To receive pertinent written, and up-to-date information about LIBERTY, the managed care services LIBERTY provides, the Participating Providers and dental offices, as well as Members rights and responsibilities.
- To privacy and to be treated with respect and recognition of their dignity when receiving dental care.
- To be fully informed about the appropriate or medically necessary treatment options for any condition, regardless of the coverage or cost for the care discussed.
- To file a grievance verbally or in writing about LIBERTY, a participating provider, dental office staff, any care received, or any other aspects that are part of his or her dissatisfaction.
- To express a grievance regarding any violation of his or her rights, as stated in the applicable state laws, through the grievance process of the health care provider or heath care facility that served him or her and to the appropriate state licensing agency.

- A member has the right to request an appeal of any denial/adverse benefit determination within the applicable timeframes as mandated by applicable state and federal laws.
- To request an expedited review of a grievance or appeal for cases involving imminent and serious threats to his or her health.
- To request a no-cost second opinion with a general dentist or specialist.
- To the right to request a state fair hearing with an Administrative Law Judge or for external review.
- To make recommendations regarding LIBERTY's/Plan's members' rights and responsibilities policies.
- To fully participate with caregivers in the decision-making process surrounding their health care.
- To a prompt and reasonable response to questions and requests, including information about the definition of emergency care.
- To know who is providing medical services and who is responsible for his or her care.
- To know what patient support services are available, including whether an interpreter is available if he or she does not speak English.
- To get no-cost written member information in other formats (such as braille, large-size print, audio and accessible electronic formats) upon request and in a timely manner appropriate for the format being requested.
- To know what rules and regulations apply to his or her conduct.
- To be given by the health care provider information concerning diagnosis, planned course of treatment, alternatives, risks, and prognosis.
- To request information regarding the decision-making of their dental care.
- To refuse any treatment, except as otherwise provided by law.
- Emancipated minors have the right to make decisions regarding their dental care, with appropriate legal documentation.
- To formulate advance directives.
- The right to be given, upon request, full information and necessary counseling on the availability of known financial resources for his or her care.
- To receive, upon request, prior to treatment, a reasonable estimate of charges for proposed dental services.
- To receive a copy of a reasonably clear and understandable, itemized bill and, upon request, to have the charges explained.
- To access emergency dental services outside of the Plan's network.
- To impartial access to medical treatment or accommodations, regardless of race, national origin, religion, sexual orientation, handicap, or source of payment.
- To treatment for any emergency medical condition that will deteriorate from failure to provide treatment, without prior authorization.

- To know if medical treatment is for purposes of experimental research and give his/her consent or refusal to participate.
- A member has the right to access the health information about them as provided by 45 CFR 164.524, including the right to inspect or obtain a copy, or both.
- A member has the right to request in writing the transmission of their PHI to another person or entity they designate as specified by 45 CFR 164.524(c)(3).
- A member has the right to amend their protected health information as provided by 45 CFR 164.526.
- A member has the right to receive an accounting of disclosures as provided by 45 CFR 164.528.
- A member has the right to request restriction of the uses and disclosures of their information, including the right to receive confidential communications as provided by 45 CFR 164.522.

MEMBER RESPONSIBILITIES

LIBERTY Ohio Medicaid members have the **following responsibilities**:

- To provide, to the best of their abilities, accurate and complete information that LIBERTY and its participating dentists need to provide the highest quality of health care services.
- For providing to the health care provider, to the best of his or her knowledge, accurate and complete information about present complaints, past illnesses, hospitalizations, medications, and other matters relating to his or her health.
- For ensuring that another person does not use their dental ID card.
- To closely follow the treatment plans and home care instructions for the care that they have agreed upon with their health care practitioners.
- For participating in understanding their health problems and developing mutually agreed upon treatment goals to the degree possible.
- For reporting unexpected changes in his or her condition to the health care provider.
- For reporting to the health care provider whether he or she comprehends a contemplated course of action and what is expected of him or her.
- For keeping appointments and, when he or she is unable to do so for any reason, for notifying the health care provider or health care facility at least twenty-four (24) hours in advance.
- For assuring that the financial obligations of his or her health care are fulfilled as promptly as possible.
- For following health care facility rules and regulations affecting patient care and conduct.
- For his or her actions if treatment is refused or the health care provider's instructions are not followed.
- For reporting any suspected fraud, waste, or abuse.

CONFIDENTIAL COMMUNICATIONS FOR SENSITIVE SERVICES

Federal law states that members can request confidential communications regarding the receipt of sensitive services. These types of services can include:

- Bills and attempts to collect payment
- A Notice of Adverse Benefit Determination
- An Explanation of Benefit notice
- A Plan's request for additional information regarding a claim
- A notice of a contested claim
- The name and address of a provider, description of services received, and other information related to a visit.

To request confidential communications from LIBERTY for any of the services listed above, a member can call our Member Services Department, or a member can submit a request in writing by mail to the following:

- By mail to: LIBERTY Dental Plan, Attn. Compliance Department, PO Box 26110, Santa Ana, CA 92799-6110
- By phone to: LIBERTY's Member Services at 888-352-7924 or TTY 877-855-8039

NATIONAL PROVIDER IDENTIFIER (NPI)

In accordance with the Health Insurance Portability and Accountability Act (HIPAA), LIBERTY requires a National Provider Identifier (NPI) for all HIPAA-related transactions, including claims, claim payment, coordination of benefits, eligibility, referrals, and claim status. The provider must ensure a type I or a type II NPI in accordance to how they are submitting claims. If you are a solo practitioner, you are a Type 1, and if you are a group/ organization your billing NPI is Type 2. You must register NPPES with the correct information for LIBERTY to validate.

HOW TO APPLY FOR AN NPI

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

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

VOLUNTARY PROVIDER CONTRACT TERMINATION

Providers must submit notice of withdrawal from the network at least ninety (90) calendar days before the effective date of the withdrawal. Providers must continue to treat Members until the last day of the month following the date of termination. Affected Members are given advance written notification informing them of their transitional rights.

Certain contractual rights survive termination, such as the agreement to furnish records during a grievance, appeal or claims review. Please consult your provider contract for your responsibilities beyond termination.

MATERIAL MODIFICATIONS

LIBERTY is committed to providing Providers with a forty-five (45) day written notification before any material modifications as required by applicable law.

STANDARDS OF ACCESSIBILITY

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

COMPLIANCE WITH THE STANDARDS OF ACCESSIBILITY AND AVAILABILITY

LIBERTY monitors compliance with the standards set above through dental facility audits, provider/member surveys, and other Quality Management processes. LIBERTY may seek corrective action for providers that are not meeting accessibility standards.

"Appointment waiting time" is defined as the time from the initial request for dental services by a member or the member's treating provider, to the earliest date offered for the appointment for services. This includes the time for obtaining authorization from the LIBERTY, completing any other requirements of the Plan, or our contracting providers.

Type of Appointment	Access to Care Standards
After-Hours/Emergency Availability	24 hours a day, 7 days a week
Emergency Care	Patient must be seen within twenty-four (24) hours of a **request for services that do not require prior authorization**
Urgent Care Services	Patient must be seen within forty-eight (48) hours for services that **require prior authorization require authorization**
Routine Sick Patient Care	Patient must be seen within seven (7) days
Primary Dental Care	Patient must be seen within thirty (30) days
Follow Up Dental Services	Patient must be seen within thirty (30) days after assessment

EMERGENCY SERVICES AND AFTER-HOURS EMERGENCIES

Emergency Care it is the responsibility of every dentist practicing in the state of Ohio to provide either personally, or through another licensed dentist, to provide or make arrangement for twenty-four (24) hours of emergency services for all patients of record.

In the event the primary dental provider is not available to see an emergency patient within twenty-four (24) hours, it is his/ her responsibility to ensure that emergency services are available.

If the patient is unable to access emergency care within our guidelines and must seek services outside of your facility, you may be held financially responsible for the total costs of such services. Additionally, if your office is unable to meet LIBERTY guidelines, LIBERTY has the right to transfer some or all Medicaid enrollment to another provider, close your office to new enrollment, or take other action deemed necessary by LIBERTY to ensure timely access to all Members.

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. Missed or canceled appointments should be noted in the Member's records. Medicaid Members cannot be charged for broken or missed appointments.

RECALL, FAILED OR CANCELED APPOINTMENTS

Contracted dentists are expected to have an active recall system for established patients who have not completed their treatment plans, for regular maintenance visits, or for patients who fail to keep or cancel their appointments.

RECALL SYSTEM REQUIREMENT

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

If a written process is utilized, the following language is suggested for missed appointments:

- "We missed you when you did not come for your dental appointment on month/date. Regular check-ups are needed to keep your teeth healthy."
- "Please call to reschedule another appointment. Call us ahead of time if you cannot keep the appointment. Missed appointments are very costly to us. Thank you for your help."

Dental offices indicate that Medicaid patients sometimes fail to show up for appointments. LIBERTY offers the following suggestions to decrease the "no show" rate.

- Contact the Member by phone or postcard prior to the appointment to remind the individual of the time and place of the appointment.
- If the appointment is made through a government supported screening program, contact staff from these programs to ensure that scheduled appointments are kept.

OFFICE COMPLIANCE VERIFICATION PROCEDURES

In conjunction with its office claim audits described in section 4, LIBERTY will measure compliance with the requirement to maintain a patient recall system.

FACILITY PHYSICAL ACCESS FOR THE DISABLED – AMERICANS WITH DISABILITIES ACT

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

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

The ADA sets requirements for new construction and alterations of buildings and facilities, including healthcare 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.

TELE-DENTISTRY (TELE-MEDICINE)

Ohio Medicaid dental Providers have the flexibility to use tele-dentistry as a modality to render services based upon service categories and parameters, using designated CDT codes as is the current policy, when in compliance with ALL the following requirements:

- The procedure is a diagnostic (D0100-D0999) or preventive (D1000-D1999) service. Tele-dentistry is not allowable for all other service categories and CDT codes (D2000-D9999) except D9995 and D9996, which are the tele-dentistry modality codes; and D9430 office visit observation (during regularly scheduled hours – no other services performed).

- Providers must inform the patient before the initial delivery of tele-dental services about the use of tele-dentistry and obtain verbal or written consent from the patient for the use of tele-dentistry as an acceptable mode of delivering dental care services. Providers also need to document when a patient consents to receive services, and such documentation must be maintained in the patient's medical (dental) record.
- All services rendered through tele-dentistry must comply with the Ohio Medicaid policies and LIBERTY Clinical Criteria and Guidelines, including documentation requirements to substantiate the corresponding technical and professional components of billed CDT codes.
- A patient who receives tele-dentistry services under these provisions shall also have the ability to receive in-person services from the dentist or dental practice or assistance in arranging a referral for in-person services.
- The referral to the dentist or dental practice must be documented to use asynchronous tele-dentistry to establish a patient relationship. The procedure does not require an in-person presence of the patient in a dental facility, such as administration of anesthesia, direct visualization, or instrumentation of the mouth by a licensed dentist.
- Procedures do not involve the insertion/removal of dental devices or products – such as crowns, implants, removable partials or dentures, or orthodontic appliances.

TELE-DENTISTRY CDT CODES

- D9995 (Tele-dentistry – Synchronous; Real – Time Encounter) and
- D9996 (Tele-dentistry – Asynchronous; information stored and forwarded to a dentist for subsequent review).
- D9430 office visit for observation (during regularly scheduled hours – no other services performed)

For additional information on Tele-dentistry, you may access and view the following: **libertydentalplan.com/Resources/Videos/TeleDentistry-Providers.mp4**

TREATMENT PLAN GUIDELINES

All Members must be presented with an appropriate written treatment plan containing an explanation of the prescribed treatment, the benefits available for the prescribed treatment, and any related costs. Treatment plans must include covered Medicaid services.

DENTAL TREATMENT REQUIRING AUTHORIZATION

Authorization is a utilization tool that requires Participating Providers to submit "documentation" associated with certain dental services for a Member. Participating Providers will not be paid if this "documentation" is not provided to LIBERTY.

Participating Providers must hold the Member, LIBERTY, Plan and the Ohio Department of Medicaid (ODM) harmless as set forth in the Provider Participation Agreement if coverage is denied for failure to obtain authorization (either before or after service is rendered).

LIBERTY utilizes specific dental utilization criteria as well as an authorization process to manage utilization of services. LIBERTY' s operational focus is to assure compliance with its utilization criteria. The criteria are included in this manual (see Clinical Criteria section). Please review these criteria as well as the Benefits covered to understand the decision-making process used to determine payment for services rendered.

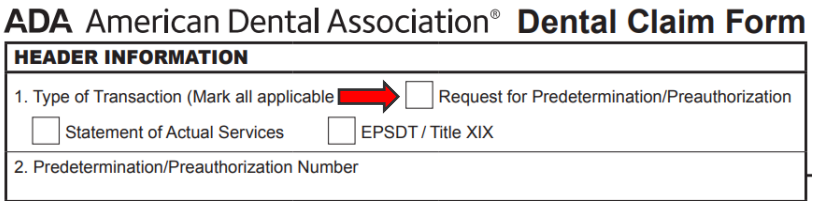
Authorization and documentation submitted before non-emergency treatment begins.
Services that require authorization (non-emergency) should not be started prior to the determination of coverage (approval or denial of the authorization).

Non-emergency treatment started prior to the determination of coverage will be performed at the financial risk of the dental office. If coverage is denied, the treating dentist will be financially responsible and may not balance bill the Member, the Plan, and/or LIBERTY.

Your submission of "documentation" must include, but is not limited to:

- Radiographs,
- Narratives, or other information where requested (See Exhibits for specifics by code)
- CDT codes on the claim form

Your submission should be sent on a current **ADA approved claim form**. The tables of Covered Services (Exhibits) contain a column marked Authorization Required. A "Yes" in this column indicates that the services listed requires authorization (documentation) to be considered for reimbursement.


ADA American Dental Association® Dental Claim Form

HEADER INFORMATION

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

2. Predetermination/Preauthorization Number

After a LIBERTY Dental Director or clinical designee, licensed dentists, reviews the documentation, the submitting office will be provided an authorization number. The authorization number will be provided within two (2) business days from the date the documentation is received. The authorization number will be issued to the submitting office by mail and must be submitted with the other required claim information after the treatment is rendered.

SUBMITTING AUTHORIZATION REQUESTS AND X-RAYS

- Electronic submission using the LIBERTY Provider portal
- Electronic submission using National Electronic Attachment (NEA) is recommended. For more information, please visit **http://www.nea-fast.com/** and click the "Learn More" button. To register, visit **https://vynedental.com/fastattach/** and select "Register Now."
- Submission of duplicate radiographs (which we will recycle and not return)
- Submission of original radiographs with a self-addressed stamped envelope (SASE) so that we may return the original radiographs. **Note**: that determinations will be sent separately, and any radiographs received without a SASE will not be returned to the sender.
- **All** radiographs should include member's name, identification number, and office name to ensure proper handling.

AUTHORIZATION AND DOCUMENTATION SUBMITTED WITH CLAIM (EMERGENCY TREATMENT)

LIBERTY recognizes that emergency treatment may not permit authorization to be obtained prior to treatment. In these situations, services that require authorization, but are rendered under emergency conditions, will require the same "documentation" be provided with the claim when the claim is sent for payment. It is essential that the Participating Provider understand that claims sent without this "documentation" will be denied.

Non-Covered Procedures and Treatment Plans: Non-covered services may be offered and presented to Medicaid Members. Treatment plans and informed consents must be signed showing patient acceptance of the treatment, and for any costs for non-covered treatment.

LIBERTY Members cannot be denied their plan benefits. Providers must not make performance of covered services contingent upon Members payment for non-covered services. All accepted or declined treatment plans must be signed and dated by the patient or his/her guardian and the treating dentist.

Non-Covered Procedures – Important Note: For Members electing non-covered services, a separate written informed consent must be obtained that clearly states:

- The treatment plan,
- The non-covered services elected,
- The applicable costs of the non-covered services and
- The Member's understanding and acceptance of the non- covered services must be obtained prior to the commencement of treatment.

Note: Please use the non-covered services document in the forms section of this Reference Guide, which is also available on our website at **LIBERTY Informed Consent for Alternative Treatment**.

Medicaid members cannot be charged for non-covered services, unless the member has been properly informed of all non-covered services, and your office has obtained an adequate informed consent form signed by the member consenting to treatment and accepting financial responsibility.

Providers who perform non-covered services must obtain financial and treatment consents signed by the Member/patient or legal representative, as applicable, that are clear.
Concise, and understandable by a prudent layperson. Failure to do so may result in non-payment by the Plan. Medicaid Members are protected from financial responsibility for charges that were not clearly presented prior to treatment.

In such cases, Medicaid Members who file a grievance and can prove they did not approve such services, will not be subject to collection activity. Providers will not be able to bill Members or collect payments for non-covered services that were not properly approved by the Member/patient with documented informed consent.

Please consult the plan schedule of benefits to determine covered and non-covered services.

You may also send in proposed treatment for prior authorization to determine whether a proposed service is covered or not. By virtue of your signed provider agreement, you agree to cooperate with corporate business practices and quality management processes such as grievances, appeals, and providing care and service in accordance with plan documents.

EARLY AND PERIODIC SCREENING, DIAGNOSTIC AND TREATMENT (EPSDT) BENEFIT
Members ages 0-20 must be provided medically necessary dental services in accordance with 42 Code of Federal Regulation §440.40(b), Early and Periodic Screening, Diagnosis and Treatment Program (EPSDT).

LIBERTY provides comprehensive, diagnostic and preventive dental services to eligible Members up to age 21. Services that exceed the Ohio Medicaid Managed Care Program benefit or frequency limitations must be medically necessary, and may include emergency, preventive and therapeutic services for dental disease.

PRIOR-AUTHORIZATION OF EPSDT DENTAL SERVICES

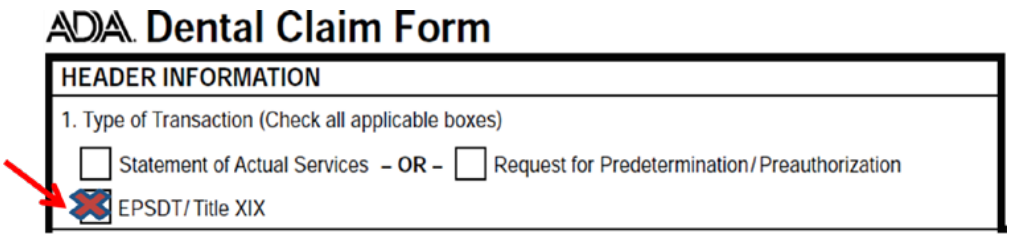
For all EPSDT service(s), a prior authorization is required for any dental service that is not listed on the state Medicaid benefit schedule, and any service(s) that are listed on the Medicaid benefit schedule that is subject to frequency limitations, or periodicity schedule guidelines.

Any EPSDT service(s) that were not submitted for a prior-authorization described above will be denied and the members cannot be held financially responsible for the denied services. For all prior-authorization requests, medical necessity will be determined based on radiographic and/or otherdocumented rationale.

PRIOR-AUTHORIZATION IS REQUIRED FOR:

- Medically necessary dental services not listed in the benefits schedule and
- Medically necessary dental services listed in the benefit schedule but are more than frequency limitations

Providers requesting a prior-authorization or billing for EPSDT services should select the "EPSDT" box in section 1 of the ADA dental claim form:


ADA Dental Claim Form

HEADER INFORMATION

1. Type of Transaction (Check all applicable boxes)

☐ Statement of Actual Services – OR – ☐ Request for Predetermination/Preauthorization

☒ EPSDT/Title XIX

- Prior Authorization request(s) will be clinically reviewed for medical necessity; and
- Approved Prior Authorization will be reimbursed based on your current fee schedule.

AMERICAN ACADEMY OF PEDIATRICS PERIODICITY SCHEDULE

https://downloads.aap.org/AAP/PDF/periodicity_schedule.pdf

You can learn more about ESPDT benefit though the Ohio Disability Rights website at:
https://www.disabilityrightsohio.org/medicaid-epsdt

SECOND OPINIONS

Members and/or providers can request a consultation with another network dentist for a second opinion to confirm the diagnosis and/or treatment plan. The dentist can refer a Member to the Member Services Department, Monday through Friday, 8 a.m. to 8 p.m. EST to make the request. Second opinions may be request for non-covered services.

CONTINUITY OF CARE

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

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

- All care rendered to LIBERTY Members must be properly documented in the patient's dental charts according to established documentation standards.
- Communication between the Primary Dental Provider and dental specialist shall occur when Members are referred for specialty dental care.
- Dental chart documentation standards are included in the Ohio Medicaid Clinical Criteria and Guidelines.
- Dental chart audits will verify compliance to documentation standards.
- During facility on-site audits, LIBERTY monitors compliance with continuity and coordination of care standards.
- After treatment with a dental specialist is performed, with exception to Members with special health care needs, the Provider is responsible for evaluating the need for and scheduling the Member for any appropriate follow-up care.

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA)

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

Federal HIPAA laws require practitioners to use current CDT codes to report dental procedures. 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, providers agree to abide by all HIPAA requirements, Quality Management Program requirements, and that Member protected Personal Health Information (PHI) may be shared with LIBERTY as per the requirement in the HIPAA laws that enable the sharing of such information for treatment, payment, and health care operations (TPO), as well as for peer review and quality management and improvement requirements of health plans. There is no need for special Member authorizations when submitting member PHI for these purposes.

OUR COMMITMENT IS DEMONSTRATED THROUGH OUR ACTIONS

LIBERTY has appointed a Privacy Officer to develop, implement, maintain, and provide

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

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

Copies of LIBERTY's HIPAA policies are available upon request by contacting LIBERTY's Member Service department at 888.352.7924/TTY: 877-855-8039.

SAFEGUARDING PROTECTED HEALTH INFORMATION (PHI)

As a dental provider your office is fully aware that the Health Insurance Portability Accountability Act (HIPAA) requires the protection and confidential handling of patient Protected Health Information (PHI).

HIPAA requires health care providers to develop and implement safeguards that ensure the confidentiality and security of all forms of PHI (whether electronic, verbal, or tangible) when transmitted or stored. Failure to properly safeguard PHI can result in data breaches, enforcement actions, and significant monetary penalties, and LIBERTY Members, is a violation of LIBERTY's provider agreement.

If LIBERTY discovers that a provider has transmitted LIBERTY Member PHI via a potentially non-secure method, or if we are otherwise notified that a provider may not be properly safeguarding such PHI, we will contact the provider to investigate the matter. Non-compliance will result in a Corrective Action Plan and continued, or egregious non-compliance will lead to contract termination.

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

Review and adhere to LIBERTY's Secure Use & Transmission of e-PHI policy, located at **Provider Resource Library - Provider Resource Library (libertydentalplan.com)**

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

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

   B. Use physical and technical safeguards to ensure that monitors cannot be viewed by unauthorized individuals, and that screens automatically lock on devices, after a reasonable period of inactivity.

   C. Maintain protocols to ensure faxes containing PHI are issued to the correct Member, and that increased precautions are applied when faxing especially sensitive information (such as sensitive diagnoses).

2. **VERBAL PHI**
   A. Do not discuss Member information in public areas (including waiting rooms, hallways and other common areas), even if you believe you are masking the Member's identity. Ensure conversations within examination rooms or operatories cannot be overheard by those outside of the room. Use heightened discretion when discussing sensitive diagnoses or other sensitive matters, including when such discussions occur with the Member in an exam room or operatory. Best practices include:
      - Implementing appropriate physical safeguards such as closed doors and insulated walls for exam rooms and operatories. Use ambient music or white noise to cover conversations in common areas
      - Arranging waiting areas to minimize one Member overhearing conversations with another
      - Posting a sign requesting that Members who are waiting to sign-in or be seen, do not congregate in reception area
      - Ensuring unauthorized persons cannot overhear phone calls and limiting what is communicated by phone and voicemail to the minimum necessary information to accomplish the required purpose. Also, please avoid use of speaker phones
3. **TANGIBLE PHI**
   A. Do not display or store paper or other tangible PHI in common areas. Do not leave such PHI unattended on desks or in exam rooms or operatories. Never dispose of paper or other tangible PHI in the trash. Use secure methods to destroy and dispose of such PHI (for example, cross-cut shredder)
   B. Lock away all PHI during close of business (for example, in a locked cabinet)
   C. Close window blinds to prevent outside disclosure
   D. Do not overstuff mailing envelopes; and print mailing addresses accurately and clearly to minimize the possibility that mail is lost in transit
   E. Take precautions to ensure PHI is not lost while transporting from one location to another, and never leaving tangible PHI in vehicles unattended

ANTI-DISCRIMINATION

Discrimination is against the law. LIBERTY complies with all applicable Federal civil rights laws and does not discriminate, exclude people, or treat them differently based on race, color, religion, national origin, age, disability, or sex.

LANGUAGE ASSISTANCE SERVICES

LIBERTY provides free language assistance services to ensure Limited English Proficient (LEP) Members have appropriate access to interpretation and written translation services when accessing dental care. LIBERTY requires that services be provided in a culturally competent manner to all Members, including those with LEP or reading skills, and diverse cultural and ethnic backgrounds.

LIBERTY provides free aids and services to people with disabilities, and free language assistance services to people whose primary language is not English, such as:

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

If you need these services, please contact us at 888.352.7924, TTY: 877-855-8039.

LIBERTY is prohibited from discriminating or taking punitive action against any provider for making a complaint to BMS or other regulatory body in good faith.

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

- Phone: (888) 704-9833
- TTY: (800) 735-2929
- Fax: (714) 389-3529
- Email: **compliancehotline@libertydentalplan.com**
- Online: **https://www.libertydentalplan.com/About-LIBERTY-Dental/Compliance/Contact-Compliance.aspx**

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

- U.S. Department of Health and Human Services
- 200 Independence Avenue, SW Room 509F, HHH Building Washington, D.C. 20201
- (800) 368-1019, (800) 537-7697 (TDD)
- Online at: **https://www.hhs.gov/civil-rights/filing-a-complaint/complaint-process/index.html**
- Grievance forms are available at **http://www.hhs.gov/ocr/office/file/index.html**

INTERPRETATION SERVICES FOR LIMITED ENGLISH PROFICIENT PATIENTS:

- Interpreting services, including American Sign Language, are available to Members 24 hours a day, 7 days a week at no cost by contacting LIBERTY's Member Services Department at 800-267-6610 & TTY/TDD 877-855-8039.

- Members who reside in the state of Ohio and are enrolled in Ohio Medicaid have the right to an interpreter when receiving treatment and services.
- LIBERTY is offering free telephonic interpretation through our language service vendor. The Member must be fully informed that an interpreter is available to him or her at no cost.
- If a Member requests to use LIBERTY's language assistance services, please document the request in the Member's dental record.
- To engage an interpreter once the Member is ready to receive services, please call 800-267-6610 TTY/TDD: 877-855-8039. 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.
- LIBERTY discourages the use of family or friends as interpreters and strongly discourages the use of minors as interpreters for Members except in emergencies if the minor demonstrates the ability to interpret complex dental information.
- Providers must also fully inform the Member that he or she has the right not to use family, friends, or minors as interpreters.
- If a Member prefers not to use the interpretation services after s/he has been told that a trained interpreter is available free of charge, the Member's refusal to use the trained interpreter shall be documented in the Member's dental record, when in a provider setting, or the Member's administrative file (call tracking record) in the Member Services setting.
- Language preferences of Members will be available to directly contracted dentists upon request through telephone inquiries.
- Written Member Informing Materials in threshold languages and alternative formats are available to Members at no cost and can be requested by contacting LIBERTY's Member Services Department at 800-267-6610/ TTY/TDD: 877-855-8039.

IDENTIFYING AND REPORTING ABUSE, NEGLECT AND EXPLOITATION OF MEMBERS

The Ohio Abuse Hotline accepts reports 24 hours a day and 7 days a week of known or suspected child abuse, neglect, or abandonment, and reports of known or suspected abuse, neglect, or exploitation of a vulnerable adult.

- Ohio Adult Protective Services Abuse Hotline: 855.644.6277
- Ohio Child Protective Services Abuse Hotline: 855.642.4453

Definitions

- **Abuse** — Non-accidental infliction of physical and/or emotional harm.
- **Physical Abuse** — Causing the infliction of physical pain or injury to an individual.

- **Sexual Abuse** — Unwanted touching, fondling, sexual threats, sexually inappropriate remarks or other sexual activity with an adult with disabilities; touching, fondling, sexual threats, sexually inappropriate remarks or any other sexual activity with an older person when the older person is unable to understand, unwilling to consent, threatened or physically forced to engage in sexual activity.
- **Neglect** — Repeated conduct or a single incident of carelessness that results or could reasonably be expected to result in serious physical or psychological/emotional injury or substantial risk of death (this includes self-neglect and passive neglect).
- **Exploitation** — Illegal use of assets or resources of an adult with disabilities. It includes, but is not limited to, misappropriation of assets or resources of the alleged victim by undue influence, by breach of fiduciary relationship, by fraud, deception, extortion or in any manner contrary to law.

HOW TO REPORT HUMAN TRAFFICKING

OHIO IS ZERO-TOLERANCE FOR HUMAN TRAFFICKING
REPORT HUMAN TRAFFICKING The National Human Trafficking Hotline 1-888-373-7888 The U.S Department of Justice Hotline 1-888-428-7581 Ohio Abuse Hotline 1-800-282-0515 Report it to your local authorities

SECTION 8. CLINICAL DENTISTRY GUIDELINES AND PRACTICE PARAMETERS

LIBERTY's Clinical Criteria, Guidelines and Practice Parameters (CCGs) are developed by LIBERTY's Dental Directors with input from participating panel general dentists and specialists. LIBERTY utilizes the American Dental Association's (ADA) "Dental Practice Parameters", American Academy of Pediatrics (AAP), American Association of Oral and Maxillofacial Surgeons (AAOMS), American Association of Endodontics (AAE), clinical principals within community dental standards.

The Clinical Criteria Guidelines are available on Liberty's website at the following link or by scanning the QR code:

Link to PDF:
https://www.libertydentalplan.com/Resources/Documents/2023_Clinical_Criteria_Guidelines_Practice_Parameters.pdf

DISCLAIMER: Please note that specific Plan/Program guidelines supersede the information contained in these Clinical Dentistry Practice Parameters. The practice parameters are the default set of practice parameters when plan documentation is silent on a particular topic.

Participating general dentists and specialists agree to comply with these Clinical Criteria, Guidelines and Practice Parameters by virtue of their signed LIBERTY contract agreement.

SECTION 9. QUALITY MANAGEMENT PROGRAM DESCRIPTION

LIBERTY's Quality Management and Improvement (QMI) Program is designed to ensure that licensed dentists are reviewing the quality of dental care provided, that quality of care problems are identified and corrected, and 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 non-clinical 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 clinical designee, licensed dentists, 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.

QMI PROGRAM GOALS AND 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 Members'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 PDPs 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 and appeals. The QMI document describes the programs, 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 degree to which dental providers and specialty providers are available within a designated service area.
- **Availability of Care:** ease and timeliness to which patients can obtain the care that they need. The degree to which the correct care is provided, given the current community standards.
- **Continuity of Care:** the degree to which the quality of care is coordinated from one setting of care or provider of care to another within a given timeframe.
- **Quality of Care:** the degree to which the dental care provided and 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 Member.

QUALITY MANAGEMENT PROGRAM COMMITTEES

Oversight of the QMI Program is provided through a committee structure, which allows for the flow of information to and from the Board of Directors. The QMI Program employs six (6) major Committees and additional sub-committees to ensure that dental care delivery decisions are made independent of financial and administrative decisions.

- **Quality Management and Improvement Committee (QMIC):** The Committee reviews, formulates, and approves all aspects of dental care provided by LIBERTY's Network Providers, including the structure under which care is delivered, the process and outcome of care, utilization and access to care, availability, referrals to specialists, continuity of care, safety, appropriateness, and any problem resolution in the dental delivery system identified by the Peer Review and Utilization Management 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 Reviews:** 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 Network Manager.
    - A non-passing score must be reviewed by the Dental Director, or clinical designees, licensed dentists, 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 PQIs, grievances, utilization outlier status, potential fraud, waste or abuse, or other administrative reasons.
    - Upon identification of a PQI, LIBERTY's Dental Director, or clinical designee, licensed dentists, may apply corrective action plans as necessary to ensure offices are following 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 refer to Peer Review for recommendations for the office terminated from the network.

- **Access and Availability (A&A):** 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 is monitored and CAPs are developed if deficiencies occur. Activities are reviewed by the QMI Committee quarterly, or more frequently, if necessary.
- **Credentialing:** Our Credentialing Program includes initial credentialing and re-credentialing at thirty-six (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.
- **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 are 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.
- **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.
- **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.
- **Peer Review Committee (PRC):** The Peer Review Committee is responsible for identification and resolution of quality-of-care issues 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. The PRC focus is on improving care to Members and minimizing potential risk cases, identifying trends of questionable care, and developing corrective action plans to ensure resolutions.

- **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.
    - PQIs 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.
    - LIBERTY commonly investigates PQIs from grievances ruled against the dental provider utilization patterns, significant departure from expected contractual behavior or compliance, external vendor and business partner identification, and others.
    - The Dental Director or clinical designee, licensed dentists, 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.
- **Grievances and Appeals:** The Grievance and Appeals Department investigates and resolves issues for the services or operations that are the subject of concern and ensures that issues presented by LIBERTY Members and providers 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 Utilization Management Committee is to maximize the effectiveness of care provided to the Member. The Utilization Management Committee monitors over- and under-utilization 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.

UTILIZATION MANAGEMENT

LIBERTY's Utilization Management (UM) Program is designed to meet Ohio Department of Medicaid and Federal regulation, while providing Members access to high-quality, cost-effective medically necessary care. Monitor over and under-utilization of services, identify treatment patterns for analysis, and ensures that utilization decision is made in a timely manner which accommodate the urgency of the situation and minimizes any disruption in the provision of care.

THE FOCUS OF THE UM PROGRAM INCLUDES:

- Evaluating requests for dental care services by determining whether the service or good is Medical Necessary consistent with the Member's diagnosis and level of care required.

- Providing access to medically appropriate, cost-effective dental care services in a culturally sensitive manner and facilitating timely communication of clinical information among Providers.
- Reducing overall expenditures by developing and implementing programs that encourage preventive oral health care behaviors and Member partnership.
- Facilitating communication and partnerships among Members, families, Dental Providers, Medicaid health plans, other Medicaid dental plans, Ohio Department of Medicaid and Federal regulation , and LIBERTY to enhance cooperation and appropriate utilization of dental care services.
- Reviewing, revising, and developing dental services coverage policies to ensure Members have appropriate access to new and emerging care and technology.
- Enhancing the coordination and minimizing barriers in the delivery of dental care services.

LIBERTY DOES NOT:

- Delegate any UM responsibility to a third party. We conduct all reviews in-house by our state Dental Directors and/or clinical designee, licensed dentists.
- Reward its employees or any or other individuals or entities performing UM activities for issuing denials of coverage, services, or care.
- Provide financial incentives to encourage or promote underutilization.

MEDICALLY NECESSARY SERVICES

All Medicaid dental services or goods provided, ordered, or reimbursed by LIBERTY must be medically necessary.

MEDICAL NECESSARY AS DEFINE IN OHIO ADMINISTRATIVE CODE (OAC) RULE 5160-1-01:

- Medical necessity for individuals covered by early and periodic screening, diagnosis, and treatment (EPSDT) is defined as procedures, items, or services that prevent, diagnose, evaluate, correct, ameliorate, or treat an adverse health condition such as an illness, injury, disease or its symptoms, emotional or behavioral dysfunction, intellectual deficit, cognitive impairment, or developmental disability.
- Medical necessity for individuals not covered by EPSDT is defined as procedures, items, or services that prevent, diagnose, evaluate, or treat an adverse health condition such as an illness, injury, disease or its symptoms, emotional or behavioral dysfunction, intellectual deficit, cognitive impairment, or developmental disability, and without which the person can be expected to suffer prolonged, increased, or new morbidity, impairment of function, dysfunction of a body organ or part, or significant pain and discomfort.
- Conditions of medical necessity are met if all the following apply:
    - Meets generally accepted standards of medical practice.
    - Clinically appropriate in its type, frequency, extent, duration, and delivery setting.

    - Appropriate to the adverse health condition for which it is provided and is expected to produce the desired outcome.
    - Is the lowest cost alternative that effectively addresses and treats the medical problem.
    - Provides unique, essential, and appropriate information if it is used for diagnostic purposes.
    - Not provided primarily for the economic benefit of the provider nor for the convenience of the provider or anyone else other than the recipient.
- The fact that a physician, dentist, or other licensed practitioner renders, prescribes, orders, certifies, recommends, approves, or submits a claim for a procedure, item, or service does not, in and of itself, make the procedure, item, or service medically necessary and does not guarantee payment for it.
- The definition and conditions of medical necessity articulated in this rule apply throughout the entire Medicaid program. More specific criteria regarding the conditions of medical necessity for particular categories of service may be set forth within ODM coverage policies or rules.

LIBERTY's UM program includes components of prior authorization and prospective, concurrent, and retrospective review activities. Each component is designed to provide for the evaluation of dental care and services based on LIBERTY's Members' coverage, and the appropriateness of such care and services, and to determine the extent of coverage and payment to Providers of care.

CRITERIA FOR UM DECISIONS

LIBERTY's UM program uses nationally recognized review criteria based on sound scientific medical evidence. Dentists with an unrestricted license in the state of Ohio and professional knowledge and/or clinical expertise in the related dental care specialty actively participate in the discussion, adoption, application, and annual review and approval of all utilization decision-making criteria.

The UM program uses numerous sources of information including, but not limited to, the following when making coverage determinations:

- Medical Necessity
- LIBERTY's Clinical Coverage Guidelines
- Ohio Medicaid Dental Plan Contract
- Ohio Medicaid Dental Services Coverage Policy, as appropriate
- Ohio and federal statutes and laws
- Medicaid guidelines

LIBERTY's Ohio Dental Director or clinical designee, licensed dentists, involved in the UM process apply the state of Ohio's definition of Medical Necessity criteria in context with the Member's individual circumstance and the capacity of the local dental services provider delivery system. When the above criteria do not address the individual Member's needs or unique circumstance, the Dental Director will use clinical judgment in making the determination, consistent with Medical Necessity. The review criteria and guidelines are available to the Providers upon request.

Providers may request a copy of the criteria used for specific determination of Medical Necessity, at no cost, by contacting LIBERTY's Utilization Management Department through Provider Services at the number listed in Section 1.

Care Management/Care Coordination

A Special Health Care Needs Member faces physical, behavioral, or environmental challenges daily, that place at risk their health and ability to function fully in society. This includes individuals with intellectual and developmental disabilities or related conditions; individuals with serious chronic illnesses, such as human immunodeficiency virus (HIV), schizophrenia or degenerative neurological disorders; individuals with disabilities resulting from many years of chronic illness such as arthritis, emphysema or diabetes; and children/adolescents and adults with certain environmental risk factors such as homelessness or family problems that lead to the need for placement in foster care.

We offer care management services to children and adults with special health care needs that include complex/chronic medical conditions requiring specialized health care services and persons with physical, mental/substance abuse, and/or developmental disabilities, persons who are eligible for the MLTSS program and require dental care.

Our care management programs are offered but not limited to members who:

- Have complex medical (like asthma, diabetes, HIV/AIDS and high-risk pregnancy or behavioral health issues who have associated dental related comorbidities
- With Individual Developmental Disabilities (IDD)
- With high dental services utilization
- With intensive dental health care needs
- Who reside in a nursing facility
- Who consistently access services at the highest level of care
- Are home-bound
- Are homeless
- Are identified as needing assistance in accessing or using services

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

Our care management program offers our members (children and adults) a care manager, care coordinator, and other outreach workers. They will 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 medical and dental health condition(s).
- Will work with PCPs and PDPs 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.

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.
- 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.
- A formal provider complaint 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 (CAPS)

The Dental Director or clinical designee, licensed dentists, 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

PROVIDER QMI PROGRAM RESPONSIBILITIES

LIBERTY's QMI Program handles all audits of LIBERTY by external agencies as well as conducts internal audits of various activities. LIBERTY performs chart audits and quality assessments of provider offices as part of this program. Providers may become involved in such audits due to random assignment or, as a result of, a focused report which identified a need for research into the provider's practice.

These activities are performed as part of LIBERTY's requirement to ensure that Members receive necessary and adequate care in accordance with professionally recognized standards, and to ensure that the Members receive and enjoy the full range of their covered benefits. In addition, LIBERTY is concerned that continuity of care for covered Members is ensured including access to specialty referrals and services. LIBERTY appreciates the fact that its general dentists and specialty providers work diligently to meet these various responsibilities.

CREDENTIALING/RECREDENTIALING

Effective October 01, 2022, Ohio Medicaid and MyCare providers will utilize the Provider Network Management (PNM) module from the Ohio Department of Medicaid for submitting provider applications, credentialing requests, and provider demographic updates. The PNM module will be the single point for providers to complete provider enrollment, centralized credentialing, and provider self-service.

The PNM module is replacing MITS provider portal. Please visit the following link for more details: https://managedcare.medicaid.ohio.gov/.

A provider must be registered with Ohio Department of Medicaid, have a valid OH Medicaid Dental License, Medicaid ID, and NPI to contract with LIBERTY.

LIBERTY, in conjunction with the Plan, has the sole right to determine which dentists (DDS or DMD) it shall accept and continue as Participating Providers. The purpose of the credentialing plan is to provide a general guide for the acceptance, discipline, and termination of Participating Providers. LIBERTY considers each Provider's potential contribution to the objective of providing effective and efficient dental services to Members of the Plan.

MEMBER GRIEVANCES AND APPEALS (G&A) PROCESS

LIBERTY is not delegated member Grievances and Appeals (G&A) for Anthem Blue Cross Blue Shield (BCBS). Anthem BCBS members may file a grievance and/or appeal by calling Anthem BCBS's Member Services Department, creating an account and filing a G&A online, or by printing a G&A form and mailing or faxing. Member G&A received by LIBERTY will be forwarded to Anthem BCBS to ensure timely processing according to ODM and federal standards.

The Anthem BCBS Member G&A submission information is:

- **Phone:** 888-352-7924/TTY: 877-855-8039
- **Email:** ohioga@anthem.com
- **Fax:** 888-235-9934
- **Mail:** Anthem Blue Cross Blue Shield, PO Box 62429, Virginia Beach, VA 23466-2429

LIBERTY's Member G&A process encompasses investigation, review, and a recommended resolution of the member's issue(s) to Anthem Blue Cross Blue Shield and/or contracted providers. As part of our commitment, LIBERTY works to ensure that all Members have every opportunity to exercise their rights to a fair and timely submission and resolution to any G&A.

- **All contracted provider facilities are required to display member complaint forms.**

Note: Copies of LIBERTY's G&A policies and procedures can be requested, at no cost, by contacting Member Services at 888.352.7924/TTY: 877-855-8039.

G&A RECORDS REQUESTS

Providers are **contractually required** to provide LIBERTY with copies of all Member records as a result of a member G&A within **three (3) business days** of a request from the Plan. All providers are obligated to respond to LIBERTY with a written response to the member's concerns, and all supporting documentation (clinical notes, treatment plans, financial ledgers, x-ray(s), etc.)

Failure to cooperate/comply with the G&A process or resolution may lead to disciplinary actions, including but not limited to, termination from the LIBERTY network.

G&A CULTURAL AND LINGUISTICS

LIBERTY's Member G&A 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 G&A system.

LIBERTY's Members' participation in the G&A system, for those with linguistic, cultural, or communicative impairments, is facilitated through LIBERTY's coordination of translation, interpretation, and other communication services to assist in communicating the procedures, process, and findings of the G&A system.

LIBERTY does not discriminate, penalize, or retaliate against Members or providers who request an appeal or support a Member or provider in requesting a G&A, including expedited requests.

MEMBER G&A RESOLUTION

LIBERTY adheres to State, Federal, and Plan requirements related to processing inquiries, appeals, and grievances.
Unless otherwise required by ODM and/or Anthem BCBS, LIBERTY processes inquiries, appeals, and grievances in accordance with the definitions below.

- **Acknowledgement:** Anthem BCBS mails written notification of the receipt of the G&A to the member. LIBERTY will submit a records request with a summary of the member G&A to the provider.
- **Appeal:** An appeal is a request (written or verbal) from a Member, an attorney on behalf of a Member, or a government agency registering a request for review of an adverse benefit determination made by the Plan.
- **Expedited/Fast Track:** Cases in which a member or a provider on behalf of a member feels their health would be harmed by waiting for the standard resolution timeframe, can request an "expedited/fast track review".
    - For members to qualify for an expedited/fast track review, the criteria must first be met. The expedited criteria includes but is not limited to, severe pain, bleeding, swelling, and/or loss of bodily function.
    - For members who do not qualify for an expedited/fast track review, the G&A will be processed within the standard timeframes.
- **Extension:** Members, providers on behalf of a member, LIBERTY or Anthem Blue Cross Blue Shield, if in the member's best interest, may request an extension on an Expedited/Fast Track or Standard Appeal request.
- **Grievance:** An expression of dissatisfaction about any matter other than an adverse benefit determination. Grievances can include, but are not limited to, quality of care or services provided, aspects of interpersonal relationships with Plan or dental office staff, or service charge conflicts.

- **Inquiry**: An inquiry is a request for information that does not include an expression of dissatisfaction. Inquires may include questions about benefits, plan processes or eligibility.

Member requests for G&A that are received by LIBERTY'S G&A Department are forwarded to Anthem Blue Cross Blue Shield for acknowledgement and final resolution. LIBERTY investigates the issues, compiles the findings, requests patient records (if applicable), sends the records to a clinical designee, a licensed dentist, for review and determination (if applicable), and provides Anthem Blue Cross Blue Shield with a recommendation for the resolution of the case.

Anthem Blue Cross Blue Shield is solely responsible for the final resolution of all member G&A cases.

The appropriate individuals are notified of the outcome (i.e. Plan, Member, and Provider as applicable). G&A are closed and maintained on file for tracking and trending purposes. Any member or provider acting on behalf of a member with the member's consent may appeal any utilization management determination resulting in a denial, reduction, suspension or termination of dental services.

MEMBER G&A SUBMISSION

- **Appeals:** Members or providers on behalf of a member have sixty (60) calendar days from the date of the adverse benefit determination issued by LIBERTY.
- **Grievances:** Members have the right to submit a grievance to LIBERTY at any time. The grievance can be regarding any dispute the Member or Authorized Representative has with LIBERTY, care received or any aspect that has led to the Member's dissatisfaction.

Members have the right to assign a Representative. The Representative can be any individual of the Member's choosing: spouse, family Member, attorney, Provider, POA, guardian, etc.

Member G&A requests are not required to be written. Verbal requests are accepted and do not require written and signed documentation from the Member or Authorized Representatives. A Member or Authorized Representative can submit a verbal G&A by calling Anthem at 888-352-7924/TTY: 877-855-8039.

STATE FAIR HEARINGS

Members who do not agree with the outcome of their appeal decision because it was held in full or in part, have the right to request a State Fair Hearing with an Administrative Law Judge.

Members must first participate and exhaust the internal appeal process before they can request a State Fair Hearing, except in the following circumstances:

- The Plan has failed to adhere to notice, and timing requirements required by state and federal regulations, therefore deeming the appeal process exhausted and automatically providing members with rights to file a State Fair Hearing.
- The member is requesting an expedited State Fair Hearing because of an urgent health care need that could result in seriously harm if not treated.

Members can submit a State Fair Hearing as follows:

- Create and account online at https://hearings.jfs.ohio.gov/apps/SHARE/#_frmHomeScreen
- Email: bsh@jfd.ohio.gov. Include "State Fair Hearing Request" in the subject line. Including the members name, contact information, case number, date of the notice, and why they are requesting a State Fair Hearing in the body of the email.
- Phone: ODJFC Consumer Access 866-635-3748.
- Fax: Complete, sign, and fax required documents to 1-614-728-9574
- Mail: Complete, sign and mail required documents to: Ohio DJFS, State Fair Hearings, PI Box 182825, Columbus, OH 43218-2825.
- Members can also contact their caseworks or state ombudsman for assistance in filing a State Fair Hearing.

CONTINUATION OF BENEFITS

Medicaid members can request to continue their benefits during the internal appeal and State Fair Hearing processes when all of the following conditions are met:

- The member requested an appeal within fifteen (15) days from the adverse benefit determination.
- The member appeal involves the termination, suspension, or reduction of services prior to the member receiving the previously authorized services.
- The services were ordered by an authorized provider.
- The authorization period has not expired.

If the final resolution of the appeal or the State Fair Hearing upholds the Plan's initial adverse benefit determination, the member may be held financially responsible for the cost of services furnished during the appeal and/or State Fair Hearing processes.

PROVIDER COMPLAINTS, DISPUTES AND APPEALS PROCEDURE

LIBERTY's process for contracted and non-contracted provider complaints, claim payment disputes, and clinical appeals of adverse medical necessity decisions are separate from the member appeal process.

Members have the right to file an appeal in accordance with the processes outlined above in the Member Grievances and Appeals (G&A) Process.

Providers can submit complaints, disputes and appeals both verbally and in writing to the following:

- Phone: 888-352-7924/TTY 877-855-8039
- Fax: 833-250-1814
- Online (secure email portal): https://securemail4.libertydentalplan.com/securereader/init.jsf?brand=e7149025
- Mail: LIBERTY Dental Plan, PO Box 26110, Santa Ana, CA 92799-6110
- Peer-to-Peer Consultations: Please reference contact information in Section 5 of this manual under "Peer-to-Peer Communications".

PROVIDER CLAIM PAYMENT DISPUTES

Providers have the right to request a claim payment dispute when he/she disagrees with LIBERTY's decision on a claim for any reason other than an adverse medical necessity decision. LIBERTY's provider claims dispute process allows for one level of review.

- **What is a claim payment dispute?** A request from a provider on the outcome of a claim once it has been finalized.
- **When can a provider file a claim payment dispute?** When a provider feels that a claim has been underpaid, overpaid, denied for no authorization, or payment was denied for any reason that is not associated with an adverse medical necessity review.
- **How long does a provider have to file a claim payment dispute?** A provider has three-hundred-sixty-five (365) days from the date of service or sixty (60) calendar days from the date of the Explanation of Payment, whichever is later, to file a claim payment dispute/appeal. Untimely submission will be considered by LIBERTY when good cause for the delay is clearly demonstrated.
- **What information is required to request a claim payment dispute?** All provider claims disputes/appeals must contain, at a minimum, the following information:
    - Provider's name and license number or tax ID.
    - Provider's contact information, i.e. telephone number, address, email.
    - A clear identification of the issue that is subject of the complaint or appeal, i.e. date of service, procedures, etc.
    - A clear explanation/summary of the provider's position on the claim dispute/appeal.
    - Copies of all documentation relative to the subject in support of the provider's position.
- **When will I get a response from LIBERTY a claim dispute?** LIBERTY will provide you with a written response to your claim payment dispute/appeal within sixty (60) calendar days from the date of receipt.

PROVIDER CLINICAL APPEALS OF ADVERSE MEDICAL NECESSITY DECISIONS

LIBERTY's process for provider clinical appeals of adverse medical necessity decisions, which includes both UM and post-service claims, allows for two (2) levels of review consisting of a Peer-to-Peer Consultations, and formal provider clinical appeals.

PEER-TO-PEER CONSULTATION

Providers have the right to request a Peer-to-Peer Consultation when LIBERTY issues an adverse medical necessity determination, to deny, reduce, limit, suspend or terminate a covered services or procedures based on a review from a LIBERTY clinical designee, a licensed dentist, that there is a lack of medical necessity.

- **What is a Peer-to-Peer Consultation?** A telephonic review between the treating/requesting provider and the LIBERTY clinical designee, a licensed dentist, who made the determination that a service or procedure is denied, reduced, limited, suspended or terminated based on a lack of medical necessity. The peer-to-peer consultation will clearly identify what documentation the treating/requesting provider must provide to obtain approval of the specific service or procedure, or a more appropriate course of treatment based upon acceptable dental practices of care.
- **When can a provider request a Peer-to-Peer Consultation?**
    - A provider can request a peer-to-peer consultation within two (2) business days after the receipt of the adverse medical necessity decision.
- **When will I get a response from LIBERTY on my request for a Peer-to-Peer Consultation?**
    - The LIBERTY clinical designee, a licensed dentist, will respond to requests for expedited/urgent requests within forty-eight (48) hours and within seven (7) calendar days for standard requests.
- **What if the Provider does not agree with the outcome of the Peer-to-Peer Consultation?** Providers have the right to request a second level review through the clinical appeal process directly with LIBERTY – not requiring member consent.

PROVIDER CLINICAL APPEALS

Providers have the right to request a clinical appeal of an adverse medical necessity decision made by LIBERTY. Providers are not required to use the Peer-to-Peer Consultation process before requesting a clinical appeal, although it is highly recommended by the Plan as a fast and effective resolution. Providers submitting clinical appeals without member consent are not eligible for the State Fair Hearing process. However, provider may request an External Medical Review as explained below.

- **What is a provider clinical appeal?** A request from a provider to review an adverse medical necessity determination, to deny, reduce, limit, suspend or terminate a covered services or procedures based on a review from a LIBERTY clinical designee, a licensed dentist, that there is a lack of medical necessity.

- **How long does a provider have to file a clinical appeal?** Providers have sixty (60) calendar days from the initial date of the adverse medical necessity decisions issued by LIBERTY to request a clinical appeal. Untimely submission will be considered by LIBERTY when good cause for the delay is clearly demonstrated.
- **What information is required to request a clinical appeal?** Provider clinical appeals of adverse medical necessity decision issued by LIBERTY denials must include:
    - New clinical information or information that was not already provided with the initial submission, is required.
    - Provider's name and license number or tax ID.
    - Provider's contact information, i.e. telephone number, address, email.
    - A clear identification of the issue that is subject of the complaint or appeal, i.e. date of service, procedures, etc.
    - A clear explanation/summary of the provider's position on the claim dispute/appeal.
    - Copies of all documentation relative to the subject in support of the provider's position
- **When will I get a response from LIBERTY a clinical appeal?** LIBERTY will issue a written response to provider clinical appeals within forty-eight (48) hours for expedited requests and within ten (10) calendar days for standard requests.
- **What if the Provider does not agree with the outcome of the clinical appeal?** Provider who do not agree with LIBERTY's adverse medical necessity decision can request an External Medical Review.

EXTERNAL MEDICAL REVIEW (EMR) PROCESS

To qualify for an External Medical Review (EMR), providers must first participate in LIBERTY's internal clinical appeal processes, outlined above. Failure to participate and exhaust LIBERTY's internal clinical appeal processes will result in the provider's inability to request an EMR. Services denied for reason not associated with lack of medical necessity are not subject to EMR, i.e., denials for non-covered services, frequency denials, timely filing denials.

- **What is an EMR?** Providers who have exhausted LIBERTY's internal appeal processes and do not agree with the Plan's adverse medical necessity decision can request additional review by an external medical review entity, Permedion, at no cost.
- **How long does a provider have to file am EMR?** Providers have thirty (30) calendar days from the written notice of the clinical appeal determination stating that LIBERTY's internal appeals process has been exhausted.
- **What information is required to request an EMR?** Providers must complete the Ohio Medicaid MCE External Review Request Form that is available at http://www.hmspermedion.com, select Contract Information and OH Medicaid, and submit to Permedion with all the required supporting documentation, including:

- Copies of all adverse decision letters from LIBERTY (initial denial and appeal resolution).
- Medical records, statements or letters from treating health care providers, or other information not previously submitted to LIBERTY for review. LIBERTY and Anthem BCBS will provide Permedion the documentation, as submitted by the requesting, used to make our adverse medical necessity decision.
- Providers are required to upload only new clinical information to help with the EMR review decision. The new clinical documentation may result in a change in the initial adverse medical necessity decision and prevent the need for an EMR.
- Provider must upload the Ohio Medicaid MCE External Review Request Form and all supporting new clinical documentation to Permedion's provider portal at https://ecenter.hmsy.com/.
- Provides who are new to the Permedion's EMR process and provider portal must sent their documentation through secure email to IMR@gainwelltechnologies.com to obtain portal access. Permedion will provide a response within three (3) business days for expedited requests and within thirty (30) calendar days for standard requests.
- For more information on the EMR process, contact Permedion at 800-473-0802, option 2.

PROVIDER COMPLAINTS

The ODM maintains a Managed Care Organization (MCO) complaint form. It can be used by any provider who has first attempted to work with LIBERTY directly but feels that they have been unsuccessful in obtaining an appropriate response.

Before submitting a complaint about a claim, providers should utilize LIBERTY's internal processes for issues, questions, resolution dates, and claim reprocessing dates.

LIBERTY will receive these complaints directly, in real time, from ODM and we have fifteen (15) business days to response to the provider with a resolution. LIBERTY strongly encourages providers to utilize our internal claims dispute and clinical appeals process outlined about before submitting a complaint to the ODM.

The ODM Provider Complaint form is available online at
https://providercomplaints.ohiomh.com/ComplaintForm.aspx?forceredirect=true

PROVIDER-BASED MARKETING ACTIVITIES

PROVIDERS MAY:

- Announce a new affiliation with a dental plan and give their patients a list of plans with which they contract within thirty (30) days.
- Co-sponsor event, such as health fairs, and advertise with LIBERTY in indirect ways, such as television, radio, posters, fliers and print advertisements.
- Distribute information about non-specific healthcare services and the provisions of health, welfare, and social services by the State of Ohio or local communities.
- Display LIBERTY specific materials in their own offices, as long as the provider does so for all plans with which the provider participates.

PROVIDERS ARE PROHIBITED FROM:

- Verbally or in writing comparing benefits or provider networks among dental plans, other than to confirm whether they participate in a dental network.
- Furnishing lists of their Medicaid patients to a dental plan with which they contract, or any other entity, nor can providers furnish their LIBERTY Member lists to another dental plan or assist with Medicaid enrollment.
- Offer marketing/appointment forms.
- Make phone calls or direct, urge or attempt to persuade potential Members to enroll in a plan based on financial or any other interests of the provider.
- Offer anything of value to persuade potential Members to select them as their provider.
- Accept compensation directly or indirectly from the Dental Plan for marketing activities.

SECTION 10. FRAUD, WASTE AND ABUSE

LIBERTY'S Special Investigative Unit's (SIU) primary responsibilities includes the detection, prevention, investigation, and reporting of fraud, waste, and abuse.

REPORTING FRAUD, WASTE AND ABUSE

Providers must report all instances of suspected fraud, waste, and abuse. Both fraud and abuse can expose providers to criminal and civil liability.

LIBERTY has established several options which allow for confidential reporting of violations to LIBERTY, Medicaid Program Integrity "MPI", and HHS-OIG. These options include the following internal mechanisms:

- LIBERTY'S Corporate Compliance Hotline: (888) 704-9833
- LIBERTY'S Compliance Unit email: compliancehotline@libertydentalplan.com
- LIBERTY'S Special Investigations Unit Hotline: (888) 704-9833
- LIBERTY'S Special Investigations Unit email: SIU@libertydentalplan.com

In support of the federal Whistleblower Protection Act, LIBERTY has included the Ohio Medicaid Fraud Control Unit:

- Ohio Attorney General's Office : 1-800-282-0515
- The Ohio Auditor of State (AOS) : 1-866-FRAUD or fraudohio@ohioauditor.gov
- FWA may be confidentially reported to the U.S. Department of Health & Human Services, Office of Inspector General (HHS-OIG) Whistle Phone number at 1-800-HHS-TIPS 1-800-377-4950 or TTY 1-800-377-4950.

Fraud is knowingly and willfully executing, or attempting to execute, a scheme or artifice to defraud any health care benefit program or to obtain, by means of false or fraudulent pretenses, representations, or promises, any of the money or property owned by, or under the custody or control of, any health care benefit program.

Examples of fraud may include:

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

Waste includes practices that, directly or indirectly, result in unnecessary costs to the Medicare Program, such as overusing services. Waste is generally not considered to be caused by criminally negligent actions but rather by the misuse of resources.

Examples of waste may include:

- Over-utilization of services
- Misuse of resources

Abuse includes actions that may, directly or indirectly, result in unnecessary costs to the Medicare Program. Abuse involves paying for items or services when there is no legal entitlement to that payment, and the provider has not knowingly or intentionally misrepresented facts to obtain payment.

Examples of abuse may include:

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

LIBERTY expects all providers and subcontractors to comply with applicable laws and regulations, including but not limited to the following:

- Federal and State False Claims Act
- Qui Tam Provision (Whistleblower)
- Anti-Kickback Statue
- Physician Self-Referral Law (Stark Law)
- HIPAA
- Social Security Act
- US Criminal Codes

State & Federal False Claims Laws:

- Federal False Claims Act (31 U.S.C. §§ 3729 - 3733) & Ohio False claims Act 42 CFR 438.608(a)(6)

The Federal False Claims Act is a law that prohibits a person or entity, from "knowingly" presenting or causing to be presented a false or fraudulent claim for payment or approval to the Federal government, and from "knowingly" making, using or causing to be made a false record or statement to get a false or fraudulent claim paid or approved by the Federal government.

The Act also prohibits a person or entity from conspiring to defraud the government by getting a false or fraudulent claim allowed or paid. These prohibitions extend to claims submitted to Federal health care programs, such as Medicare or Medicaid.

The Federal False Claims Act broadly defines the terms "knowing" and "knowingly." Specifically, knowledge will have been proven for purposes of the Federal False Claims Act if the person or entity:

1. Has actual knowledge of the information
2. Acts in deliberate ignorance of the truth or falsity of the information
3. Acts in reckless disregard of the truth or falsity of the information. The law specifically provides that a specific intent to defraud is not required to prove that the law has been violated.

Whistle Blower Protection Act: Private persons are permitted to bring civil actions for violations of the Federal False Claims Act on behalf of the United States (also known as "qui tam" actions) and are entitled to receive percentages of monies obtained through settlements, penalties and/or fines collected. Persons bringing these claims, also known as relators or whistleblowers, are granted protection under the law.

Specifically, any whistleblower who is discharged, demoted, suspended, threatened, harassed, or in any other manner discriminated against by his or her employer because of reporting violations of the Federal False Claims Act will be entitled to reinstatement with seniority, double back pay, interest, special damages sustained because of discriminatory treatment, and attorneys' fees and costs.

Anti-Kickback Statute: The Anti-Kickback Statute (AKS) is the popular name for The Medicare and **Medicaid** Fraud and Abuse Statute, 42 U.S.C. § 1320a-7b (b). The AKS is a federal criminal law. It prohibits offering or accepting kickbacks to generate health care business. The AKS is a healthcare law that prohibits individuals and entities from a willful and payment of "remuneration" or rewarding anything of value – such as position, property, or privileges – in exchange for patient referrals that involve payables by the Federal healthcare programs. These payables include, but are not limited to, drugs, medical supplies, and healthcare services availed by Medicare or **Medicaid** beneficiaries.

Under the provisions of the AKS, the law prohibits the soliciting, receiving, offering, or paying any remuneration (including any kickback, bribe, or rebate) directly or indirectly, overtly or covertly, in cash or kind.

Stark Law Physician Self-Referral Law: The Physician Self-Referral Law- the Stark Law refers to Section 1877 of the Social Security Act (the Act) 42 U.S.C. 1395nn. The Physician Self-Referral Law, commonly referred to as the Stark law, prohibits physicians (including dentists) from referring patients to receive "designated health/dental services" payable by Medicare or **Medicaid** from entities with which the physician (including dentist) or immediate family member has a financial relationship.

Law now insists that any medical professional who provides such a referral to a Medicare or **Medicaid** patient must concurrently provide written notice of that patient's right to go elsewhere along with a list of nearby alternatives.

Finalizing new, permanent exceptions for value-based arrangements to that will permit physicians and other health care providers to design and enter into value-based arrangements without fear that legitimate activities to coordinate and improve the quality of care for patients and lower costs would violate the physician self-referral law. This supports CMS' broader push to advance coordinated care and innovative payment models across Medicare, **Medicaid,** and private plans.

LIBERTY requires all its providers and subcontractors to report violations and suspected violations on the part of its employees, associates, persons, or entities providing care or services to all **Medicaid** Members. Examples of such violations include bribery, false claims, conspiracy to commit fraud, theft or embezzlement, false statements, mail fraud, health care fraud, obstruction of a state and/or federal health care fraud investigation, money laundering, failure to provider medically necessary services, marketing schemes, illegal remuneration schemes, identity theft, or Members' medication fraud.

FWA Training is available via our company website – we have a training program provider can download in PDF format. We also include training for Fraud, Waste, and Abuse in our Provider Orientation packets.

LIBERTY has posted LIBERTY's SIU Policy "Reporting Fraud, Waste, Abuse & Physical Abuse, Neglect, Exploitation, Unlicensed Activity" under provider compliance training resources:
https://www.libertydentalplan.com/About-LIBERTY/Compliance/Fraud-Waste-Abuse.aspx
This policy contains phone numbers for reporting fraud, waste, and abuse.

State and federal regulations require mandatory Compliance and FWA Training to be completed by providers and subcontractors, as well as their employees, within thirty (30) days of hire/contracting and annually thereafter. Records of the training must be maintained and readily available at the request of LIBERTY's Compliance Officer, CMS, or agents of both agencies. **Note:** An attestation for the completion of the FWA Training must be submitted as part of the credentialing process.

If you or your employees have not taken the Compliance and/or FWA Training, please log onto LIBERTY website: https://www.libertydentalplan.com/Providers/Provider-Training-1.aspx to complete the training. Please contact Provider Relations for additional instructions as needed. It is your responsibility and part of your contractual obligation to comply with all state and federal program requirements for your continued participation with LIBERTY dental plans.

SECTION 11. FORMS AND GUIDES

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

- Selection "Ohio" from the drop-down menu
- Click "Continue" and then click on the document
- Select and download the "Ohio Medicaid Provider Reference Guide"

Accessible resources include, but are not limited to the following:

- **Provider Portal (i-transact) registration**
- **Secure email portal access**
- **Annual Provider Compliance Training (mandatory)**
- **LIBERTY's Clinical Criteria and Guidelines**
- **Tele-Dentistry Resources**
- **Value-based Program information**
- **Directory Information Validation**
- **Americans with Disabilities Act (ADA) Survey**
- **Adult Care and Kid Care – Oral Health & Wellness Tips**
- **Clinical Guidelines for Prescribing Fluoride Supplements for Caries Prevention**
- **Opioid Risk Tool**
- **Ohio SMMC Regional State Map**

Accessible forms include, but are not limited to the following:

- **ADA Dental Claim Form**
- **Medicaid Behavior Management Report**
- **CMS Appointment of Representative Form**
- **Electronic Fund Transfer Form**
- **Consent for Non-Covered Treatment Form**
- **Provider Complaint Form**
- **Provider Dispute/Appeal Request Form**

Recommended Dental Periodicity Schedule for Pediatric Oral Health Assessment, Preventive Services, and Anticipatory Guidance/Counseling

Since each child is unique, these recommendations are designed for the care of children who have no contributing medical conditions and are developing normally. These recommendations will need to be modified for children with special health care needs or if disease or trauma manifests variations from normal. The American Academy of Pediatric Dentistry emphasizes the importance of very early professional intervention and the continuity of care based on the individualized needs of the child. Refer to the text of this best practice for supporting information and references.

AMERICA'S PEDIATRIC DENTISTS THE BIG AUTHORITY on little teeth®	AGE				
	6 TO 12 MONTHS	12 TO 24 MONTHS	2 TO 6 YEARS	6 TO 12 YEARS	12 YEARS AND OLDER
Clinical oral examination [1]	•	•	•	•	•
Assess oral growth and development [2]	•	•	•	•	•
Caries-risk assessment [3]	•	•	•	•	•
Radiographic assessment [4]	•	•	•	•	•
Prophylaxis and topical fluoride [3,4]	•	•	•	•	•
Fluoride supplementation [5]	•	•	•	•	•
Anticipatory guidance/counseling [6]	•	•	•	•	•
Oral hygiene counseling [3,7]	Parent	Parent	Patient/parent	Patient/parent	Patient
Dietary counseling [3,8]	•	•	•	•	•
Counseling for nonnutritive habits [9]	•	•	•	•	•
Injury prevention and safety counseling [10]	•	•	•	•	•
Assess speech/language development [11]	•	•	•		
Assessment developing occlusion [12]			•	•	•
Assessment for pit and fissure sealants [13]			•	•	•
Periodontal-risk assessment [3,14]			•	•	•
Counseling for tobacco, vaping, and substance misuse				•	•
Counseling for human papilloma virus/ vaccine				•	•
Counseling for intraoral/perioral piercing				•	•
Assess third molars					•
Transition to adult dental care					•

1 First examination at the eruption of the first tooth and no later than 12 months. Repeat every six months or as indicated by child's risk status/susceptibility todisease. Includes assessment of pathology and injuries.

2 By clinical examination.

3 Must be repeated regularly and frequently to maximize effectiveness.

4 Timing, types, and frequency determined by child's history, clinical findings, and susceptibility to oral disease.

5 Consider when systemic fluoride exposure is suboptimal. Up to at least 15 years.

6 Appropriate discussion and counseling should be an integral part of each visit for care.

7 Initially, responsibility of parent; as child matures, jointly with parent; then, when indicated, only child.

8 At every appointment; initially discuss appropriate feeding practices, then the role of refined carbohydrates and frequency of snacking in caries development and childhood obesity. Monitor body mass index beginning at age two.

9 At first, discuss the need for nonnutritive sucking: digits vs. pacifiers; then the need to wean from the habit before mal-occlusion or deleterious effect on the dentofacial complex occurs. For school-aged children and adolescent patients, counsel regarding any existing habits such as fingernail biting, clenching, or bruxism.

10 Initially pacifiers, car seats, play objects, electric cords; secondhand smoke; when learning to walk; with sports and routine playing, including the importance of mouthguards; then motor vehicles and high-speed activities.

11 Observation for age-appropriate speech articulation and fluency as well as achieving receptive and expressive language milestones.

12 Identify: transverse, vertical, and sagittal growth patterns; asymmetry; occlusal disharmonies; functional status including temporomandibular joint dysfunction; esthetic influences on self-image and emotional development.

13 For caries-susceptible primary molars, permanent molars, premolars, and anterior teeth with deep pits and fissures; placed as soon as possible after eruption.

14 Periodontal probing should be added to the risk-assessment process after the eruption of the first permanent molars.

SECTION 13. OHIO MEDICAID PLAN BENEFITS

Pending Medicaid Program Plan Benefits