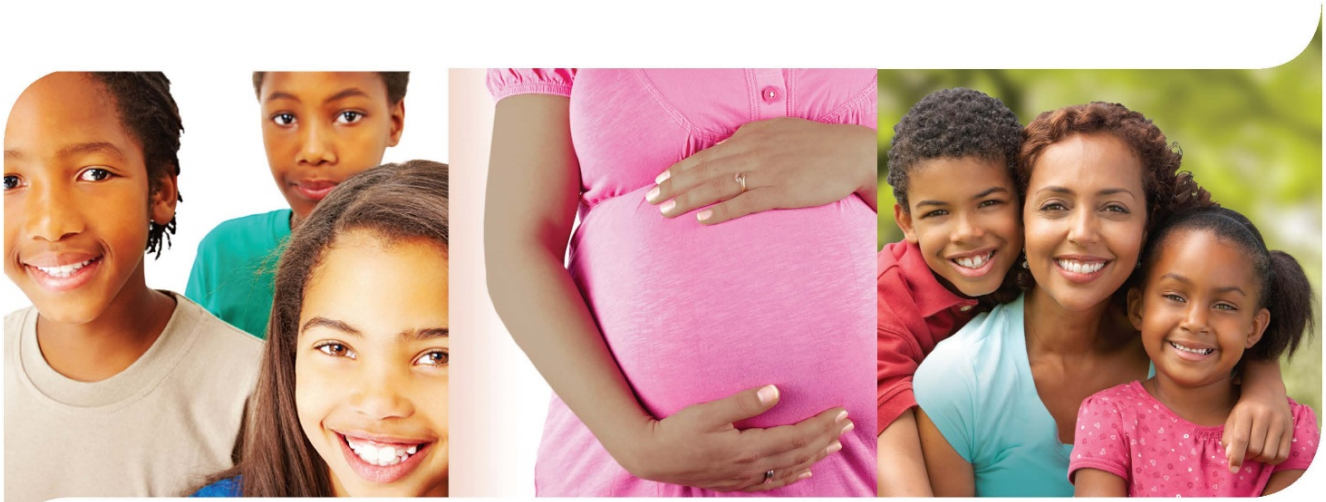

MissouriCare Health Plan (Medicaid)

Provider Reference Guide

LIBERTY DENTAL PLAN®

Making members shine, one smile at a time™

www.libertydentalplan.com

TABLE OF CONTENTS

SECTION 1. LIBERTY DENTAL PLAN INFORMATION

INTRODUCTION

Welcome to LIBERTY Dental Plan's (LIBERTY's) Missouri Provider Reference Guide. We are proud to maintain a broad network of qualified dental providers who offer both general and specialized treatment, guaranteeing widespread access to our participants.

This Provider Reference Guide serves only as a summary of certain terms of the Provider Agreement between you (or the contracting dental office/facility) and LIBERTY, and additional terms and conditions of the Provider Agreement may apply. In the event of a conflict between a term of this Provider Reference Guide and a term of the Provider Agreement, the term of the Provider Agreement shall control. You received a copy of the fully executed Provider Agreement when you joined LIBERTY's network or during orientation; however, you may also obtain a copy of the Provider Agreement at any time by submitting a request to PRInquiries@libertydentalplan.com or by contacting Professional Relations at (866) 609-0420.

OUR MISSION FOR THE MEDICAID PROGRAM AND MEDICAID PARTICIPANTS

LIBERTY's mission is to be the industry leader in improving access to quality oral health care services for the Missouri Medicaid participants. LIBERTY seeks to increase annual patient visits and improve the overall health of the Medicaid population through participant 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 participants, and LIBERTY staff members.

MISSOURI CARE MEDICAID PROVIDER CONTACT & INFORMATION GUIDE

IMPORTANT PHONE NUMBERS AND GENERAL INFORMATION

LIBERTY PROVIDER SERVICE LINE
Toll Free
(866) 609-0420

Eligibility & Benefits: Option 1
Claims: Option 2
Pre-Estimates: Option 3

Referrals & Specialty Pre-Authorizations: Option 4

Request Materials: Option 5

HOURS

Live representatives are available Monday – Friday, 8 a.m. – 6 p.m. CST

PROFESSIONAL RELATIONS DEPARTMENT

(866) 609-0420

Fax: (949) 313-0766

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

PRinquiries@libertydentalplan.com

PARTICIPANT GRIEVANCE AND APPEALS

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

Toll Free Number
(866) 609-0420

Fax: (833) 250-1814

Email:
GandA@libertydentalplan.com

Hours
Monday- Friday
8 a.m. CST– 6 p.m. CST

ELIGIBILITY & BENEFITS VERIFICATION

PROVIDER PORTAL
(i-Transact)
https://www.libertydentalplan.com/Providers/Provider-Self-Service-Tools/ITransact.aspx

or

TELEPHONE
(866) 609-0420
Option 1

PRE-APPROVAL, SUBMISSION & INQUIRIES

PROVIDER PORTAL
(i-Transact)
https://www.libertydentalplan.com/Providers/Provider-Self-Service-Tools/ITransact.aspx

TELEPHONE
(866) 609-0420
Option 4

EMAIL
referrals@libertydentalplan.com

Regular Referrals by Mail

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

Urgent Referrals and Hotline
(866) 609-0420
Option 4

Fax: (888) 334-6033

Hours
Monday- Friday
8 a.m. CST – 6 p.m. CST

CLAIMS INQUIRIES

PROVIDER PORTAL
(i-Transact)
https://www.libertydentalplan.com/Providers/Provider-Self-Service-Tools/ITransact.aspx

or

TELEPHONE
(866) 609-0420
Option 2

FAX
(888) 700-1727

CLAIMS SUBMISSIONS

PROVIDER PORTAL
(i-Transact)
https://www.libertydentalplan.com/Providers/Provider-Self-Service-Tools/ITransact.aspx

EDI
Payor ID #: CX083

EMAIL
claims@libertydentalplan.com

TELEPHONE
(866) 609-0420

General Information
Option 2

Fax: (888) 401-1129

Paper Claims by Mail
or
Corrected Claims by Mail

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

Corrected Claims by Fax
(888) 401-1129

PROVIDER WEB PORTAL (i-TRANSACT)

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

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

Please visit:
https://www.libertydentalplan.com/Providers/Provider-Self-Service-Tools/ITransact.aspx
to register as a new user and/or login.
Your "Access Code" can be found on your LIBERTY Welcome Letter. If you cannot locate your access code, or need help with the login process, please call (866) 609-0420 for assistance or email support@libertydentalplan.com

PROVIDER COMPLAINTS AND APPEALS

Providers have the right to file a non-claim related complaint or an appeal regarding provider payment or contractual issues.

Complaints and Appeals must be in writing and mailed to:

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

Toll Free Number
(866) 609-0420

Fax: (833) 250-1814

Email:
GandA@libertydentalplan.com

Hours
Monday- Friday
8 a.m. CST – 6 p.m. CST

SECTION 2. PROFESSIONAL RELATIONS AND PROVIDER TRAINING

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

- Plan contracting
- Escalated claim payment issues
- New and existing provider training and orientation
- Opening, changing, or closing a location
- Adding or terminating associates
- Credentialing and recredentialing of owner and associate dentist inquiries
- Change in name or ownership
- Taxpayer Identification Number (TIN) change
- Changes in office hours

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

	**LIBERTY Dental Plan** **ATTN: Professional Relations** P.O. Box 26110 Santa Ana, CA 92799-6110		**Professional Relations Team** M-F from 8am – 6pm **(Central)** (866) 609-0420
	Email at PRinquiries@libertydentalplan.com		

PROVIDER TRAINING

LIBERTY provides initial orientation and training to all new offices within 30 days of activation. 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.

Training modules are also available online through our Provider Portal at:
https://www.libertydentalplan.com/Providers/Provider-Self-Service-Tools/ITransact.aspx

Training programs include: Fraud, Waste and Abuse, Critical Incident Training, Code of Business Ethics and Conduct Training, Cultural Competency Training, and General Compliance Training.

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 24/7 to important information and tools through our secure online Provider Portal. Registered users will be able to:

- Submit electronic claims
- Verify participant eligibility and benefits
- View office and contract information
- Submit referrals and check status
- Access benefit plans and fee schedules
- Print monthly eligibility rosters
- Perform a provider search

ON-LINE ACCOUNT ACCESS

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

All contracted network dental offices are issued a unique Office Number and Access Code. These numbers can be found on your LIBERTY Welcome Letter. 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.

Detailed instructions on how to utilize our online services can be found in the Online Provider Portal User Guide by visiting https://www.libertydentalplan.com/Providers/Provider-Self-Service-Tools/ITransact.aspx

If you are unable to locate your Office Number and/or Access Code, please contact our Professional Relations Department at (866) 609-0420 or email at support@libertydentalplan.com.

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

SECTION 4. ELIGIBILITY

Anti-Discrimination Notice: LIBERTY complies with Federal civil rights laws, which prohibits discrimination based on race, religion, color, national origin, sex, disability, political affiliation, or beliefs.

Providers are responsible for verifying participant eligibility prior to providing dental services. The participant's Medical ID card does not guarantee eligibility. Checking eligibility will allow providers to complete medically necessary procedures and reduce the risk of denied claims.

There are several options to verify eligibility via our **Provider Portal** located at:
https://www.libertydentalplan.com/Providers/Provider-Self-Service-Tools/ITransact.aspx

The participant's last name, first name, and any combination of participant number, policy number, or date of birth is required (date of birth is recommended for best results). Reference our Provider Portal User Guide for more information on how to access our Provider Portal. In the event a participant does not appear on the monthly roster, please contact LIBERTY Dental Plan's Member Services Department at (866) 609-0420 and select Option 1.

Participant Identification Cards: Providers are to request a copy of the Participant's Medical ID card along with another proof of photo identification. Both the Medial ID and other proof of identification must be filed in the participants medical record. Presentation of an ID card does not guarantee eligibility and/or payment of benefits. Participants ID Card will be their Medical ID. Participants will not receive a separate ID card from LIBERTY Dental Plan.

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

SECTION 5. CLAIMS AND BILLING

At LIBERTY, we are committed to accurate and efficient claims processing. It is imperative that all information be accurate and submitted in the correct format. Network dentists are encouraged to submit clean claims within 45 days of completion of treatment. Payment will be denied for claims submitted more than 180 days from the date of service. LIBERTY receives dental claims in four possible formats. These formats include the following:

- HIPAA Compliant "837D" file
- Electronic submissions via clearinghouse
- Electronic submissions via LIBERTY's Provider Portal
- Paper claims

Required Timeframes for Timely Claims Submission:

TYPE OF PROVIDER OR SERVICE	TIMEFRAME FOR CLAIMS SUBMISSION
Medicaid Claims	180 from date of service
All Other Claims	180 days from date of service (recommended within 45 days)

HIPAA COMPLIANT 837D FILE

LIBERTY currently accepts HIPAA Compliant 837D files. If you would like to set up or inquire about this option, please contact our IT Department at (866) 609-0420.

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:

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

LIBERTY currently accepts electronic claims/encounters from providers through the clearinghouses listed below. If you do not have an existing relationship with a clearinghouse, please contact 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) 576-6412	www.dentalxchange.com	CX083
Emdeon (Change Healthcare)	(877) 469-3263	www.emdeon.com	CX083
Tesia	(800) 724-7240 ext. 6	www.tesia.com	CX083

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

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

PAPER CLAIMS

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

ATTN: CLAIMS DEPARTMENT

LIBERTY Dental Plan
PO Box 401086
Las Vegas, NV 89140

CLAIMS SUBMISSION PROTOCOLS AND STANDARDS

LIBERTY requires the following claims documentation:

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

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

CLAIMS STATUS INQUIRY

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

	(866) 609-0420, select Option 2		**Provider Portal:** https://www.libertydentalplan.com/Providers/Provider-Self-Service-Tools/ITransact.aspx

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 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 60 business 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 in accordance with LIBERTY's Provider Complaint Resolution Process described elsewhere in this guide.

No Contest

If the provider does not contest LIBERTY's notice of overpayment of a claim, the provider must reimburse LIBERTY within 60 working days of the provider's receipt of the notice of overpayment. If the provider fails to reimburse LIBERTY within 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 contract, 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.

In situations when the inappropriate payment caused an overpayment, LIBERTY will adhere to Missouri Statute 376.384.1(3) which states, "All health carriers shall not request a refund or offset against a claim more than twelve months after a health carrier has paid a claim except in cases of fraud or misrepresentation by the health care provider."

PROMPT PAYMENT OF CLAIMS

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

ELECTRONIC FUNDS TRANSFER (EFT)

LIBERTY's Electronic Funds Transfer Form can be located on our **Provider Portal** at:
https://www.libertydentalplan.com/Providers/Provider-Self-Service-Tools/ITransact.aspx

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, on a regular basis. The information should be submitted on a current standard ADA Dental Claims Form for all services provided to the participant. State law requires that aggregated encounter/claims data is submitted to the state on a regular basis for utilization review and analysis by Missouri Medicaid Management Information System (MMIS) to ensure that the Medicaid program is properly providing care to its participants. **LIBERTY strongly recommends that you provide claims following each visit.**

PEER-TO-PEER COMMUNICATION

If you have questions or concerns about a referral, pre-authorization and/or claim determination and would like to speak with a LIBERTY Dental Director, or the Staff Dentist responsible for the determination, you may contact:

	LIBERTY Dental Plan **ATTN: Professional Relations** PO Box 26110 Santa Ana, CA 92799-6110		**Quality Management Team** M-F from 8am – 6pm **(Central)** (888) 442-3514

Please note that when calling the phone number listed above, your call will be transferred to the Dental Director or designated Staff Dentist responsible for the determination. If the Dental Director or Staff Dentist is/are unavailable, please leave a detailed message including the Participant ID and claim number and your call will be returned.

SECTION 6. COORDINATION OF BENEFITS

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

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 Participant	Primary
Participant has a government-funded plan and individual or supplemental coverage through another carrier	Individual/Supplemental coverage is primary
Participant has two government-funded plans: Federal (Medicare) and State (Medicaid, or Medicare Advantage Value Add)	Federal coverage is primary
Participant has dental coverage through a group plan and a government-funded plan	Group plan is primary
Participant has dental coverage through a retiree plan and a government-funded plan	Government-funded plan is primary
Participant has two Medicare plans	The Plan with the earliest effective date is considered primary

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

Scenarios of COBs:

1. When LIBERTY is Primary Carrier

LIBERTY will only be considered the primary carrier for Medicaid when the participant has no other dental coverage. Medicaid is always considered the payor of last resort.

2. 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.

SECTION 7. PROFESSIONAL GUIDELINES AND STANDARDS OF CARE

PRIMARY DENTAL PROVIDER RESPONSIBILITIES AND RIGHTS

- Provide and/or coordinate all dental care for participant;
- Perform covered services that are considered within the scope of your licensure and refer to a specialty only those procedures that are deemed beyond the scope of a primary care provider
- Perform an initial dental assessment including a risk assessment;
- Provide a written treatment plan to participants upon request 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.
- Treatment plans and informed consent documents must be signed by the participant or responsible party showing understanding of the treatment plan;
- Work closely with specialty care providers to promote continuity of care;
- Cooperate with, and adhere to the LIBERTY Quality Management and Improvement Program;
- Notify LIBERTY of a participant death;
- 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 24 hours a day, 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 five years;
- Provide updated credentialing information when requested, upon renewal dates;
- Provide requested information upon receipt of patient grievance/complaint within 3 days of receiving a notice letter;
- 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.; and,
- If a participant chooses to transfer to another participating dental office; there will be no charge to the participant for copies of records maintained in chart. All copies of records must be provided to participant within 15 days of request.

SPECIALTY CARE PROVIDER RESPONSIBILITIES & RIGHTS

- Provide necessary and appropriate specialty consultation and care to participants;
- Work closely with primary dental providers to ensure continuity of care;
- Inform primary care provider when treatment is complete;
- Bill LIBERTY timely for all dental services that are authorized;
- Pre-authorize any necessary treatment, not previously approved;
- Cooperate with, and adhere to the LIBERTY Quality Management and Improvement Program;
- Notify LIBERTY of a participant death;
- 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 24 hours a day, 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 five years;
- Provide updated credentialing information when requested, upon renewal dates;
- Provide requested information upon receipt of patient grievance/complaint within 3 days of receiving a notice letter;
- Submit encounter data on EDI or standard ADA claims; and,
- 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.

ANTI-DISCRIMINATION

Discrimination is against the law. LIBERTY Dental Plan ("LIBERTY") complies with all applicable Federal civil rights laws and does not discriminate, exclude people or treat them differently based on race, color, religion, national origin, age, disability, or sex. 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 Member Services at (866) 609-0420.

LIBERTY is prohibited from discriminating or taking punitive action against any provider for making a complaint to MO HealthNet 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: compliance@libertydentalplan.com
- Online: https://www.libertydentalplan.com/About-LIBERTY-Dental/Compliance/Contact-Compliance.aspx

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

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

NATIONAL PROVIDER IDENTIFIER (NPI)

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

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

APPOINTMENT AVAILABILITY AND ACCESSIBILITY STANDARD

Providers are required to schedule appointments for eligible participants in accordance with the Medicaid Access standards listed below. LIBERTY monitors compliance and may seek corrective action for providers that are not meeting accessibility standards.

Type of Appointment	Access to Care Standards
Emergency Care	Patient must have access to emergency care 24 hours day, 7 days a week to relieve pain or prevent worsening of a condition. The dentist must be available to the participant or arrange for another participating dentist to provide services.
Urgent Care Services	Patient must be seen immediately or within 24 hours (swelling, bleeding, fever, infection)
Routine Care with symptoms	Patient must be seen within one (1) week/five (5) business days
Routine Care without symptoms	Patient must be seen within thirty (30) days
Waiting Times (defined as time spent both in the lobby and in the examination room prior to being seen by a provider)	Patient must be seen within one (1) hour from schedule appointment time

EMERGENCY SERVICES AND AFTER-HOURS EMERGENCIES

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 close your office to new enrollment, or take other action deemed necessary by LIBERTY to ensure timely access to all participants.

TREATMENT PLAN GUIDELINES

All participants 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. Non-covered services may be offered and presented to Medicaid participants. Treatment plans and informed consents must be signed showing patient acceptance of the treatment, and for any costs for non-covered treatment. LIBERTY Dental participants cannot be denied their plan benefits. All accepted or declined treatment plans must be signed and dated by the patient or his/her guardian and the treating dentist. For participants electing non-covered services please use the non-covered services document in the Provider Portal at https://www.libertydentalplan.com/Providers/Provider-Self-Service-Tools/ITransact.aspx

NON-COVERED SERVICES; IMPORTANT NOTE:

Providers who perform non-covered services must obtain financial and treatment consents signed by the participant/patient that are clear and concise and understandable by a prudent layperson. Medicaid participants are protected from financial responsibility for charges that were not clearly presented prior to treatment. In such cases, Medicaid participants who file a grievance and can prove they did not approve such services, may not be subject to collection activity. Thus, providers will not be able to bill participants or collect payments for non-covered services that were not properly approved by the participant/patient. Please consult the plan schedule of benefits to determine covered and non-covered services. You may also send in proposed treatment for pre-approval 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. A valid denial for not meeting Medical necessity from LIBERTY Dental Plan must be obtained prior to charging a participant for any procedure listed as a plan benefit under the Medicaid Program

SECOND OPINIONS

Participants and/or providers may request a consultation with another network dentist for a second opinion to confirm the diagnosis and/or treatment plan. The dentist should refer these participants to the Member Services Department, Monday through Friday, 8 a.m. to 6 p.m. (Central) to make the request.

RECALL, FAILED OR CANCELLED 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. **Medicaid Rule**: Medicaid does not allow for a failed appointment charge.

CONTINUITY AND COORDINATION OF CARE

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

- All care rendered to LIBERTY participants must be properly documented in the patient's dental charts according to established documentation standards;
- Communication between the Primary Dental Provider (Provider) and dental specialist shall occur when participants are referred for specialty dental care;
- Dental chart documentation standards are included in this Provider Reference Guide;
- Dental chart audits will verify compliance to documentation standards;
- Guidelines for adequate communications between the referring and receiving providers when participants are referred for specialty dental care are included in this provider guide;
- During facility on-site audits, LIBERTY monitors compliance with continuity and coordination of care standards; and,
- When a referral to a specialist is authorized, the Provider is responsible for evaluating the need for follow-up care after specialty care services have been rendered and scheduling the participant for any appropriate follow-up care.

PARTICIPANTS BILL OF RIGHTS AND RESPONSIBILITIES

- A participant has the right to be treated with courtesy and respect, with appreciation of his or her individual dignity, and with protection of his or her need for privacy.
- A participant has the right to a prompt and reasonable response to questions and requests.
- A participant has the right to know who is providing medical services and who is responsible for his or her care.
- A participant has the right to know what patient support services are available, including whether an interpreter is available if he or she does not speak English.
- A participant has the right to know what rules and regulations apply to his or her conduct.
- A participant has the right to be given by the health care provider information concerning diagnosis, planned course of treatment, alternatives, risks, and prognosis.
- A participant has the right to refuse any treatment, except as otherwise provided by law.
- A participant has the right to be given, upon request, full information and necessary counseling on the availability of known financial resources for his or her care.
- A participant has the right to receive, upon request, prior to treatment, a reasonable estimate of charges for proposed dental services.
- A participant has the right to receive a copy of a reasonably clear and understandable, itemized bill and, upon request, to have the charges explained.
- A participant has the right to impartial access to medical treatment or accommodations, regardless of race, national origin, religion, handicap, or source of payment.
- A participant has the right to treatment for any emergency medical condition that will deteriorate from failure to provide treatment.
- A participant has the right to know if medical treatment is for purposes of experimental research and to give his or her consent or refusal to participate in such experimental research.
- A participant has the right to express grievances regarding any violation of his or her rights, as stated in Missouri law, through the grievance procedure of the health care provider or health care facility which served him or her and to the appropriate state licensing agency.

As a participant of LIBERTY, each participant has the responsibility to behave according to the following standards:

- A participant is responsible for providing to the health care provider, to the best of his or her knowledge, accurate and complete information about present complaints, past illnesses, hospitalizations, medications, and other matters relating to his or her health.
- A participant is responsible for reporting unexpected changes in his or her condition to the health care provider.
- A participant is responsible for reporting to the health care provider whether he or she comprehends a contemplated course of action and what is expected of him or her.
- A participant is responsible for following the treatment plan recommended by the health care provider.
- A participant is responsible for keeping appointments and, when he or she is unable to do so for any reason, for notifying the health care provider or health care facility.
- A participant is responsible for his or her actions if he or she refuses treatment or does not follow the health care provider's instructions.
- A participant is responsible for assuring that the financial obligations of his or her health care are fulfilled as promptly as possible.
- A participant is responsible for following health care facility rules and regulations affecting patient care and conduct.

SECTION 8. CLINICAL DENTISTRY GUIDELINES AND PRACTICE PARAMETERS

NEW PATIENT INFORMATION

A. Registration information should minimally include:

1. Name, sex, birth date, address and telephone number, cell phone number, e-mail address, name of employer, work address and telephone number
2. Name and telephone number of person(s) to contact in an emergency
3. For minors, name of parent(s) or guardian(s) and telephone numbers, if different from above.

B. Pertinent information relative to the patient's chief complaint and dental history, including any problems or complications with previous dental treatment should always be documented.

C. Medical History - There should be a detailed medical history form comprised of questions which require a "yes" or "no" responses, minimally including:

1. Patient's current health status
2. Name and telephone number of physician and date of last visit
3. History of hospitalizations and/or surgeries
4. History of abnormal (high or low) blood pressure
5. Current medications, including dosages and indications
6. History of drug and medication use (including bisphosphonates)
7. Allergies and sensitivity to medications or materials (including latex)
8. Adverse reaction to local anesthetics
9. History of diseases:

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

- Any other disease or condition that could affect the provider's determination of necessary, appropriate and adequate dental care.

10. Pregnancy
    - Document the name of the patient's obstetrician and estimated due date.
    - Follow guidelines in the *ADA* publication, *Women's Oral Health Issues*, November 2006.
11. History of cancer, including radiation or chemotherapy
12. The medical history form must be signed and dated by the patient or patient's parent or guardian.
13. Dentist's notes following up on patient comments, significant medical issues and/or the need for a consultation with a physician should be documented on the medical history form or in the patient's progress notes.
14. Medical alerts reflecting current significant medical conditions must be uniform and conspicuously visible on a portion of the chart used during treatment.
15. The dentist must sign and date all baseline medical histories after review with the patient.
16. The medical history should be updated and signed by the patient and the dentist at least annually or as dictated by the patient's history and risk factors.

CONTINUITY OF CARE

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.

EARLY AND PERIODIC SCREENING, DIAGNOSTIC AND TREATMENT (EPSDT) BENEFIT

The EPSDT benefit provides comprehensive and preventive health care services for children under age 21 who are enrolled in Medicaid. EPSDT ensures that children and adolescents receive appropriate preventive and specialty dental services.

LIBERTY is responsible for ensuring that Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) screens are performed LIBERTY participants under the age of 21. Services must be sufficient in amount, duration, and scope to reasonably achieve their purpose and may only be limited by medical necessity.

This program is referred to nationally as the EPSDT Program. In Missouri, this program is referred to as the Healthy Children and Youth (HCY) Program. Missouri follows the American Academy of Pediatrics' (AAP), schedule for preventive pediatric health care as a minimum standard for frequency of providing full HCY screens.

The Omnibus Budget Reconciliation Act of 1989 (OBRA-89) mandated that LIBERTY provide medically necessary services to children from birth through age 20 years which are necessary to treat or ameliorate defects, physical or behavioral health or conditions identified by an EPSDT screen regardless of whether or not the services are covered under the Medicaid State Plan. Services must be sufficient in amount, duration, and scope to reasonably achieve their purpose and may only be limited by medical necessity. LIBERTY is responsible for providing all EPSDT/HCY services for their eligible members.

MISCELLANEOUS

Reference Section 9 of the Missouri MO HealthNet Provider Manual for Healthy Children and Youth Program; Healthy Children and Youth Screening Guides; and AAP periodicity schedule that are available online at the MO HealthNet Division website www.dss.mo.gov/mhd for additional information. Special bulletins may also be referred online for additional information.

PAYMENT FOR EPSDT SERVICES

Services for managed care members under the age of 21 which are recommended as the result of an EPSDT screening must be sufficient in amount, duration, and scope to reasonably achieve their purpose and may only be limited by medical necessity. When submitting an authorization for an EPSDT related service please check the EPSDT/Title XIX box in the upper left-hand corner of the current American Dental Association (ADA) Dental Claim Form.

Right of Participants to Obtain Medically Necessary Dental Services

LIBERTY provides coverage for dental services that are listed on the Missouri Medicaid benefit schedule for children under age 21, pregnant females and adults any other dental service that is deemed to be medically necessary. The frequency guidelines for treatment allowed by LIBERTY follow the MO Medicaid Periodicity Schedule (which mirrors the American Academy of Pediatrics periodicity schedule).

Prior Authorization/Pre-Authorization of Dental Services

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

Prior Authorization/Pre-Authorization Expectations

"Prior Authorization/Pre-Authorization" requires that the provider obtain written authorization to perform the procedure prior to performing the service. "Prior Authorization/Pre-Authorization" requires specific documentation to establish medical necessity or justification for the procedure.

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/Pre-Authorization" request prior to performing the procedure. If LIBERTY approves the "Prior Authorization/Pre-Authorization" there is no need to submit documentation with claim submission.

INFECTION CONTROL

All contracted dentists must comply with the Centers for Disease Control (CDC) guidelines as well as other related federal and state agencies for sterilization and infection control protocols in their offices, including adequate and confirmable monitoring of sterilization devices. Offices are not allowed to pass an infection control fee or any kind (including "sterile tray") onto LIBERTY Dental Plan participants.

DENTAL RECORDS/PARTICIPANT RECORDS

Participant dental records must be kept and maintained in compliance with applicable state and federal regulations. Complete dental records of active or inactive patients must be accessible for a minimum of five years, even if the facility is no longer under contract. The provider must have a confidentiality policy to ensure privacy and security provisions according to the Health Insurance Portability and Accountability Act (HIPAA).

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

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

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 participants' protected health information. We are committed to complying with the requirements and standards of the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Our commitment is demonstrated through our actions.

As a health care provider and covered entity, you and your staff are responsible for complying with all HIPAA privacy and security provisions. Participant information shall be treated as confidential and comply with all federal and state laws and regulations regarding the confidentiality of patient records.

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

For more information on HIPAA, please visit the HHS website at www.cms.hhs.gov/HIPAAgeninfo

BASELINE CLINICAL EVALUATION DOCUMENTATION

A. Observations of the initial evaluation are to be recorded in writing and charted graphically where appropriate, including missing or impacted teeth, existing restorations, prior endodontic treatment(s), fixed and removable appliances.

B. Assessment of TMJ status (necessary for adults) and/or classification of occlusion (necessary for minors) should be documented.

C. Periodontal screening and evaluation must be documented, including an evaluation of bone levels, gingival recession, inflammation, etiologic factors (e.g., plaque and calculus), mobility, and furcation involvements. Periodontal documentation may include a full mouth periodontal probing in cases where periodontal disease is identified.

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

E. Periodontal evaluations and oral cancer screenings should be updated at appropriate intervals, dictated by the patient's history and risk factors, and must be done at least annually.

TELEDENTISTRY (TELEMEDICINE)

A. **Standards of Care Requirements for use of Teledentistry**: Dentists using teledentistry will be held to the same standard of care as practitioners engaging in traditional in-person care delivery, including the requirements to meet all technical, clinical, confidentiality and ethical standards required by law.

RADIOGRAPHS

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

B. An adequate number of initial radiographs should be taken to make an appropriate diagnosis and treatment plan. Refer to the current, published ADA/FDA radiographic guidelines: *The Selection of Patients for Dental Radiographic Examinations.* The treating dentist should determine the radiographs necessary for each patient. Standing orders for radiographs are discouraged.

C. D0210 Intraoral – complete series (including bitewings)

A radiographic survey of the whole mouth, usually consisting of 14-22 periapical and posterior bitewing images intended to display the crowns and roots of all teeth, periapical areas and alveolar bone. Frequency limitations exist for complete series of radiographs.

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

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

D. Decisions about the types of recall films should also be made by the dentist and based on current *ADA/FDA* radiographic guidelines, including the complexity of previous and proposed care, caries, periodontal susceptibility, types of procedures and time since the patient's last radiographic examination.

E. A panoramic radiograph is a screening film and is not a substitute for periapical and/or bite wing radiographs when a dentist is performing a comprehensive evaluation.

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

G. Radiographs should exhibit good contrast.

H. Diagnostic digital radiographs should be printed on photographic quality paper and exhibit good clarity and brightness.

I. Recent radiographs must be mounted, labeled left/right and dated.

J. Any patient refusal of radiographs should be documented.

K. X-ray duplication fee

When a participant is transferred from one provider to another, diagnostic copies of all x-rays less than two years old should be duplicated for the second provider.

If the transfer is initiated by the provider or the participant, the participant may not be charged any X-ray duplication fees. Medicaid plans do not allow a charge for x-ray duplication.

PREVENTION

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

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

- participant education in oral hygiene and dietary instruction and tobacco cessation
- periodic evaluations and prophylaxis procedures
- topical or systemic fluoride treatment
- sealants
- Periodontal disease prevention may include a comprehensive program of plaque removal and control in addition to the following procedures:
- oral and systemic health information including tobacco cessation
- oral hygiene and dietary instructions
- prophylaxis procedures on a regular basis
- occlusal evaluation
- correction of malocclusion and malpositioned teeth
- restoration and/or replacement of broken down, missing or deformed teeth

B. D1110 and D1120 – prophylaxis procedures

- Procedure D1110 applies to patients who are 13 years old and older.
- Procedure D1120 applies

C. D1208 – topical application of fluoride procedures and D1206 – fluoride varnish

D. Other areas of prevention may include:

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

- occlusal guards for athletics or occlusal traumatism

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

TREATMENT PLANNING

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

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

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

D. Treatment Plans for Medicaid participants must include covered services. Other non-covered services may be discussed. Participants must have access to their benefits.

E. Informed Consent Process

1. Dentists must document that all recommended treatment options have been reviewed with the patient and that the patient understood the risks, benefits, alternatives, expectancy of success, the total financial responsibilities for all proposed procedures.

2. In addition, the patient should be advised of the likely results of doing no treatment.

3. Appropriate informed consent documentation must be signed and dated by the patient and dentist for the specific treatment plan that was accepted.

4. If a patient refuses recommended procedures, the patient must sign a specific "refusal of care" document. Refusal of non-covered services in lieu of covered services is not grounds for patient dismissal.

F. Poor Prognosis

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

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

LIBERTY's licensed Staff dentist adjudicate prognosis determinations for the above procedures on a case-by-case basis as best determined by the presenting radiographs, narrative and any history on file.

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

Participants have the right to elect extraction of a tooth requiring treatment over restoring it.

G. Covered services are available to the participant at no charge. In the event the patient elects to select a non-covered alternate treatment they are fully responsible for such services. Documentation must clearly show that the participant was offered a plan benefit and elected to pay for Non-Covered Services.

REQUEST FOR PRE-ESTIMATE

Review Medicaid Plan Benefits to determine which procedures require pre-approval.

PROGRESS NOTES

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

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

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

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

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

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

G. Transcription of illegible progress notes may be required and is the responsibility of the treating dentist/dental office. Requests for transcription may be ordered by LIBERTY as part of grievance resolution, peer review or other quality management processes. Providers agree to cooperate with any such requests by virtue of their contract.

ENDODONTICS

Palliative Treatment

Palliative services are applicable per visit, not per tooth, and include all the treatment provided during the visit other than necessary x-rays. A description of emergency and palliative treatment should be documented.

Endodontic Pulpal Debridement and Palliative Treatment

If root canal therapy (RCT) is continued at the same facility, initial pulpal debridement is an integral part of the RCT. LIBERTY's payment for the RCT is considered to be payment in full. Hence, no separate fee may be charged for pulpal debridement (D3221) or palliative treatment (D9110).

If a patient is referred to a specialist for RCT after "opening" a tooth, the General Dentist may appropriately report either procedure D3221 or if that procedure is not listed, the procedure D9110 for palliative treatment.

Procedure D3332 is appropriate to report if, after "opening" a tooth a dentist determines that RCT is contradicted due to a cracked tooth or poor prognosis.

If a participant had a tooth chamber "opened" during an out-of-area emergency, root canal therapy may remain a covered benefit.

If RCT was started prior to the patient's eligibility with the Plan, completion of the root canal therapy may not be covered by LIBERTY Dental Plan

Not all procedures require authorization.

Documentation needed for authorization or prepayment review of procedure:

- Sufficient and appropriate radiographs clearly showing the adjacent and opposing teeth and a pre-operative radiograph of the tooth to be treated; bitewings, periapicals or panorex. A dated post-operative radiograph must be submitted for review for payment.
- Treatment rendered under emergency conditions, when authorization is not possible, will still require that appropriate radiographs clearly showing the adjacent and opposing teeth, pre-operative radiograph and dated post-operative radiograph of the tooth treated with the claim for retrospective review for payment. In cases where pathology is not apparent, a written narrative justifying treatment is required.

Note: For benefit purposes providers should document endodontic dates of service as the dates when procedures have been entirely completed, subject to review.

1. Diagnostic techniques used when considering possible endodontic procedures may include an evaluation of:
    - Pain and the stimuli that induce or relieve it by the following tests:
        - Thermal
        - Electric
        - Percussion
        - Palpation
        - Mobility
    - Non-symptomatic radiographic lesions
2. Treatment planning for endodontic procedures and prognosis may include consideration of the following:
    - Strategic importance of the tooth or teeth
    - Prognosis – endodontic procedures for teeth with a guarded or poor 5-year prognosis (endodontic, periodontal or restorative) are not covered
    - Presence and severity of periodontal disease
    - Restorability and tooth fractures
    - Excessively curved or calcified canals
    - Following an appropriate informed consent process, if a patient elects to proceed with a procedure that is not covered, the participant is responsible for the dentist's

usual fee. The dentist should have the participant sign appropriate informed consent documents and financial agreements.

- Teeth that are predisposed to fracture following endodontic treatment should be protected with an appropriate restoration; most posterior teeth should be restored with a full coverage restoration.

- Occlusion

- Patients have the right to elect extraction as an alternative to endodontic therapy.

3. Clinical Guidelines

- Diagnostic pre-operative radiographs of teeth to be endodontically treated must reveal all periapical areas and alveolar bone.

- A rubber dam should be used and documented (radiographically or in the progress notes) for most endodontic procedures. Documentation is required for any inability to use a rubber dam.

- Gutta percha is the endodontic filling material of choice and should be densely packed and sealed. All canals should be obturated.

- Post-operative radiograph(s), showing all canals and apices, must be taken immediately after completion of endodontic treatment.

- In the absence of symptoms, post-operative radiographs should be taken at appropriate periodic intervals.

4. Endodontic referral necessity

In cases where a defect or decay is seen to be "approaching" the pulp of a tooth and the need for endodontic treatment is not clear, LIBERTY expects the General Dentist to proceed with the decay removal and possible temporization prior to any referral to an Endodontist.

5. Endodontic Irrigation

Providers are contractually obligated to provide services for covered root canal procedures. The choice of endodontic irrigates is made by the treating dentist. Medicaid participants cannot be charged for endodontic irrigation materials (such as *BioPure)*.

6. Pulpotomy

- A pulpotomy may be indicated in a primary or permanent tooth when pulpal pathology is limited to the coronal pulp and the tooth has a reasonable period of retention and function.

- Apexification may be indicated in a permanent tooth when there is evidence of a vital and normal pulp with an incompletely developed root or roots to allow maturation and completion of the root apex. Endodontic treatment should be completed when the root is fully formed.

7. Pulp Cap

    - This procedure is not to be used for bases and liners
    - Direct pulp capping is indicated for mechanical or accidental pulp exposures in relatively young teeth and may be indicated in the presence of a small, exposed vital or normal pulp
    - Indirect pulp treatment is a procedure performed to preserve the vitality of the tooth. The tooth must meet the following diagnostic criteria: reversible pulpitis and deep caries in close proximity to the pulp, no radiographic evidence of internal or external root resorption or other pathologic changes. The procedure is intended to excavate caries as close as possible to the pulp, place a caries arresting protective liner, and restore and seal the tooth bacterial contamination.

      Indirect pulp treatment in primary teeth is preferable to a pulpotomy when the pulp is normal or has a diagnosis of reversible pulpitis. Teeth with immature roots should be selected to promote continued root development and apexogenesis.

8. Endodontic surgical treatment, if covered, should be considered only in special circumstances, including:

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

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

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

ORAL SURGERY

A. Each dental extraction should be based on a clearly recorded diagnosis for which extraction is the treatment of choice of the dentist and the patient.

B. General dentists are expected to provide routine oral surgery, including:

1. uncomplicated extractions and emergency palliative care
2. routine surgical extractions
3. incision and drainage of intra-oral abscesses
4. minor surgical procedures and postoperative services

C. Extractions may be indicated in the presence of non-restorable caries, untreatable periodontal disease, pulpal and periapical disease not amendable to endodontic therapy, to facilitate surgical removal of a cyst or neoplasm, or when overriding medical conditions exist, providing compelling justification to eliminate existing or potential sources of oral infection.

D. When teeth are extracted, all portions of the teeth should be removed. If any portion of a tooth (or teeth) is not removed, patient notification must be documented.

E. Post extraction socket irrigation, regardless of the type of material used, is inclusive with the extraction. Medicaid participants cannot be charged for oral surgery irrigation materials.

F. Local anesthesia is preferred in the absence of specific indications for the use of general anesthesia.

G. Minor contouring of bone and soft tissues during a surgical extraction are considered a part of and included in a surgical extraction, D7210.

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

THIRD MOLAR EXTRACTIONS AND BENEFIT DETERMINATION

LIBERTY licensed clinical reviewers adjudicate benefits on a case-by-case basis.

Documentation needed for authorization procedure:

- Diagnostic quality periapical and/or panoramic radiographs,
- Radiographs must be mounted, contain the patient name and the date the radiographs were taken, not the date of submission)
- Duplicate radiographs must be labeled Right (R) and Left (L), include the patient name and the date the radiograph(s) were taken, not the date of submission.
- Extraction of impacted wisdom teeth or surgical removal of residual tooth roots will require a written narrative of medical necessity that is tooth specific.

Authorization for extraction of impacted third molars:

Surgical extraction of impacted and erupted third molar teeth is a covered service. Indications of removal and criteria or conditions allowable for reimbursement are to include erupted, partially erupted, and unerupted/impacted third molars. One or more of the following conditions must be present and documented in the participant dental record:

1. Pain
2. Pericoronitis
3. Carious lesion
4. Facilitation of the management of or limitation of progression of periodontal disease
5. Non-treatable pulpal or periapical lesion
6. Acute and/or chronic infection
7. Ectopic position
8. Abnormalities of tooth size or shape precluding normal function
9. Facilitation of orthodontic tooth movement and promotion of dental stability
10. Tooth impeding the normal eruption of an adjacent tooth
11. Tooth in line of fracture
12. Impacted tooth
13. Pathology associated with tooth
14. Pathology associated with impacted tooth (odontogenic cysts, neoplasms)
15. Tooth involved in tumor resection
16. Preventive or prophylactic removal, when indicated, for patients with medical or surgical conditions or treatments
17. Clinical findings of fractured tooth or teeth
18. Internal or external resorption of tooth or adjacent teeth
19. Anatomical position causing potential damage to adjacent teeth
20. Patient's informed refusal of nonsurgical treatment options

Definition of Impacted Tooth: "An unerupted or partially erupted tooth that is positioned against another tooth, bone, or soft tissue so that complete eruption is unlikely."

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

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

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

All suspicious lesions should be biopsied and examined microscopically.

PERIODONTICS

All children, adolescents and adults should be evaluated for evidence of periodontal disease. However, in most cases pocket depths less than 4 mm do not indicate the presence of periodontal disease. The determination of the presence of periodontal disease may also rely on the presence of bleeding on probing or evidence of radiographic bone loss (loss of attachment). In the absence of active periodontal disease, it is appropriate to document the patient's periodontal status as being within normal limits (WNL).

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

Periodontal treatment sequencing:

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

"The gross removal of plaque and calculus that interfere with the ability of the dentist to perform a comprehensive oral evaluation. This preliminary procedure does not preclude the need for additional procedures."

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

Note, this procedure:

1. must be supported by radiographic evidence of heavy calculus
2. is not a replacement code for procedure D1110

B. D4341/D4342 – Periodontal scaling and root planing (SRP) – Refer to Plan Benefits for Pre-approval Guidelines

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

1. Considered within the scope of a General Dentist or a dental hygienist
2. Supported when full mouth periodontal pocket charting demonstrates at least 5 mm pocket depths. It is common for radiographs to reveal evidence of bone loss and/or the presence of interproximal calculus.

3. Scaling and root planing procedures (D4341/D4342) are generally not performed in the same quadrants or areas for 2 years following initial completion of these services.

4. In general, only 2 quadrants may be performed on any date of service.

5. Sufficient time to properly and judiciously perform meticulous calculus and plaque removal on all aspects of the root must be allowed.

6. SRP is not intended for a "difficult cleaning" or to be used "because it has been a long time since the last cleaning." Rather it is a judicious and meticulous treatment procedure to clean the roots of the tooth. **Evidence of loss of attachment must be present**.

Definitive Treatment vs. Pre-Surgical scaling and root planing:

1. For early stages of periodontal disease, this procedure is used as definitive treatment and the patient may not need to be referred to a Periodontist based upon tissue response and the patient's oral hygiene.

2. For later stages of periodontal disease, the procedure may be considered pre-surgical treatment and the patient may need to be referred to a Periodontist, again based on tissue response and the patient's oral hygiene.

Note: LIBERTY requires that both definitive and pre-surgical scaling and root planing to be provided at a primary facility before considering referral requests to a periodontal specialist.

Two quadrants per appointment

Periodontal scaling and root planing are arduous and time consuming, involving instrumentation of the crown and root surfaces of the teeth to remove plaque, calculus, and stains from these surfaces.

As a guideline, LIBERTY benefits only two quadrants per appointment. If a clinician recommends and/or completes more than two quadrants per appointment, documentation supporting the additional quadrant(s) must be included with any claim and in the patient's progress notes.

1. Local anesthesia is commonly used. If it is not used, the reason(s) should be documented. The use of topical anesthetics is considered a part of and included in this procedure.

2. Home care oral hygiene techniques should be introduced and demonstrated.

3. A re-evaluation following scaling and root planning should be performed. This re-evaluation should be performed at least 4-6 weeks later and include: a description of tissue response; pocket depths changes; sites with bleeding or exudate; evaluation of the patient's homecare effectiveness.

Scaling and root planing are considered the primary treatment for participants who have been diagnosed with periodontal disease. D4381and D4921are only considered for reimbursement as a separate procedure when medical necessity has been established. Only when medical necessity has been established and approved by LIBERTY Staff Dentist and performed on the same day as D4341/D4342 will payment be considered.

D1110 and D4341/D4342

It is generally not appropriate to perform D1110 and D4341/D4342 on the same date of service. LIBERTY's licensed staff dentist may review documented rationale for any such situations on a case-by-case basis.

Soft Tissue Management Programs (STMP)

Any collection of periodontal and other services bundled together as a "soft tissue management" program must preserve the participant's right to their Medicaid benefit. Participants have the benefit for all the periodontal and other codes listed in this provider guide. Only non-covered service may be presented to the Medicaid participant for additional payment. Patients must sign a non-covered services form if they choose to accept soft tissue management procedures in addition to any covered procedures listed in the plan designs.

Periodontal surgical procedures

- The patient must exhibit a willingness to accept periodontal treatment and practice an appropriate oral hygiene regimen prior to consideration for periodontal surgical procedures.
- Case history, including patient motivation to comply with treatment and oral hygiene status, must be documented.
- Patient motivation may be documented in a narrative by the attending dentist and/or by a copy of patient's progress notes documenting patient follow through on recommended regimens.
- In most cases, there must be evidence of scrupulous oral hygiene for at least three months prior to the periodontal surgery, prepayment review will be required.
- Consideration for a direct referral to a Periodontist would be considered on a by-report basis.
- Periodontal surgical procedures are covered only in cases that exhibit a favorable long-term prognosis. Surgical procedures for the retention of teeth that are being used as prosthetic abutments is covered only when the teeth would exhibit adequate bone support for the forces to which they are, or will be, subjected.
- Periodontal pocket reduction surgical procedures may be covered in cases where the pocket depths are 5 mm's or deeper, following soft tissue responses to scaling and root planing.
- Osseous surgery procedures may not be covered if:
    - Pocket depths are 5 mm's or less and appear to be maintainable by non-surgical means (i.e. periodontal maintenance and root planing).
    - Osseous surgery and regenerative procedures should also correct and reshape deformities in the alveolar bone where indicated.
    - Soft tissue gingival grafting should be done to correct gingival deficiencies where appropriate.

RESTORATIVE

Diagnosis and Treatment Planning

It is appropriate to restore teeth with radiographic evidence of caries, lost tooth structure, defective or lost restorations, and/or for post-endodontic purposes. Sequencing of treatment must be appropriate to the needs of the patient.

Restorative procedures must be reported using valid/current *CDT* procedure codes as published by *The American Dental Association*. This source includes nomenclature and descriptors for each procedure code.

Treatment results, including margins, contours and contacts, should be clinically acceptable. The long-term prognosis for continued function should be good (estimated at 5 years or more).

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

B. Restorative procedures in operative dentistry include amalgam, composites, crowns, and other cast or milled restorations, as well as the use of various temporary materials.

Operative Dentistry Guidelines

Placement of restoration includes:

- Local anesthesia;
- Adhesives;
- Bonding agents;
- Indirect pulp capping;
- Bases and liners;
- Acid etch procedures;
- Polishing;
- Temporary restorations; and,
- Replacement of defective or lost fillings is a benefit, even in the absence of decay.

Amalgam Fillings, Safety & Benefits

American Dental Association Statement: Food and Drug Administration Action on Dental Amalgam

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

Dental amalgam is a cavity-filling material made by combining mercury with other metals such as silver, copper and tin. Numerous scientific studies conducted over the past several decades, including two large clinical trials published in the Journal of the American Medical Association, indicate dental amalgam is a safe, effective cavity-filling material for children and others. And, in its 2009 review of the scientific literature on amalgam safety and, the ADA's Council on Scientific Affairs reaffirmed that the scientific evidence continues to support amalgam as a valuable, viable and safe choice for dental patients…" Visit https://www.ada.org/en/member-center/oral-health-topics/amalgam to obtain further information on amalgam topics and references.

A. The choice of restorative materials depends on the nature and extent of the defect to be restored, location in the mouth, stress distribution expected during mastication and esthetic requirements.

   i. The procedures of choice for treating caries or the replacement of an existing restoration not involving or undermining the cusps of posterior teeth is generally amalgam or composite.

   ii. The procedures of choice for treating caries or the replacement of an existing restoration not involving or undermining the incisal edges of an anterior tooth is composite.

   iii. Restorations for chipped teeth may be covered.

iv. The replacement of clinically acceptable amalgam fillings with alternative materials (composite, crown, etc.) is considered cosmetic and is not covered.

v. Restorative procedures for teeth exhibiting a poor prognosis due to gross carious destruction of the clinical crown at/or below the bone level, advanced periodontal disease, untreated periapical pathology or poor restorability are not covered.

vi. Pulpotomies and pre-formed crowns for primary teeth are covered only if the tooth is expected to be present for at least six months.

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

viii. When incisal edges of anterior teeth are undermined because of caries or replacement of a restoration undermining the incisal edges or a fracture, the procedures of choice may include crowns.

ix. Crowns should only be considered when cusp support is needed, and tooth cannot be treated with a filling restoration.

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

ORTHODONTICS

Orthodontic procedures are limited to recipients under the age of 21 who meet the orthodontic requirements as stated in the Missouri Medicaid and Dental Benefits and Limitations Handbook. Prior authorization is required for all orthodontic services. If you are requesting a benefit which exceeds the standard orthodontic benefit, please submit the request on a current ADA Dental Claim Form with a narrative explaining why the additional service is needed.

A copy of the ADA Dental Claim Form is available on our **Provider Portal** at:
https://www.libertydentalplan.com/Providers/Provider-Self-Service-Tools/ITransact.aspx

CRITERIA FOR ORTHODONTIC SERVICES

LIBERTY utilizes the orthodontic criteria established by MO HealthNet in making medical necessity determinations. These criteria are excerpted (October 12, 2018) below for your reference.

13 CSR 70-35.010 DENTAL BENEFITS AND LIMITATIONS, MISSOUR CODE OF STATE REGULATIONS

Orthodontia Services. When an eligible participant is believed to have a condition that may require orthodontic treatment, the attending dentist should refer the participants to a qualified dentist or orthodontist for preliminary examination to determine if the treatment will be approved. The fact that the participants has moderate or even severe orthodontic problems or has been advised by a dentist or orthodontist to have treatment is not, by itself, a guarantee that the patient will qualify for orthodontia services through MO HealthNet. Coverage is determined solely by meeting the criteria listed below in subsections (5)(A) and (5)(B) or (5)(C).

(A) To be eligible for orthodontia services, the participant must meet all of the following general requirements:

1. Be under twenty-one (21) years of age; and
2. Have all dental work completed; and
3. Have good oral hygiene documented in the child's treatment plan; and
4. Have permanent dentition. Exceptions to having permanent dentition are as follows:
   A. Participant has a primary tooth retained due to ectopic or missing permanent tooth; or
   B. Participant may have primary teeth present if they have cleft palate, severe traumatic deviations, or an impacted maxillary central incisor; or
   C. Participant may have primary teeth if they are thirteen (13) years of age or older.
   D. The orthodontia provider has provided to the Division written documentation which proves that orthodontic treatment is medically necessary under one of the criteria in subsection 5(C).

(B) The determination whether or not a participant will be approved for orthodontic services shall be initially screened using the Handicapping Labio-Lingual Deviation (HLD) Index. The HLD Index must be fully completed in accordance with the instructions in Section 14.3 of the MO HealthNet Dental Provider Manual and **must be submitted** with the ADA Claim Form.

LIBERTY will approve orthodontic services when the participant meets all the criteria in section (A) above and one (1) of the criteria listed in paragraphs 1. to 7. below-

1. Has a cleft palate;
2. Has a deep impinging overbite when the lower incisors are damaging the soft tissue of the palate (lower incisor contact only on the palate is not sufficient);
3. Has a cross-bite of individual anterior teeth when damage of soft tissue is present;
4. Has severe traumatic deviations;
5. Has an over-jet greater than nine-millimeter (9mm) or reverse over-jet of greater than three and one-half millimeters (3.5mm);
6. Has an impacted maxillary central incisor; or
7. Scores twenty-eight (28) points or greater on the HLD Index.

(C) If the participant does not meet any of the criteria in subsection (B), LIBERTY will consider whether orthodontic services should be provided based upon other evidence that orthodontic services are medically necessary as indicated in Section 13.42.C. of the MO HealthNet Dental Provider Manual and in 13 CSR 70-35.010 (5)(C). The treating orthodontist/dentist must submit a written, detailed explanation of the medical necessity of the orthodontia services along with the completed HLD Index, the ADA Claim form and treatment plan. All documentation must be completed, signed and dated by the treating orthodontist/dentist. If medical necessity is based on a medical condition (as stated in 13 CSR 70-35.010 (5)(C)2.), additional documentation from a licensed medical doctor, board certified to diagnose the medical condition, justifying the need for the orthodontia services must be submitted along with documentation from the treating orthodontist/dentist. Likewise, if medical necessity is based on the presence of mental, emotional, and/or behavioral problems, disturbances or dysfunctions (as stated in 13 CSR 70-35.010 (5)(C)3.), additional documentation from a licensed psychiatrist or a licensed psychologist who has limited his or her practice to child psychiatry or child psychology justifying the need for orthodontia services must be submitted along with the required documentation from the treating orthodontist/dentist.

(D) Orthodontic treatment shall not be considered to be medically necessary when –

1. The orthodontic treatment is for aesthetic or cosmetic reasons only; or
2. The orthodontic treatment is to correct crowded teeth only, if the child can adequately protect the periodontium with reasonable oral hygiene measures; or
3. The child has demonstrated a lack of motivation to maintain reasonable standards of oral hygiene and oral hygiene is deficient

SECTION 13.42E, COMPREHENSIVE ORTHODONTIC TREATMENT, MO HEALTHNET DENTAL BILLING BOOK

Comprehensive orthodontic treatment includes, but is *not* limited to:

- Complete diagnostic records and a written treatment plan;
- Placement of all necessary appliances to properly treat the participant (both removable and fixed appliances);
- All necessary adjustments;
- Removal of appliances at the completion of the active phase of treatment;
- Placement of retainers or necessary retention techniques;
- Adjustment of the retainers and observation of the participant for a proper period of time.

SECTION 14.3, THE HANDICAPPING LABIO-LINGUAL DEVIATION (HLD) INDEX, MO HEALTHNET DENTAL MANUAL

The Omnibus Budget Reconciliation Act of 1989 (OBRA '89) mandates that Medicaid-covered services be provided for individuals under the age of 21 when service is medically necessary, regardless of whether the service is covered by the State Medicaid Plan.

SECTION 14.3A, GUIDELINES AND RULES FOR APPLYING THE HLD INDEX, MO HEALTHNET DENTAL MANUAL

1) Orthodontic benefits are available to eligible beneficiaries under the age of 21 with severe malocclusions and in cases of medical necessity as determined by the orthodontic consultant when the treating orthodontist/dentist submits documentation supporting medical necessity. Benefits are for participants with permanent dentition except in cleft palate cases, severe traumatic deviations, or an impacted maxillary central incisor or with mixed dentition when the beneficiary has reached the age of 13.

2) Study models *must* be of diagnostic quality. To meet diagnostic requirements, study models *must* be properly poured and adequately trimmed with no large voids or positive bubbles present. Dental study models should simulate centric occlusion of the patient when the models are placed on their heels. Study models that do *not* meet the diagnostic requirements described above are *not* accepted.

3) Only teeth that have erupted and are visible on the study models should be considered, measured, counted and recorded.

4) In cases submitted for deep impinging bite with tissue damage, the lower teeth *must* be clearly touching the palate and tissue indentations, or other evidence of soft tissue damage ***must*** be visible on the study models.

5) Either of the upper central incisors *must* be used to measure overjet, overbite (including reverse overbite), mandibular protrusion, and open bite. Do *not* use the upper lateral incisors or cuspids for these measurements.

6) The following definitions and instructions apply when using the HLD Index to identify ectopic eruptions. Examples of ectopic eruption (and ectopic development) of teeth include:
   - When a portion of the distal root of the primary second molar is resorbed during the eruption of the first molar;
   - Transposed teeth;
   - Teeth in the maxillary sinus;
   - Teeth in the ascending ramus of the mandible; and
   - Situations where teeth have developed in locations other than the dental arches.
   - In all other situations, teeth deemed to be ectopic *must* be more than 50% blocked out and clearly out of the dental arch.
   - In cases of mutually blocked-out teeth only one is counted.

INSTRUCTIONS FOR THE HLD INDEX MEASUREMENTS
Section 14.4 B MO HealthNet Dental Manual

Procedure:

- Position the patient's teeth in centric occlusion
- Record all measurements in the order given and round off to the nearest millimeter
- Enter the score "0" if condition is absent
- The use of a recorder (assistant or hygienist) is recommended

Conditions 1 through 6 are considered automatic qualifiers under the MO HealthNet Division orthodontic program. If one of the automatic qualifiers is met, the remaining sections of the form do not need to be completed.

1. Cleft palate deformities – automatic qualification; however, if the deformity cannot be demonstrated on the study model, the condition must be diagnosed by properly credentialed experts and the diagnosis must be supported by documentation. If present, enter an "X" and score no further.
2. Deep impinging overbite – tissue damage of the palate must be clearly visible in the mouth. On study models, the lower teeth must be clearly touching the palate and the tissue indentations or evidence of soft tissue damage must be clearly visible. If present, enter an "X" and score no further.
3. Crossbite of individual anterior teeth – damage of soft tissue must be clearly visible in the mouth and reproducible and visible on the study models. Gingival recession must be at least 1 1/2 mm deeper than the adjacent teeth. If present, enter an "X" and score no further. In the case of a canine, the amount of gingival recession should be compared to the opposite canine.
4. Severe traumatic deviations – these might include, for example, loss of a premaxillary segment by burns or accident, the result of osteomyelitis, or other gross pathology. If present, enter an "X" and score no further.
5. Overjet – this is recorded with the patient's teeth in centric occlusion and is measured from the labial surface of a lower incisor to the labial surface of an upper central incisor. Measure parallel to the occlusal plan. Do not use the upper lateral incisors or cuspids. The measurement may apply to only one tooth if it is severely protrusive. Reverse overjet may be measured in the same manner. Do not record overjet and mandibular protrusion (reverse overjet) on the same patient. (Note: If the overjet is greater than 9 mm or reverse overjet is greater than 3.5 mm enter an "X" and score no further.)
6. Impacted Maxillary Central Incisor, automatic qualification. If present, enter an “X” and score no further.
7. Overjet – this is recorded with the patient's teeth in centric occlusion and is measured from the labial surface of a lower incisor to the labial surface of an upper central incisor. Measure parallel to the occlusal plan. Do not use the upper lateral incisors or cuspids. The measurement may apply to only one tooth if it is severely protrusive. Do not record overjet and mandibular protrusion (reverse overjet) on the same patient.
8. Overbite – a pencil mark on the tooth indicating the extent of the overlap assists in making this measurement. Hold the pencil parallel to the occlusal plane when marking and use the

incisal edge of one of the upper central incisors. Do not use the upper lateral incisors or cuspids. The measurement is done on the lower incisor from the incisal edge to the pencil mark. "Reverse" overbite may exist and should be measured on an upper central incisor - from the incisal edge to the pencil mark. Do not record overbite and open bite on the same patient. Enter the measurement in millimeters.

9. Mandibular (dental) protrusion or reverse overjet – measured from the labial surface of a lower incisor to the labial surface of an upper center incisor. Do not use the upper lateral incisors or cuspids for this measurement. Do not record mandibular protrusion (reverse overjet) and overjet on the same patient. The measurement in millimeters is entered on the score sheet and multiplied by five (5).

10. Open bite – measured from the incisal edge of an upper central incisor to the incisal edge of a lower incisor. Do not use the upper lateral incisors or cuspids for this measurement. Do not record overbite and open bite on the same patient. The measurement in millimeters is entered on the score sheet and multiplied by four (4).

11. Ectopic eruption – count each tooth excluding third molars. Enter the number of teeth on the score sheet and multiply by three (3). If condition No. 11, anterior crowding, is also present with an ectopic eruption in the anterior portion of the mouth, score only the most severe condition (the condition represented by the most points). DO NOT SCORE BOTH CONDITIONS.

12. Anterior crowding – anterior arch length insufficiency must exceed 3.5 mm. Mild rotations that may react favorably to stripping or mild expansion procedures are not to be scored as crowded. Enter one (1) points for a maxillary arch with anterior crowding and one (1) points for a mandibular arch with anterior crowding (two points maximum for anterior crowding) and multiply by five (5). If condition No. 10, ectopic eruption, is also present in the anterior portion of the mouth, score only the most severe condition (the condition represented by the most points). DO NOT SCORE BOTH CONDITIONS

13. Labio-lingual spread – use a Boley gauge (or disposable ruler) to determine the extent of deviation from a normal arch. Where there is only a protruded or lingually displaced anterior tooth, the measurement should be made from the incisal edge of that tooth to a line representing the normal arch. Otherwise, the total distance between the most protruded tooth and the most lingually displaced adjacent anterior tooth is measured. In the event that multiple anterior crowding of teeth is observed, all deviations should be measured for labio-lingual spread but only the most severe individual measurement should be entered on the on the score sheet. Enter the measurement in mm.

14. Posterior crossbite – this condition involves one or more posterior teeth, one of which must be a molar. The crossbite must be one in which the maxillary posterior teeth involved may be palatal to normal relationships or completely buccal to the mandibular posterior teeth. The presence of posterior crossbite is indicated by a score of four (4) on the score sheet.

HANDICAPPING LABIO-LINGUAL DEVIATION INDEX (HLD) SCORE SHEET

Name (Last, First):_____LIBERTY Participant#_____DOB: _____

All necessary dental work completed? Yes_____No_____*Patient oral hygiene:* Excellent_____Good____Poor_____
(all dental work must be completed, and oral hygiene must be good BEFORE orthodontic treatment is approved)

PROCEDURE (use this score sheet and a Boley Gauge or disposable ruler):

- **Indicate by checkmark next to A, B and/or C which criteria you are submitting for review**
- **Position the patient's teeth in centric occlusion;**
- **Record all measurements in the order given and round off to the nearest millimeter (mm);**
- **ENTER SCORE "0" IF CONDITION IS ABSENT**

A.__CONDITIONS 1-6 ARE AUTOMATIC QUALIFIERS (indicate with an "X" if condition is present)

1. **Cleft palate**
2. Deep impinging bite **with** signs of tissue damage, not just touching palate _____
3. Anterior crossbite **with** gingival recession _____
4. **Severe traumatic deviation** (i.e., accidents, tumors, etc. attach description) _____
5. Overjet **9 mm** or greater or reverse overjet **3.5 mm** or greater _____
6. **Impacted maxillary central incisor** (can be TX in early mixed dentition) _____

B.__**CONDITIONS 7-14 MUST SCORE 28 POINTS OR MORE TO QUALIFY**

7. **Overjet** (one upper central incisor to labial of the most labial lower incisor) mm____x 1 = _____
8. **Overbite** (maxillary central incisor relative to lower anteriors) mm____x 1 = _____
9. Mandibular protrusion (reverse overjet, **"underbite"**) mm ___x 5 = _____
10. **Openbite** (measure from a maxillary central incisor to mandibular incisors) mm ____x 4 = _____
11. **Ectopic teeth** (excluding third molars, see note below) # teeth ____x 3 = _____

Note**: If anterior crowding and ectopic eruption are present in the anterior portion of the mouth, score only the most severe condition; **do not score both

12a. **Anterior crowding of maxilla** (greater than 3.5 mm) if present score __1 x 5 = _____
12.b. **Anterior crowding of mandible** (greater than 3.5 mm) if present score __1 x 5 = _____
13. **Labio-lingual** spread (either measure a displaced tooth from the normal arch form or labial-lingual distance between adjacent anterior teeth) mm__1 = _____
1_ x 4 = _____
14. Posterior **crossbite** (1 must be a molar), score only 1 time – if present score

TOTAL SCORE (must score 28 points or more to qualify) _____

C.__**MEDICAL NECESSITY**

LIBERTY will consider whether orthodontic services should be provided based upon other evidence that orthodontic services are medically necessary as indicated in Section 13.42.C of the Dental Provider Manual and in 13 CSR 70-35.010(5)(C). **The treating dentist/orthodontist must submit a written detailed explanation of the medical necessity of the orthodontia services along with the completed HLD Index, PA request form and treatment plan.**

Provider Signature _____ Date _____

Updated 11/1/2013

LIBERTY ORTHODONTIA COVERAGE CRITERIA

(A) To be eligible for orthodontia services, the participant must meet all of the following general requirements:

1. Be under twenty-one (21) years of age; and
2. Have all dental work completed; and
3. Have good oral hygiene documented in the child's treatment plan; and
4. Have permanent dentition. Exceptions to having permanent dentition are as follows:
   A. Participant has a primary tooth retained due to ectopic or missing permanent tooth; or
   B. Participant may have primary teeth present if they have cleft palate, severe traumatic deviations, or an impacted maxillary central incisor; or
   C. Participant may have primary teeth if they are thirteen (13) years of age or older.
   D. The orthodontia provider has provided to the Division written documentation which proves that orthodontic treatment is medically necessary under one of the criteria in (C) below.

(B) The determination whether or not a participant will be approved for orthodontic services shall be initially screened using the Handicapping Labio-Lingual Deviation (HLD) Index. The HLD Index must be fully completed in accordance with the instructions in Section 14.3 of the MO HealthNet Dental Provider Manual and **must be submitted** with the Prior Authorization (PA) form. LIBERTY will approve orthodontic services when the participant meets all the criteria in section (A) above and one (1) of the criteria listed in paragraphs 1. to 7. below-

1. Has a cleft palate;
2. Has a deep impinging overbite when the lower incisors are damaging the soft tissue of the palate (lower incisor contact only on the palate is not sufficient);
3. Has a cross-bite of individual anterior teeth when damage of soft tissue is present;
4. Has severe traumatic deviations;
5. Has an over-jet greater than nine-millimeter (9mm) or reverse over-jet of greater than three and one-half millimeters (3.5mm);
6. Has an impacted maxillary central incisor; or
7. Scores twenty-eight (28) points or greater on the HLD Index.

(C) If the participant does not meet any of the criteria in subsection (B), LIBERTY will consider whether orthodontic services should be provided based upon other evidence that orthodontic services are medically necessary as indicated in Section 13.42.C. of the MO HealthNet Dental Provider Manual and in 13 CSR 70-35.010 (5)(C). The treating orthodontist/dentist must submit a written, detailed explanation of the medical necessity of the orthodontia services along with the completed HLD Index, the pre- authorization request form and treatment plan. All documentation must be completed, signed and dated by the treating orthodontist/dentist. If medical necessity is based on a medical condition (as stated in 13 CSR 70-35.010 (5)(C)2.), additional documentation from a licensed medical doctor, board certified to diagnose the medical condition, justifying the need for the orthodontia services must be submitted along with documentation from the treating orthodontist/dentist. Likewise, if medical necessity is based on the presence of mental, emotional, and/or behavioral problems, disturbances or dysfunctions (as stated in 13 CSR 70-35.010 (5)(C)3.), additional documentation from a licensed psychiatrist or a licensed psychologist who has limited his or her practice to child psychiatry or child psychology justifying the need for orthodontia services must be submitted along with the required documentation from the treating orthodontist/dentist.

OrthoCAD Submission Form

Date:_____

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

Provider Information		
Dentist Name:	**Provider NPI #**	**Location ID #**
Address:	**City, State, Zip**	**Area code & Phone number:**

Treatment Requested	
Code:	**Description of request:**

October 12, 2018

MO Orthodontic Continuation of Care Submission Form

Date: _____

MEMBER Name (First & Last):	Date of Birth:
Address:	City, State, Zip:
SSN of ID#:	Current Member Insurance Plan/Group#:
Initial Banding Date:	Member Insurance at time of Initial Banding:
Months of Active Treatment Completed:	Months of Active Treatment Remaining:

CHANGE IN PROVIDER AND/OR CHANGE IN MEMBER INSURANCE BETWEEN MEDICAID PLANS

☐ Member initiated treatment with a different Provider (non-affiliated) while covered by the same OR different **Medicaid** program/vendor.

Required for submission:

- ☐ **Completed ADA form for preauthorization of CDT Code D8999.**
- ☐ **Copy of original Medicaid Prior Authorization for Comprehensive Orthodontic Treatment (Prior Authorization from Medicaid program/vendor for Comprehensive Orthodontic Treatment approved prior to initiation of orthodontic treatment).**

***If required information above is cannot be provided, the case will be reviewed as outlined below.**

CHANGE IN PROVIDER AND/OR CHANGE IN MEMBER INSURANCE FROM NON-MEDICAID TO MEDICAID

☐ Member initiated treatment while covered by a **NON-Medicaid** program/vendor (FFS or Commercial Insurance plan) OR Self-Pay and Member is now covered by a **Medicaid** program/vendor with the same OR different Provider.

Required for submission:

- ☐ **Completed ADA form for preauthorization of CDT Code D8999.**
- ☐ **Diagnostic records (a copy of the original study models/OrthoCad equivalent and/or a complete set of diagnostic photographs and/or a panorex film). Progress records will be accepted if original records are not available. Documentation should demonstrate qualifying criteria for severe handicapping malocclusion.**

CHANGES THAT DO NOT HAVE TO BE SUBMITTED FOR CONTINUATION OF CARE PREAUTHORIZATION

- *Changes between treating providers that are affiliated with the same group practice and changes between different affiliated practice locations. To ensure timely payment, please make sure that any claim is submitted with the correct Group (Billing) and Provider NPI information.*
- *Initiation of Comprehensive Orthodontic Treatment after completion of Interceptive or Limited Orthodontic Treatment (Phased treatment). Please submit a prior-authorization (with any required documentation per plan) with the correct ADA Code for Comprehensive Ortho (D8070-D8090)*

October 12, 2018

RESTORATIVE CODE GUIDELINES

D1351 - Sealant – per tooth

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

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

D2140-D2335, and D2391- D2394 - Amalgam Restorations and Resin-based composite restorations

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

D9910 – application of desensitizing medicament

Appropriate reporting of these procedures is clearly detailed below.

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

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

CROWNS

Single Crowns – REFER TO PLAN BENEFITS FOR PRE-APPROVAL REQUIREMENTS

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

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

C. When anterior teeth have incisal edges/corners that are undermined or missing because of caries, a defective restoration or are fractured off, the treatment of choice may then become a porcelain fused to a base metal crown or porcelain/ceramic substrate crown.

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

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

Post and core procedures include buildups

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

"D2954 prefabricated post and core in addition to crown core is built around a prefabricated post. This procedure includes the core material"

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

Outcomes

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

REMOVABLE PROSTHODONTICS

A. Partial Dentures

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

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

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

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

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

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

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

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

B. Complete Dentures

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

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

   LIBERTY allows one denture per 60 months per arch

C. Interim Complete Dentures

These non-covered appliances are only intended to replace teeth during the healing period, prior to fabrication of a subsequent, covered complete denture. The need for replacement of an interim or immediate denture is not evidence of inappropriate care or wrongdoing. However, the management of patient expectation must be performed by the treating dentist to ensure that the participant understands the need for replacement dentures so soon after having the first set, including the acceptance of any additional cost.

D. Repairs and Relines

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

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

SECTION 9. SPECIALTY CARE REFERRAL GUIDELINES

SPECIALTY CARE REFERRAL

Specialty Care Direct Referral Requests

For Specialty Care, we allow Direct Referral for participants to seek treatment at a contracted specialist without prior approval/referral from LIBERTY.

For Network General Dentists: The referral must be made to a network specialist. If there is no network specialist available, you must obtain prior authorization from LIBERTY. All referrals must be made in compliance with Plan Referral Guidelines. Please have the participant sign and date all Specialty Referral Request Forms. All necessary diagnostic x-rays must be attached and sent to the network specialist.

For Network Specialists: Only the covered services referred by the Network General Dentist may request authorization for any covered service not listed on the referral form by submitting a pre-authorization on an ADA approved claim form.

Additional details are included in the Specialty Care Direct Referral Request Form available on our **Provider Portal** at: https://www.libertydentalplan.com/Providers/Provider-Self-Service-Tools/ITransact.aspx

SECTION 10. 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 participants, including participants 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 his/her designee, oversees the QMI Program and ensures that day-to-day quality assurance functions are carried out in compliance with dental program contracts and applicable requirements.

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 participants. 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 participant'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 participants' dental health. LIBERTY also implements measures to prevent any further decline in condition or deterioration of dental health status when a participant's condition is not amenable to improvement. LIBERTY has established quality-of-care guidelines that include recommendations developed by organizations and specialty groups such as the American Academy of Pediatric Dentistry, the American Academy of Endodontists, the American Academy of Periodontists, the American Association of Oral Surgeons and the American Dental Association. LIBERTY applies these guidelines equally to Primary Dental Providers and specialists and uses them to evaluate care provided to participants.

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, participant rights and responsibility, and participant and provider grievances and appeals. The QMI document describes the programs and processes and activities that make up this integrated effort.

- Providing immediate and responsive feedback to participants, 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
- Participant health education

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

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

QUALITY MANAGEMENT PROGRAM CONTENT AND 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 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:** 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, Utilization Management or Potential Quality Issue (PQI) Committees.
    - **Quality Assurance Review**: The Quality Assurance Review process is intended to assess the structure, process and outcome of dental care provided under LIBERTY's programs. The quality assessment's goal is to identify any significant deficient areas, so quality improvement actions may be taken to ensure the office meets professionally recognized standards.
    - **Pre-Contractual Facility Review:** When required by client or regulation, a pre-contractual facility audit is conducted as a part of the initial contracting process. An

applicable On-Site Assessment Structural Review audit tool will be used, and the audit will be performed by a trained and calibrated auditor. A non-passing score must be reviewed by the Dental Director, or designee, to determine whether a Corrective Action Plan (CAP) must be implemented before active provider status is received.

- **Focus Reviews**: The Dental Director or designee may determine the need for focus reviews triggered by various findings such as PQIs, grievances, utilization outlier status, potential fraud, waste or abuse or other administrative reasons.

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

- **Access and Availability**: LIBERTY's AA Committee has established standards for geographic access and for timeliness of preventive care appointments, routine appointments, urgent appointments, emergency care, after hours care access, wait time in the provider office, and elements of telephone service. Opportunities for improvement are identified, decisions are made, and specific interventions are implemented to improve performance where needed. Compliance with access and availability standards 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 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 participants, 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. 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. The PRC is focused improving care to participants and minimizing potential risk cases, identifying trends of questionable care and developing corrective action plans to ensure resolutions. The PRC identifies opportunities for improvement, with the goal of examining complex cases and options for treatment across the spectrum of care. LIBERTY's Peer Review activities routinely include the participation of providers and specialists when appropriate.
    - **Potential Quality Issues (PQIs):** As part of the QMI Program, LIBERTY has policies and procedures in place that allow us to investigate PQIs from a variety of sources, and then routinely collate quality information about providers. LIBERTY commonly investigates PQIs from grievances ruled against the dental provider, office onsite assessments with deficient critical or structural indicators, aberrant utilization patterns, significant departure from expected contractual behavior or compliance, external vendor and business partner identification, and others. The Dental Director or designee reviews each case to assess the quality of care/service provided and provides a determination for corrective action based on the severity of an individual case. Follow-up actions, including provider counseling and/or CAPs are required of all involved providers for whom a quality-of-care or service issue is confirmed.
- **Grievances and Appeals:** The grievance unit investigates and resolves issues for the services or operations that are the subject of concern and ensures that issues presented by LIBERTY participants are resolved in a fair and timely manner. LIBERTY's grievance and appeal program, policies and procedures are consistent with applicable program, state and/or federal requirements.
- **Utilization Data Review:** The goal of the UM Committee is to maximize the effectiveness of care provided to the participant. The UM 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 contractual requirements and federal regulations, while providing participants access to high-quality, cost-effective medically necessary care.

The focus of the UM program is on:

- Evaluating requests for dental care services by determining whether the service or good is Medical Necessary consistent with the Participant'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 Participant partnership
- Facilitating communication and partnerships among Participants, families, Dental Providers, Medicaid health plans, other Medicaid dental plans, and LIBERTY in an effort to enhance cooperation and appropriate utilization of dental care services
- Reviewing, revising and developing dental services coverage policies to ensure Participants have appropriate access to new and emerging care and technology
- Enhancing the coordination and minimizing barriers in the delivery of dental care services

Medically Necessary Services

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

- Be necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain
- Be individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the patient's needs
- Be consistent with generally accepted professional medical standards as determined by the Medicaid program, and not experimental or investigational
- Be reflective of the level of service that can be safely furnished, and for which is not equally effective and more conservative or less costly treatment is available statewide
- Be furnished in a manner not primarily intended for the convenience of the recipient, the recipient's caretaker, or the provider

The fact that a provider has prescribed, recommended, or approved dental care, goods, or services does not, in itself, make such care, goods or services medically necessary or a medical necessity or a covered service.

In addition, each Medically Necessary service must be sufficient in amount, duration and scope to reasonably achieve its purpose.

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 Participants' coverage, and the appropriateness of such care and services, and to determine the extent of coverage and payment to Providers of care.

LIBERTY does not reward its employees or any or other individuals or entities performing UM activities for issuing denials of coverage, services or care. LIBERTY does not provide financial incentives to encourage or promote underutilization.

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 Missouri 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
- Medicaid Dental Plan Contract
- Dental Handbooks, as appropriate
- Missouri and federal statutes and laws
- Medicaid guidelines

LIBERTY's Missouri Dental Director or other qualified clinical reviewer involved in the UM process apply the definition of Medical Necessity criteria in context with the participant's individual circumstance and the capacity of the local dental services provider delivery system. When the above criteria do not address the individual participant'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 by contacting

LIBERTY's Utilization Management Department via Provider Services. The phone number is listed on LIBERTY's website at www.libertydentalplan.com.

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 participant and provider satisfaction surveys. Participant satisfaction surveys assess the quality and appropriateness of care to participants, while provider satisfaction surveys summarize and provide analysis of opportunities for improvement. Other opportunities to implore participant and provider input include:

- Participant
    - Correspondence sent to our Member Services Department
    - Grievance and appeal actions

    - Call center interaction with participants
- Provider
    - Training seminars
    - Visits to provider offices
    - Local/regional meetings
    - Participation in dental associations and other dental organizations
    - Call center interaction with participants

PROVIDER COLLABORATION

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

- Completion of a Participating Provider Agreement
- Distribution of a LIBERTY Provider Reference Guide to each provider
- Each applying dentist's completion of a provider profile form, which gives us the information needed to conduct a first-level assessment of the dentist's qualifications
- A comprehensive credentialing process that adheres to NCQA standards
- Targeted structural and/or process audits of providers who have been identified through utilization analysis and grievance and satisfaction data as having potential quality issues
- Random structural reviews that assess the provider's physical facility, as well as the provider's office protocols regarding emergencies, booking appointments, sterilization and related procedures
- Chart audits that assess the provider's process of care and conformity with professional dental practice, appropriate dental management and quality of care standards
- Re-credentialing of each network provider every 36 months
- A formal provider 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 our **Provider Portal** at:
https://www.libertydentalplan.com/Providers/Provider-Self-Service-Tools/ITransact.aspx

Corrective Action Plans (CAP)

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

- Clinical peer review
- Special claims review
- Referral to the applicable state dental board
- Onsite assessments
- Mandatory prior authorization
- Participant 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 participants receive necessary and adequate care in accordance with professionally recognized standards, and to ensure that the participants receive and enjoy the full range of their covered benefits. In addition, LIBERTY is concerned that continuity of care for covered participants 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

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

- Current State dental license for each participating dentist;
- Current DEA license, (does not apply to Orthodontists);
- Current evidence of malpractice insurance for at least one million ($1,000,000) per incident and three million ($3,000,000) annual aggregate for each participating dentist;

- Current certificate of a recognized training residency program with completion, (for specialists);
- Current permit of general anesthesia or conscious oral sedation, if administered, for the appropriate dentist;
- Immediate notification of any professional liability claims, suits, or disciplinary actions;
- Verification is made by referencing the State Dental Board and National Practitioner Data Bank.

All provider credentials are continually monitored and updated on an on-going basis. Providers will receive notification of planned or pending re-credentialing activities at least 60 days prior to the end of the 36-month period since the last credentialing cycle. This lead time allows providers an opportunity to submit current copies of the requested documents.

PROVIDER ONBOARDING AND ORIENTATION

For all accepted providers, the local Professional Relations Representative presents a provider orientation within 30 days after activation at which time the provider receives a copy of LIBERTY's Provider Reference Guide (this guide). This Provider Reference Guide obligates all providers to abide by LIBERTY's QMI Program Policies and Procedures. The Reference Guide is considered an addendum to the Provider Agreement and incorporated into the Provider Agreement by reference. To resolve any issues for the new provider, and following orientation, a representative will make a follow-up service call within 60 days either in person or by telephone.

LIBERTY maintains detailed information for each provider including credentialing information, quality and utilization performance metrics, audit results, copies of signed agreements, addenda, and related business correspondence.

GRIEVANCES, PROVIDER CLAIMS COMPLAINTS AND APPEALS

All participant and provider complaints, grievances, disputes, and appeals are received and processed by LIBERTY. No aspect of this process is delegated to an outside entity.

In order to provide excellent service to our participants, LIBERTY maintains a process by which participants can obtain timely resolution to their inquiries and complaints. This process allows for:

- The receipt of correspondence from participants, in writing or by telephone;
- Thorough research;
- Participant education on plan provisions;
- Timely resolution.
- Initiating a State Fair Hearing within ninety (90) days of LIBERTY's action or appeal

PARTICIPANT GRIEVANCES (COMPLAINTS)

Definition: any written or oral expression of dissatisfaction that is not a request for a review of an adverse benefit determinations. Medicaid participant grievances can be submitted at any time and do not have a timely filing limitation in accordance with federal regulations.

The LIBERTY participant grievance process encompasses investigation, review and resolution of participant issues. Participants can submit a grievance via telephone, fax, e-mail, letter, or grievance form. Grievance forms can be obtained from LIBERTY's Member Services Department or LIBERTY's website as forms must be kept in your dental facility and given to participants when

appropriate. Providers must be aware of how to assist a participant in filing a grievance and know how to provide a grievance form to a participant upon request.

The LIBERTY Intake Analyst mails notification of the receipt of a standard grievance to the participant and provider within 10 business days. Standard grievances are resolved within 30 calendar days unless an expedited issue is identified, in which cases, those issues are resolved within 72 hours or sooner as required.

As a contracted provider, you have agreed to fully cooperate with quality management processes such as the grievance resolution process. You may be contacted to provide copies of records (including, but not limited to, x-rays, progress notes, financial documents, etc.) and a narrative of your perception of the incident. In most cases the Grievances and Appeals Analysts and Staff Dentist seek to provide additional explanation to the grieving participant and relies on your records to do so. Collection of all necessary information to properly evaluate each grievance is imperative. If the necessary information is not received, LIBERTY will be required to make a determination using only the information provided by the participant and the information on file. Failure to provide the necessary information could lead to corrective actions, that include, but are not limited to, participant reimbursement or office counseling.

LIBERTY can only help you through the grievance process with your cooperation in supplying complete records. LIBERTY's Grievances and Appeals Analyst records and reviews all participant issues involving complaints, grievances or appeals and is responsible for the collection of all necessary and appropriate documentation needed to reach a fair and accurate resolution. Any issue relating to technical quality of dentistry rendered by a network provider is reviewed by a licensed Staff Dentist. In order to identify systemic deficiencies, the Grievances and Appeals Analyst completes the case investigation and then a grievance history review is performed.

PARTICIPANT APPEALS

Definition: A request made to LIBERTY by a participant, authorized representative or a provider acting on behalf of a participant to review an action by the Plan, including, but not limited to, a delay, modification or denial of services or a previous grievance determination. Medicaid participants may appeal any resolutions or claims determination made by LIBERTY. The request for appeal must be received by LIBERTY within 60 calendar days of receipt of the initial adverse determination.

The Grievances and Appeals Analyst will compile all the information used in the initial determination and any additional information received and forward it to a Staff Dentist or Dental Director. LIBERTY will review any appeal with Staff Dentist or Dental Director having no prior involvement in the decision and no vested interest in the case.

PROVIDER COMPLAINTS

Definition: A grievance, appeal or request for reconsideration of a claim payment that has been denied, adjusted or contested or a dispute over reimbursement requested through an overpayment notice received from a contracted or non-contracted provider. Provider Complaints can be submitted in writing, electronically, via regular mail and must be submitted within the below timeframes:

- Non-Claim related complaints: within 45 days from the date the issue occurred

- Claim related complaints or appeals: within 90 days from the date of final determination of the claim

Providers may register a complaint (or appeal) to LIBERTY's Grievances and Appeals Department at the contact information listed below regarding any aspect of business dealings with LIBERTY or on behalf of a participant/patient. Complaints, grievances, disputes or appeals submitted on behalf of a participant/patient will be addressed through LIBERTY's participant appeal process and require written consent/authorization from the participant/patient. A provider complaint submitted on behalf of a participant will **not** be resolved through LIBERTY's Provider Complaint Resolution Process. Complaints, grievances, disputes or appeals from a provider or on behalf of the participant/patient must include any supporting documentation that may help yield a satisfactory resolution, including any requested action or outcome to resolve the issue.

Issues relating to contracted or formerly contracted providers who believe they have been adversely impacted by the policies, procedures, decisions, or actions of LIBERTY may also be submitted to the Grievances and Appeals Department in accordance with LIBERTY's Provider Complaint Resolution Policy.

Each contracted provider complaint must contain, at a minimum, the following information: provider's name; provider's license number, provider's contact information, and:

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

For **claims related** complaints, LIBERTY will acknowledge the receipt of a provider's complaint within 10 business days of receipt either verbally or in writing along with the expected date of resolution as well as in writing within 10 business days that we have received the complaint. A final resolution will be provided to the provider in writing within 30 calendar days of receipt of all information necessary to make a fair and accurate decision or such other time as required by the Government Authority.

For **non-claims related** complaints, LIBERTY will acknowledge the receipt of a provider complaint within 10 business days of receipt either verbally or in writing along with the expected date of resolution. A final resolution will be provided to the provider in writing within 30 calendar days of receipt of all information necessary to make a fair and accurate decision or such other time as required by a Government Authority

Sending a Contracted Provider Complaint to LIBERTY must include the information listed above for each contracted provider complaint. All contracted provider complaints must be sent to the attention of the Grievances and Appeals Department at the following address:

	**LIBERTY Dental Plan** **ATTN: Grievances and Appeals Department** P.O. Box 401086 Las Vegas, NV 89140		**Grievance & Appeals Team** M-F from 8 am – 8 pm **(Central)** (866) 609-0420
	Email at GandA@libertydentalplan.com		

Time Period for Submission of Provider Complaints

Medicaid contracted provider grievances, complaints or appeals for a claims related issue must be received by LIBERTY within 90 calendar days from the action that led to the complaint (or the most recent action if there are multiple actions). Non-claims related complaints must be received within 45 days of the date of the issue. LIBERTY may allow exceptions on a case-by-case basis, pending the receipt of good cause from the provider explaining the delay.

Contracted Provider Complaint Inquiries

All inquiries regarding the status of a contracted provider complaint or about filing a contracted provider complaint must be directed to the Grievances and Appeals Department at: (866) 609-0420.

A summary of the Provider Complaint timeframes is listed below:

Provider Complaint Type	Provider Timeframe to Submit Complaint	Acknowledgement Timeframe of Receipt of Complaint	LIBERTY Timeframe to Resolve Complaint
Claims Related	90 days from final determination of the claim	• 10 business days of receipt, verbally or in writing	• Within 30 calendar days of receipt
Non-Claims Related	45 days from date the issue occurred	• 10 business days of receipt, verbally or in writing	• Within 30 calendar days of receipt

SECTION 11. FRAUD, WASTE AND ABUSE

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

Reporting Fraud, Waste and Abuse

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

LIBERTY has included the U.S. Department of Health & Human Services, Office of Inspector General (HHS-OIG) Whistle Phone number to report suspected FWA confidentially by dialing 1-800-HHS-TIPS 1-800-377-4950 or TTY 1-800-377-4950.

Providers must report all instances of suspected fraud, waste, and abuse.

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; and,
- Soliciting, offering or receiving a kickback, bribe or rebate.

Waste includes practices that, directly or indirectly, result in unnecessary costs to the Medicaid 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; and,
- Misuse of resources.

Abuse includes actions that may, directly or indirectly, result in unnecessary costs to the Medicaid 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; and,
- Billing for services that were not medically necessary.

Both fraud and abuse can expose providers to criminal and civil liability.

LIBERTY expects all of its 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

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 participants. 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 participants' medication fraud.

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

State and federal regulations require mandatory Compliance and FWA Training to be completed by providers and subcontractors, as well as their employees, within 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, MO HealthNet, 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 at 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 12. FORMS

Electronic forms are available for download from LIBERTY Dental Plan's **Provider Portal** at:
https://www.libertydentalplan.com/Providers/Provider-Self-Service-Tools/ITransact.aspx

SECTION 13. MISSOURI CARE MEDICAID PLAN BENEFITS

MEDICAID PROGRAM OVERVIEW

Medicaid provides medical coverage to eligible, low-income children, seniors, disabled adults and pregnant women. The state and federal government share the costs of the Medicaid program.

CHILD & FOSTER CARE MEDICAID PLAN BENEFITS

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

Code	Description	Limitations	Pre-Authorization Required	Documentation/ X-Rays Required
Diagnostic Services				
D0120	Periodic oral evaluation	1 of (D0120, D0145) every 6 month(s) per provider or location. Not within 6 months of D0150.		
D0140	Limited oral evaluation	Not reimbursable on the same day as D0120 and D0150. Not allowed on same day as Non-Emergency definitive treatment.		
D0145	Oral evaluation under age 3	1 of (D0120, D0145) every 6 month(s) per provider or location. Not within 6 months of D0150.		
D0150	Comprehensive oral evaluation	1 (D0150) in a Lifetime per provider or location. Not within 6 months of D0120 or D0145.		
D0171	Re-evaluation, post-operative office visit	1 (D0171) every 6 month(s)		
D0210	Intraoral, complete series of radiographic images	1 of (D0210, D0330) every 24 month(s)		
D0220	Intraoral, periapical, first radiographic image	1 (D0220) every day		
D0230	Intraoral, periapical, each add'l radiographic image			
D0240	Intraoral, occlusal radiographic image	2 (D0240) every 24 month(s)		
D0250	Extra-oral 2D projection radiographic image, stationary radiation source	1 (D0250) every day		

Code	Description	Limitations	Pre-Authorization Required	Documentation/ X-Rays Required
D0270	Bitewing, single radiographic image	1 of (D0270, D0272, D0274 or D0277) every 6 month(s)		
D0272	Bitewings, two radiographic images			
D0274	Bitewings, four radiographic images			
D0277	Vertical bitewings, 7 to 8 radiographic images			
D0310	Sialography			Narrative of medical necessity with claim submission
D0330	Panoramic radiographic image (age 6-20)	1 of (D0210, D0330) every 24 month(s). D0330 for ages 6 and over.		
D0340	2D cephalometric radiographic image, measurement and analysis	Only covered for orthodontic purposes		
D0350	2D oral/facial photographic image, intra-orally/extra-orally	Narrative of medical necessity shall be maintained in participant records		
D0351	3D photographic image	1 (D0351) every 12 month(s)		
D0415	Collection of micro-organisms for culture	Narrative of medical necessity shall be maintained in participant records		Narrative of medical necessity with claim submission
D0460	Pulp vitality tests	2 (D0460) every 12 month(s). Includes multiple teeth and contralateral comparison(s). Narrative of medical necessity shall be maintained in participant records		
Preventive Services				
D1110	Prophylaxis, adult	1 of (D1110, D4910) every 6 month(s). D1110 for ages 13 and over		
D1120	Prophylaxis, child	1 (D1120) every 6 month(s)		
D1206	Topical application of fluoride varnish	1 (D1206) every 6 month(s)		
D1208	Topical application of fluoride, excluding varnish	1 (D1208) every 6 month(s)		

Code	Description	Limitations	Pre-Authorization Required	Documentation/ X-Rays Required
D1351	Sealant, per tooth	1 of (D1351, D1353) every 3 year(s) per tooth. Sealants may be placed on the occlusal or occlusal-buccal surfaces of lower molars or occlusal or occlusal-lingual surfaces of upper molars. Teeth must be caries free. Sealant will not be covered when placed over restorations. D1351 for ages 5 and over.		
D1353	Sealant repair, per tooth			
D1354	Interim caries arresting medicament application, per tooth	1 (D1354) every 6 month(s) per tooth. 4 (D1354) in a Lifetime per tooth. Not allowed with history of any prior or same day D2000, D3000 code series on same tooth. Ages 0-5		
D1510	Space maintainer, fixed, unilateral	1 of (D1510, D1520) every 24 month(s) per quadrant		
D1516	Space maintainer, fixed, bilateral, maxillary	1of (D1516, D1517, D1526, D1527) every 24 month(s) per arch		
D1517	Space maintainer, fixed, bilateral, mandibular			
D1520	Space maintainer, removable, unilateral	1 of (D1510, D1520) every 24 month(s) per arch		
D1526	Space maintainer, removable, bilateral, maxillary	1 of (D1516, D1517, D1526, D1527) every 24 month(s) per arch		Narrative of medical necessity with claim submission
D1527	Space maintainer, removable, bilateral, mandibular			
D1550	Re-cement or re-bond space maintainer	Not covered within 6 month(s) of placement		

Code	Description	Limitations	Pre-Authorization Required	Documentation/ X-Rays Required
Restorative Services				
D2140	Amalgam, one surface, primary or permanent	1 of (D2140-D2335, D2391-D2394) every 6 month(s) per tooth, per surface		
D2150	Amalgam, two surfaces, primary or permanent			
D2160	Amalgam, three surfaces, primary or permanent			
D2161	Amalgam, four or more surfaces, primary or permanent			
D2330	Resin-based composite, one surface, anterior			
D2331	Resin-based composite, two surfaces, anterior			
D2332	Resin-based composite, three surfaces, anterior			
D2335	Resin-based composite, four or more surfaces, involving incisal angle			
D2390	Resin-based composite crown, anterior	1 (D2390) every 6 month(s) per tooth		
D2391	Resin-based composite, one surface, posterior	1 of (D2140-D2335, D2391-D2394) every 6 month(s) per tooth, per surface		
D2392	Resin-based composite, two surfaces, posterior			
D2393	Resin-based composite, three surfaces, posterior			
D2394	Resin-based composite, four or more surfaces, posterior			
D2710	Crown, resin-based composite (indirect)	1 of (D2710-D2792) every 60 month(s) per tooth		Pre-op x-ray with claim submission
D2720	Crown, resin with high noble metal			
D2721	Crown, resin with predominantly base metal			

Code	Description	Limitations	Pre-Authorization Required	Documentation/ X-Rays Required
D2722	Crown, resin with noble metal	1 of (D2710-D2792) every 60 month(s) per tooth		Pre-op x-ray with claim submission
D2740	Crown, porcelain/ceramic			
D2750	Crown, porcelain fused to high noble metal			
D2751	Crown, porcelain fused to predominantly base metal			
D2752	Crown, porcelain fused to noble metal			
D2780	Crown, ¾ cast high noble metal			
D2781	Crown, ¾ cast predominantly base metal			
D2782	Crown, ¾ cast noble metal			
D2783	Crown, ¾ porcelain/ceramic			
D2790	Crown, full cast high noble metal			
D2791	Crown, full cast predominantly base metal			
D2792	Crown, full cast noble metal			
D2910	Re-cement or re-bond inlay, onlay, veneer, or partial coverage	Not covered within 6 months of placement		
D2920	Re-cement or re-bond crown	Not covered within 6 months of placement		
D2929	Prefabricated porcelain/ceramic crown, primary tooth	1 of (D2929-D2934) every 36 month(s) per tooth		
D2930	Prefabricated stainless-steel crown, primary tooth			
D2931	Prefabricated stainless-steel crown, permanent tooth			
D2932	Prefabricated resin crown			
D2933	Prefabricated stainless-steel crown with resin window			
D2934	Prefabricated esthetic coated stainless steel crown, primary tooth			

Code	Description	Limitations	Pre-Authorization Required	Documentation/ X-Rays Required
D2940	Protective restoration	Temporary restoration intended to relieve pain. Not to be used as a base liner or under a restoration		
D2950	Core buildup, including any pins when required	1 of (D2950, D2952, D2954) every 60 month(s) per tooth		
D2951	Pin retention, per tooth, in addition to restoration	1 (D2951) in a Lifetime per tooth		
D2952	Post and core in addition to crown, indirectly fabricated	1 of (D2950, D2952, D2954) every 60 month(s) per tooth		
D2954	Prefabricated post and core in addition to crown			
D2980	Crown repair necessitated by restorative material failure	1 (D2980) in a Lifetime per tooth		Pre-op x-ray and narrative of medical necessity with claim submission
Endodontic Services				
D3110	Pulp cap, direct (excluding final restoration)	1 (D3110) per Lifetime per tooth		
D3120	Pulp cap, indirect (excluding final restoration)	1 (D3120) in a Lifetime per tooth Not payable in conjunction with (D3110, D3220, D3221, D3222, D3230, D3310, D3330, D3351, D3352, D3353, D3410). This procedure code is not utilized as a protective liner when caries are not in close proximity to the pulp.		Pre-Op x-rays with claim submission
D3220	Therapeutic pulpotomy (excluding final restoration)	Not to be used by Provider completing endodontic treatment (D3220 or D3221)		
D3221	Pulpal debridement, primary and permanent teeth			

Code	Description	Limitations	Pre-Authorization Required	Documentation/ X-Rays Required
D3310	Endodontic therapy, anterior tooth (excluding final restoration)	1 of (D3310 – D3330) in a Lifetime per tooth		Pre-op x-ray with claim submission
D3320	Endodontic therapy, premolar tooth (excluding final restoration)			
D3330	Endodontic therapy, molar tooth (excluding final restoration)			
D3346	Retreatment of previous root canal therapy, anterior	1 of (D3346-D3348) in a Lifetime per tooth. Same Provider may not submit within two years of root canal therapy		Pre-op x-ray with claim submission
D3347	Retreatment of previous root canal therapy, premolar			
D3348	Retreatment of previous root canal therapy, molar			
D3348	Retreatment of previous root canal therapy, molar			
D3351	Apexification/recalcification, initial visit			Pre-op x-ray with claim submission
D3352	Apexification/recalcification, interim medication replacement			Pre-op x-ray with claim submission
D3353	Apexification/recalcification, final visit			Pre-op x-ray with claim submission
D3410	Apicoectomy, anterior	1 of (D3410-D3425) in a Lifetime per tooth		Pre-op x-ray with claim submission
D3421	Apicoectomy, premolar (first root)			
D3425	Apicoectomy, molar (first root)			
D3426	Apicoectomy (each additional root)	1 (D3426) in a Lifetime per tooth		Pre-op x-ray with claim submission
D3450	Root amputation, per root	1 (D3450) in a Lifetime per tooth	Yes	Pre-op x-ray and narrative of medical necessity
D3910	Surgical procedure for isolation of tooth with rubber dam		Yes	Pre-op x-ray and narrative of medical necessity

Code	Description	Limitations	Pre-Authorization Required	Documentation/ X-Rays Required
Periodontal Services				
D4210	Gingivectomy or gingivoplasty, four or more teeth per quadrant	1 of (D4210, D4211) every 36 month(s) per quadrant		Pre-op x-ray, periodontal charting and narrative of medical necessity with claim submission
D4211	Gingivectomy or gingivoplasty, one to three teeth per quadrant			
D4212	Gingivectomy or gingivoplasty, restorative procedure, per tooth	1 (D4212) every 36 month(s) per tooth		Pre-op x-ray, periodontal charting and narrative of medical necessity with claim submission
D4240	Gingival flap procedure, four or more teeth per quadrant	1 of (D4240, D4241) every 36 month(s) per quadrant		Pre-op x-ray, periodontal charting and narrative of medical necessity with claim submission
D4241	Gingival flap procedure, one to three teeth per quadrant			
D4245	Apically positioned flap	1 (D4245) in a Lifetime per quadrant		Pre-op x-ray, periodontal charting and narrative of medical necessity with claim submission
D4249	Clinical crown lengthening, hard tissue	1 (D4249) in a Lifetime per quadrant		Pre-op x-ray, periodontal charting and narrative of medical necessity with claim submission
D4260	Osseous surgery, four or more teeth per quadrant	1 of (D4260, D4261) every 36 month(s) per quadrant	Yes	Pre-op x-ray, periodontal charting and narrative of medical necessity
D4261	Osseous surgery, one to three teeth per quadrant		Yes	
D4263	Bone replacement graft, retained natural tooth, first site, quadrant	1 (D4263) every 36 month(s) per tooth	Yes	Pre-op x-ray, periodontal charting and narrative of medical necessity
D4264	Bone replacement graft, retained natural tooth, each additional site	2 of (D4264) every 36 month(s) per tooth	Yes	Pre-op x-ray, periodontal charting and narrative of medical necessity
D4265	Biologic materials to aid in soft and osseous tissue regeneration		Yes	Pre-op x-ray, periodontal charting and narrative of medical necessity
D4266	Guided tissue regeneration, resorbable barrier, per site	1 of (D4266, D4267, D4270-D4278) every 36 month(s) per tooth or site	Yes	Pre-op x-ray, periodontal charting and narrative of medical necessity
D4267	Guided tissue regeneration, non-resorbable barrier, per site		Yes	

Code	Description	Limitations	Pre-Authorization Required	Documentation/ X-Rays Required
D4268	Surgical revision procedure, per tooth	1 (D4268) every 36 month(s) per quadrant	Yes	Pre-op x-ray, periodontal charting and narrative of medical necessity
D4270	Pedicle soft tissue graft procedure	: 1 of (D4266, D4267, D4270-D4278) every 36 month(s) per tooth or site	Yes	Pre-op x-ray, periodontal charting and narrative of medical necessity
D4273	Autogenous connective tissue graft procedure, first tooth		Yes	
D4274	Mesial/distal wedge procedure, single tooth		Yes	
D4275	Non-autogenous connective tissue graft, first tooth		Yes	
D4276	Combined connective tissue & double pedicle graft		Yes	
D4277	Free soft tissue graft, first tooth		Yes	
D4278	Free soft tissue graft, each additional tooth		Yes	
D4320	Provisional splinting, intracoronal	1 of (D4320, D4321) in a Lifetime per arch		Pre-op x-ray, periodontal charting and narrative of medical necessity with claim submission
D4321	Provisional splinting, extracoronal			
D4341	Periodontal scaling and root planing, four or more teeth per quadrant	1 of (D4341, D4342) every 24 month(s) per quadrant		Pre-op x-ray and periodontal charting with claim submission
D4342	Periodontal scaling and root planing, one to three teeth per quadrant			

Code	Description	Limitations	Pre-Authorization Required	Documentation/ X-Rays Required
D4355	Full mouth debridement to enable comprehensive evaluation and diagnosis, subsequent visit	1 (D4355) in a Lifetime. Not allowed within 6 months after D1110. Payment allowed with D0140. Not payable with D0120 or D0150.	Yes	Pre-op x-ray and narrative of medical necessity
D4910	Periodontal maintenance procedures	1 of (D1110, D1120, D4910) every 6 months		
D4920	Unscheduled dressing change (other than treating dentist or staff)			
Removable Prosthodontic Services				
D5110	Complete denture, maxillary	1 of (D5110 – D5120) every 60 month(s) per arch. Not within 60 months of D5130, D5140.		Pre-op x-ray with claim submission
D5120	Complete denture, mandibular			
D5130	Immediate denture, maxillary	1 of (D5130, D5140) in a Lifetime		Pre-op x-ray with claim submission
D5140	Immediate denture, mandibular			
D5211	Maxillary partial denture, resin base	1 of (D5211-D5226) every 60 month(s) per arch. Minimum of one or more anterior teeth or 3 or more posterior teeth (excluding 3rds) For age 8 and over		Pre-op x-ray with claim submission
D5212	Mandibular partial denture, resin base			
D5213	Maxillary partial denture, cast metal, resin base			
D5214	Mandibular partial denture, cast metal, resin base			
D5225	Maxillary partial denture, flexible base			
D5226	Mandibular partial denture, flexible base			

Code	Description	Limitations	Pre-Authorization Required	Documentation/ X-Rays Required
D5410	Adjust complete denture, maxillary	1 of (D5410-D5422) every 12 month(s) per arch. Not covered within 6 months of placement of denture or after rebase/reline		
D5411	Adjust complete denture, mandibular			
D5421	Adjust partial denture, maxillary			
D5422	Adjust partial denture, mandibular			
D5511	Repair broken complete denture base, mandibular			
D5512	Repair broken complete denture base, maxillary			
D5520	Replace missing or broken teeth, complete denture			
D5611	Repair resin partial denture base, mandibular			
D5612	Repair resin partial denture base, maxillary			
D5621	Repair cast partial framework, mandibular	Covered for age 8 and over		
D5622	Repair cast partial framework, maxillary	Covered for age 8 and over		
D5630	Repair or replace broken retentive/clasping materials, per tooth			
D5640	Replace broken teeth, per tooth			
D5650	Add tooth to existing partial denture			

Code	Description	Limitations	Pre-Authorization Required	Documentation/ X-Rays Required
D5660	Add clasp to existing partial denture, per tooth			
D5710	Rebase complete maxillary denture	1 of (D5710-D5761) every 36 month(s) per arch. Not covered within 12 months of placement		
D5711	Rebase complete mandibular denture			
D5720	Rebase maxillary partial denture			
D5721	Rebase mandibular partial denture			
D5730	Reline complete maxillary denture, chairside			
D5731	Reline complete mandibular denture, chairside			
D5740	Reline maxillary partial denture, chairside			
D5741	Reline mandibular partial denture, chairside			
D5750	Reline complete maxillary denture, laboratory			
D5751	Reline complete mandibular denture, laboratory			
D5760	Reline maxillary partial denture, laboratory			
D5761	Reline mandibular partial denture, laboratory			
D5820	Interim partial denture, maxillary	1 of (D5820, D5821) in a Lifetime. Not covered within 24 months of (D5211, D5212, D5213, D5214, D5225 or D5226)		Pre-op x-ray with claim submission
D5821	Interim partial denture, mandibular			
D5850	Tissue conditioning, maxillary	1 of (D5850, D5851) every 60 months. Prior to new denture impressions only		
D5851	Tissue conditioning, mandibular			

Code	Description	Limitations	Pre-Authorization Required	Documentation/ X-Rays Required
Fixed Prosthodontic Services				
D6205	Pontic, indirect resin-based composite	1 of (D6205-D6549, D6720-D6792) every 60 months, per tooth	Yes	Pre-op x-ray and narrative of medical necessity
D6210	Pontic, cast high noble metal		Yes	
D6211	Pontic, cast predominantly base metal		Yes	
D6212	Pontic, cast noble metal		Yes	
D6240	Pontic, porcelain fused to high noble metal		Yes	
D6241	Pontic, porcelain fused to predominantly base metal		Yes	
D6242	Pontic, porcelain fused to noble metal		Yes	
D6245	Pontic, porcelain/ceramic		Yes	
D6250	Pontic, resin with high noble metal		Yes	
D6251	Pontic, resin with predominantly base metal		Yes	
D6252	Pontic, resin with noble metal		Yes	
D6545	Retainer, cast metal for resin bonded fixed prosthesis		Yes	
D6548	Retainer, porcelain/ceramic, resin bonded fixed prosthesis		Yes	
D6549	Resin retainer, for resin bonded fixed prosthesis		Yes	

Code	Description	Limitations	Pre-Authorization Required	Documentation/ X-Rays Required
D6720	Retainer crown, resin with high noble metal	1of (D6205-D6549, D6720-D6792) every 60 months per tooth	Yes	Pre-op x-ray and narrative of medical necessity
D6721	Retainer crown, resin with predominantly base metal		Yes	
D6722	Retainer crown, resin with noble metal		Yes	
D6740	Retainer crown, porcelain/ceramic		Yes	
D6750	Retainer crown, porcelain fused to high noble metal		Yes	
D6751	Retainer crown, porcelain fused to predominantly base metal		Yes	
D6752	Retainer crown, porcelain fused to noble metal		Yes	
D6780	Retainer crown, ¾ cast high noble metal		Yes	
D6781	Retainer crown, ¾ cast predominantly base metal		Yes	
D6782	Retainer crown, ¾ cast noble metal		Yes	
D6783	Retainer crown, ¾ porcelain/ceramic		Yes	
D6790	Retainer crown, full cast high noble metal		Yes	
D6791	Retainer crown, full cast predominantly base metal		Yes	
D6792	Retainer crown, full cast noble metal		Yes	
D6930	Re-cement or re-bond fixed partial denture	1 (D6930) every 60 month(s). Not covered within 6 months of placement		

Code	Description	Limitations	Pre-Authorization Required	Documentation/ X-Rays Required
D6980	Fixed partial denture repair, restorative material failure	1 (D6980) in a Lifetime per site		Pre-op x-ray and narrative of medical necessity with claim submission
Oral & Maxillofacial Services				
D7111	Extraction, coronal remnants, primary tooth			
D7140	Extraction, erupted tooth or exposed root			
D7210	Extraction, erupted tooth requiring removal of bone and/or sectioning of tooth	Removal of asymptomatic tooth not covered		Pre-op x-ray with claim submission
D7220	Removal of impacted tooth, soft tissue	Removal of asymptomatic tooth not covered	Yes	Pre-op x-ray
D7230	Removal of impacted tooth, partially bony		Yes	
D7240	Removal of impacted tooth, completely bony		Yes	
D7241	Removal impacted tooth, complete bony, complication	Unusual complications such as nerve dissection, separate closure of the maxillary sinus or aberrant tooth position. Removal of asymptomatic tooth not covered	Yes	Pre-op x-ray
D7250	Removal of residual tooth roots (cutting procedure)	Not payable to the dentist or group that removed the tooth.		Pre-op x-ray with claim submission
D7260	Oroantral fistula closure		Yes	Pre-op x-ray and narrative of medical necessity
D7270	Tooth reimplantation and/or stabilization, accident			Pre-op x-ray and narrative of medical necessity with claim submission
D7280	Exposure of an unerupted tooth	Will not be payable unless the orthodontic treatment has been authorized as a covered benefit		Pre-op x-ray and narrative of medical necessity with claim submission

Code	Description	Limitations	Pre-Authorization Required	Documentation/ X-Rays Required
D7283	Placement, device to facilitate eruption, impaction	1 (D7283) in a Lifetime per tooth. Requires prior approval of D8080. Only approved if in conjunction with approved orthodontic treatment		Pre-op x-ray and narrative of medical necessity with claim submission
D7285	Incisional biopsy of oral tissue, hard (bone, tooth)			Pathology Report with claim submission
D7286	Incisional biopsy of oral tissue, soft			Pathology Report with claim submission
D7287	Exfoliative cytological sample collection			Pathology Report with claim submission
D7290	Surgical repositioning of teeth			Pre-op x-ray and narrative of medical necessity with claim submission
D7291	Transseptal fiberotomy/supra crestal fiberotomy, by report			Pre-op x-ray and narrative of medical necessity with claim submission
D7296	Corticotomy, one to three teeth or tooth spaces, per quadrant	1 of (D7296, D7297) in a Lifetime per quadrant	Yes	Pre-op x-ray and narrative of medical necessity
D7297	Corticotomy, four or more teeth or tooth spaces, per quadrant		Yes	
D7310	Alveoloplasty with extractions, four or more teeth per quadrant	1 of (D7310, D7320) in a Lifetime per quadrant. D7310 or D7320 only payable in preparation of full dentures.		Pre-op x-ray and narrative of medical necessity with claim submission
D7320	Alveoloplasty, w/o extractions, four or more teeth per quadrant			
D7410	Excision of benign lesion, up to 1.25 cm		Yes	Pathology Report
D7411	Excision of benign lesion greater than 1.25 cm		Yes	Pathology Report
D7412	Excision of benign lesion, complicated		Yes	Pathology Report

Code	Description	Limitations	Pre-Authorization Required	Documentation/ X-Rays Required
D7413	Excision of malignant lesion up to 1.25 cm		Yes	Pathology Report
D7414	Excision of malignant lesion greater than 1.25 cm		zYes	Pathology Report
D7415	Excision of malignant lesion, complicated		Yes	Pathology Report
D7471	Removal of lateral exostosis, maxilla or mandible	1 (D7471) in a Lifetime per arch	Yes	Pre-op x-ray and narrative of medical necessity
D7472	Removal of torus palatinus		Yes	Pre-op x-ray and narrative of medical necessity
D7473	Removal of torus mandibularis		Yes	Pre-op x-ray and narrative of medical necessity
D7485	Surgical reduction of osseous tuberosity		Yes	Pre-op x-ray and narrative of medical necessity
D7510	Incision & drainage of abscess, intraoral soft tissue	Meet medical criteria and approval. Not allowed on same date as extraction.		Pre-op x-ray and narrative of medical necessity with claim submission
D7520	Incision & drainage of abscess, extraoral soft tissue			Pre-op x-ray and narrative of medical necessity with claim submission
D7871	Non-arthroscopic lysis and lavage			Pre-op x-ray and narrative of medical necessity with claim submission
D7960	Frenulectomy (frenectomy or frenotomy), separate procedure	1 (D7960) in a Lifetime		Narrative of medical necessity with claim submission
D7970	Excision of hyperplastic tissue, per arch	1 (D7970) in a Lifetime per arch		Narrative of medical necessity with claim submission
D7971	Excision of pericoronal gingiva			Pre-op x-ray and narrative of medical necessity with claim submission
D7972	Surgical reduction of fibrous tuberosity			Pre-op x-ray and narrative of medical necessity with claim submission

Code	Description	Limitations	Pre-Authorization Required	Documentation/ X-Rays Required
Orthodontic Services				
Prior Authorization/Pre-Authorization including Handicapping Labio-Lingual Deviation Index (HLD) Score Sheet, cephalometric and panoramic image is required for all orthodontic services. The participant must be eligible on each date of service. If the participant becomes ineligible during active orthodontic treatment, the participant is responsible to pay any remaining balance.				
D8030	Limited orthodontic treatment of the adolescent dentition	Covered based on medical necessity with Pre-Auth	Yes	X-rays, tracings, photographs and study models or OrthoCad
D8050	Interceptive orthodontic treatment of the primary dentition (age 0-12)	Covered based on medical necessity or with Pre-Auth	Yes	X-rays, tracings, photographs and study models or OrthoCad
D8060	Interceptive orthodontic treatment of the transitional dentition (age 0-12)	Covered based on medical necessity or with Pre-Auth	Yes	X-rays, tracings, photographs and study models or OrthoCad
D8080	Comprehensive orthodontic treatment of the adolescent dentition	Covered based on medical necessity or a score of 28 or higher, HLD required with Pre-Auth	Yes	X-rays, tracings, photographs and study models or OrthoCad
D8090	Comprehensive orthodontic treatment of the adult dentition	Covered based on medical necessity or a score of 28 or higher, HLD required with Pre-Auth	Yes	X-rays, tracings, photographs and study models or OrthoCad
D8210	Removable appliance therapy			Narrative of medical necessity with claim submission
D8220	Fixed appliance therapy			Narrative of medical necessity with claim submission
D8660	Pre-orthodontic treatment examination to monitor growth and development	1 (D8660) every 6 month(s)		
D8670	Periodic orthodontic treatment visit	1 (D8670) only payable when there is a paid D8080 on file. Maximum of 22 visits reimbursed		
D8680	Orthodontic retention (removal f appliances, construction and placement of retainer (s).	1 (D8680) in a Lifetime with approved orthodontic treatment		
D8695	Removal of fixed orthodontic appliances, other than completion of treatment	1 (D8695) in a Lifetime	Yes	Narrative of medical necessity
D8999	Unspecified orthodontic procedure, by report	1 (D8999) in a Lifetime for Debanding only		Photos, x-rays, final de-banding date with claim submission

Code	Description	Limitations	Pre-Authorization Required	Documentation/ X-Rays Required
Adjunctive General Services				
D9110	Palliative (emergency) treatment, minor procedure			
D9212	Injection for diagnosis purposes. It is not to be used for a second division block.			Narrative of medical necessity with claim submission
D9222	Deep sedation/general anesthesia, first 15-minute increment	1 (D9222) per day. Not allowed on same day as (D9230, D9239, D9243, D9248)		Narrative of medical necessity with claim submission
D9223	Deep sedation/general anesthesia, each subsequent 15-minute increment	Additional sedation units covered in the minimum amount necessary to complete the treatment plan. Not to be billed with (D9230, D9239, D9243 or D9248)		Narrative of medical necessity with claim submission
D9230	Inhalation of nitrous oxide/analgesia, anxiolysis	1 (D9230) per day. Not allowed on the same day as (D9222, D9223, D9239, D9243, or D9248)		Narrative of medical necessity required with claim submission
D9239	Intravenous moderate (conscious) sedation/analgesia, first 15-minute increment	1 (D9239) per day. Not allowed on same day as (D9222, D9223, D9230, D9248)		Narrative of medical necessity with claim submission
D9243	Intravenous moderate (conscious) sedation/analgesia, each subsequent 15-minute increment	Additional sedation units covered in the minimum amount necessary to complete the treatment plan. Not to be billed with (D9222, D9223, D9230 or D9248)		Narrative of medical necessity with claim submission
D9248	Non-intravenous conscious sedation	Not allowed on the same day as (D9222, D9223, D9230, D9239 or D9243)		Narrative of medical necessity with claim submission
D9310	Consultation - diagnostic service provided by dentist or physician other than requesting dentist or physician	Only payable to specialists. Not covered with any other services other than radiographs on the same day.		
D9420	Hospital or ambulatory surgical center call		Yes	Narrative of medical necessity

Code	Description	Limitations	Pre-Authorization Required	Documentation/ X-Rays Required
D9610	Therapeutic parenteral drug, single administration			Narrative of medical necessity with claim submission
D9910	Application of desensitizing medicament	Emergency treatment only		Narrative of medical necessity shall be maintained in patient records.
D9943	Occlusal guard adjustment		Yes	
D9944	Occlusal guard – hard appliance, full arch		Yes	
D9945	Occlusal guard – soft appliance, full arch		Yes	
D9995	Teledentistry – synchronous; real-time encounter			
D9996	Teledentistry – asynchronous; information stored and forwarded to dentist for subsequent review			

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

Code	Description	Limitations	Pre-Authorization Required (ADULT)	Pre-Authorization Required (PREGNANT WOMAN)	Documentation/ X-Rays Required
Diagnostic Services					
D0120	Periodic oral evaluation	1 (D0120) every 6 month(s) per provider or location. Not within 6 months of D0150	Not Covered		
D0140	Limited oral evaluation	Not reimbursable on the same day as D0120 and D0150. Not allowed on same day as Non-Emergency definitive treatment			
D0150	Comprehensive oral evaluation	1 (D0150) in a Lifetime per provider or location. Not within 6 months of D0120			
D0171	Re-evaluation, post-operative office visit	1 (D0171) every 6 month(s)	Not Covered		
D0210	Intraoral, complete series of radiographic images	1 of (D0210, D0330) every 24 month(s)	Not Covered		
D0220	Intraoral, periapical, first radiographic image	1 (D0220) per day			
D0230	Intraoral, periapical, each add 'l radiographic image				
D0240	Intraoral, occlusal radiographic image	2 (D0240) every 24 month(s)	Not Covered		
D0250	Extra-oral 2D projection radiographic image, stationary radiation source	1 (D0250) per day	Not Covered		

Code	Description	Limitations	Pre-Authorization Required (ADULT)	Pre-Authorization Required (PREGNANT WOMAN)	Documentation/ X-Rays Required
D0270	Bitewing, single radiographic image	1 of (D0270, D0272, D0274, D0277) every 6 month(s)	Not Covered		
D0272	Bitewing, two radiographic images				
D0274	Bitewings, four radiographic images				
D0277	Vertical bitewings, 7 or 8 radiographic images		Not Covered		
D0310	Sialography		Not Covered		Narrative of medical necessity with claim submission
D0330	Panoramic radiographic image	1 (D0330) every 24 months			
D0340	2D cephalometric radiographic image, measurement and analysis	Only covered for orthodontic purposes			
D0351	3D Photographic Image	1 (D0351) every 12 month(s)	Not Covered		
Preventive Services					
D1110	Prophylaxis, adult	1 of (D1110, D4910) every 6 month(s)			
D1208	Topical application of fluoride, excluding varnish	1 (D1208) every 6 month(s)	Not Covered		
D1353	Sealant repair – per tooth	1 (D1353) every 3 year(s) per tooth	Not Covered		
D1550	Re-cement or re-bond space maintainer	Not covered within 6 months of placement	Not Covered		
Restorative Services					
D2140	Amalgam, one surface, primary or permanent	1 of (D2140-D2335, D2391-D2394) every 6 month(s) per tooth, per surface			
D2150	Amalgam, two surfaces, primary or permanent				
D2160	Amalgam, three surfaces, primary or permanent				
D2161	Amalgam, four or more surfaces, primary or permanent				

Code	Description	Limitations	Pre-Authorization Required (ADULT)	Pre-Authorization Required (PREGNANT WOMAN)	Documentation/ X-Rays Required
D2330	Resin-based composite, one surface, anterior	1 of (D2140-D2335, D2391-D2394) every 6 month(s) per tooth, per surface			
D2331	Resin-based composite, two surfaces, anterior				
D2332	Resin-based composite, three surfaces, anterior				
D2335	Resin-based composite, four or more surfaces, involving incisal angle				
D2390	Resin-based composite crown, anterior	1 (D2390) every 6 month(s) per tooth			
D2391	Resin-based composite, one surface, posterior	1 of (D2140-D2335, D2391-D2394) every 6 month(s) per tooth, per surface			
D2392	Resin-based composite, two surfaces, posterior				
D2393	Resin-based composite, three surfaces, posterior				
D2394	Resin-based composite, four surfaces or more, posterior				
D2740	Crown - porcelain/ceramic	1 (D2740) every 60 month(s) per tooth	Not Covered		Pre-Op x-ray(s) with claim submission
D2910	Re-cement or re-bond, onlay, veneer, or partial coverage	Not covered within 6 months of initial placement	Not Covered		
D2920	Re-cement or re-bond crown	Not covered within 6 months of placement	Not Covered		

Code	Description	Limitations	Pre-Authorization Required (ADULT)	Pre-Authorization Required (PREGNANT WOMAN)	Documentation/ X-Rays Required
D2929	Prefabricated porcelain/ceramic crown, primary tooth	1 of (D2929- 2933) every 36 month(s) per tooth	Not Covered		Pre-operative x-ray(s) with claim submission
D2930	Prefabricated stainless-steel crown, primary tooth		Not Covered		
D2931	Prefabricated stainless-steel crown, permanent tooth		Not Covered		
D2932	Prefabricated resin crown		Not Covered		
D2933	Prefabricated stainless-steel crown with resin window		Not Covered		
D2940	Protective restoration	Temporary restoration intended to relieve pain. Not to be used as a base liner or under a restoration			
D2950	Core buildup, including any pins when required	1 of (D2950, D2952, D2954) every 60 month(s) per tooth			
D2951	Pin retention, per tooth, in addition to restoration	1 (D2951) in a Lifetime per tooth	Not Covered		
D2952	Post and core in addition to crown, indirectly fabricated	1 of (D2950, D2952, D2954) every 60 month(s) per tooth	Not Covered		
D2954	Prefabricated post and core in addition to crown		Not Covered		
Endodontic Services					
D3220	Therapeutic pulpotomy (excluding final restoration)	Not to be used by Provider completing endodontic treatment (D3220 or D3221)	Not Covered		
D3221	Pulpal debridement, primary and permanent teeth		Not Covered		
D3230	Pulpal therapy (resorbable filling), anterior, primary tooth (excluding final restoration)	1 (D3230) in a Lifetime per tooth	Not Covered		X-rays with claim submission

Code	Description	Limitations	Pre-Authorization Required (ADULT)	Pre-Authorization Required (PREGNANT WOMAN)	Documentation/ X-Rays Required
D3310	Endodontic therapy, anterior tooth (excluding final restoration)	1 of (D3310 – D3330) in a Lifetime per tooth	Not Covered		Pre-op x-ray with claim submission
D3320	Endodontic therapy, premolar tooth (excluding final restoration)		Not Covered		
D3330	Endodontic therapy, molar tooth (excluding final restoration)		Not Covered		
D3346	Treatment of previous root canal therapy, anterior	1 of (D3346-D3348) in a Lifetime per tooth. Same Provider may not submit within two years of root canal therapy	Not Covered		Pre and post-operative x-ray(s) with claim submission
D3347	Retreatment of previous root canal therapy, premolar		Not Covered		
D3348	Retreatment of previous root canal therapy, molar		Not Covered		
D3351	Apexification/recalcification, initial visit		Not Covered		Pre and post-operative x-ray(s) with claim submission
D3352	Apexification/recalcification, interim medication replacement		Not Covered		Pre and post-operative x-ray(s) with claim submission
D3353	Apexification/recalcification, final visit		Not Covered		Pre and post-operative x-ray(s) with claim submission
D3410	Apicoectomy, anterior	1 of (D3410-D3425) in a Lifetime per tooth	Not Covered		Pre-op x-ray with claim submission
D3421	Apicoectomy, premolar (first root)		Not Covered		
D3425	Apicoectomy, molar (first tooth)		Not Covered		
D3426	Apicoectomy, (each additional root)	1 (D3426) in a Lifetime per tooth	Not Covered		Pre-op x-ray with claim submission

Code	Description	Limitations	Pre-Authorization Required (ADULT)	Pre-Authorization Required (PREGNANT WOMAN)	Documentation/ X-Rays Required
D3450	Root amputation, per root	1 (D3450) in a Lifetime per tooth	Not Covered	Yes	Pre-op x-ray and narrative of medical necessity
Periodontal Services					
D4210	Gingivectomy or gingivoplasty, four or more teeth per quadrant	1 of (D4210, D4211) every 36 month(s) per quadrant	Not Covered		Pre-op x-ray, periodontal charting and narrative of medical necessity with claim submission
D4211	Gingivectomy or gingivoplasty, one to three teeth per quadrant		Not Covered		
D4212	Gingivectomy or gingivoplasty, restorative procedure, per tooth	1 (D4212) every 36 month(s) per tooth	Not Covered		Pre-op x-ray, periodontal charting and narrative of medical necessity with claim submission
D4240	Gingival flap procedure, four or more teeth per quadrant	1 of (D4240, D4241) every 36 month(s) per quadrant	Not Covered		Pre-op x-ray, periodontal charting and narrative of medical necessity with claim submission
D4241	Gingival flap procedure, one to three teeth per quadrant		Not Covered		
D4245	Apically positioned flag	1 (D4245) in a Lifetime per quadrant	Not Covered		Pre-op x-ray, periodontal charting and narrative of medical necessity with claim submission
D4260	Osseous surgery, four or more teeth per quadrant	1 of (D4260, D4261) every 36 month(s) per quadrant	Not Covered	Yes	Pre-op x-ray, periodontal charting and narrative of medical necessity
D4261	Osseous surgery, one to three teeth per quadrant		Not Covered	Yes	

Code	Description	Limitations	Pre-Authorization Required (ADULT)	Pre-Authorization Required (PREGNANT WOMAN)	Documentation/ X-Rays Required
D4265	Biologic materials to aid in soft and osseous tissue regeneration		Not Covered	Yes	Pre-op x-ray, periodontal charting and narrative of medical necessity
D4275	Soft tissue allograft	1 (D4275 – D4278) every 36 month(s) per tooth or site .	Not Covered	Yes	Pre-op x-ray, periodontal charting and narrative of medical necessity
D4276	Combined connective tissue & double pedicle graft		Not Covered	Yes	
D4277	Free soft tissue graft procedure (including donor site surgery), first tooth or edentulous tooth position in graft		Not Covered	Yes	
D4278	Free soft tissue graft procedure (including donor site surgery), each additional contiguous tooth or edentulous tooth position in same graft site		Not Covered	Yes	
D4320	Provisional splinting, intracoronal	1 of (D4320, D4321) in a Lifetime per arch	Not Covered		Pre-op x-ray, periodontal charting and narrative of medical necessity with claim submission
D4321	Provisional splinting, extracoronal		Not Covered		
D4341	Periodontal scaling and root planing, four or more teeth per quadrant	1 of (D4341, D4342) every 24 month(s) per quadrant			Pre-op x-ray and periodontal charting with claim submission
D4342	Periodontal scaling and root planing, one to three teeth per quadrant				
D4355	Full mouth debridement to enable comprehensive evaluation and diagnosis, subsequent visit	1 (D4355) in a Lifetime. Not allowed within 6 months after D1110. Payment allowed with D0140. Not payable with D0120 or D0150.			Pre-op x-ray and narrative of medical necessity with claim submission

Code	Description	Limitations	Pre-Authorization Required (ADULT)	Pre-Authorization Required (PREGNANT WOMAN)	Documentation/ X-Rays Required
D4910	Periodontal maintenance procedures	1 of (D1110, D1120, D4910) every 6 months			
D4920	Unscheduled dressing change (other than treating dentist or staff)		Not Covered		
Removable Prosthodontic Services					
D5110	Complete denture, maxillary	1 of (D5110-D5120) every 60 month(s) per arch. Not within 60 months of D5130, D5140.	Not Covered		Pre-op x-ray with claim submission
D5120	Complete denture, mandibular		Not Covered		
D5130	Immediate denture, maxillary	1 of (D5130, D5140) in a Lifetime per arch. Not within 60 months of D5110, D5120.	Not Covered		Pre-op x-ray with claim submission
D5140	Immediate denture, mandibular		Not Covered		
D5211	Maxillary partial denture, resin base	1 of (D5211-D5226) every 60 month(s) per arch. Minimum of one or more anterior teeth or 3 or more posterior teeth (excluding 3rds)	Not Covered		Pre-op x-ray with claim submission
D5212	Mandibular partial denture, resin base		Not Covered		
D5213	Maxillary partial denture, cast metal, resin base		Not Covered		
D5214	Mandibular partial denture, cast metal, resin base		Not Covered		
D5225	Maxillary partial denture, flexible base (age 8+)		Not Covered		
D5226	Mandibular partial denture, flexible base (age 8+)		Not Covered		
D5410	Adjust complete denture, maxillary	1 of (D5410-D5422) every 12 months per arch. Not covered within 6 months of placement of denture or after rebase/reline.	Not Covered		
D5411	Adjust complete denture, mandibular		Not Covered		
D5421	Adjust partial denture, maxillary		Not Covered		
D5422	Adjust partial denture, mandibular		Not Covered		

Code	Description	Limitations	Pre-Authorization Required (ADULT)	Pre-Authorization Required (PREGNANT WOMAN)	Documentation/ X-Rays Required
D5511	Repair broken complete denture base, mandibular		Not Covered		
D5512	Repair broken complete denture base, maxillary		Not Covered		
D5520	Replace missing or broken teeth, complete denture		Not Covered		
D5611	Repair resin partial denture base, mandibular		Not Covered		
D5612	Repair resin partial denture base, maxillary		Not Covered		
D5621	Repair cast partial framework, mandibular		Not Covered		
D5622	Repair cast partial framework, maxillary		Not Covered		
D5630	Repair or replace broken clasp, per tooth		Not Covered		
D5640	Replace broken teeth, per tooth		Not Covered		
D5650	Add tooth to existing partial denture		Not Covered		
D5660	Add clasp to existing partial denture, per tooth		Not Covered		
D5710	Rebase complete maxillary denture	1 of (D5710-D5761) every 36 month(s) per arch. Not covered within 12 months of placement.	Not Covered		
D5711	Rebase complete mandibular denture		Not Covered		
D5720	Rebase maxillary partial denture		Not Covered		
D5721	Rebase mandibular partial denture		Not Covered		
D5730	Reline complete maxillary denture, chairside		Not Covered		
D5731	Reline complete mandibular denture, chairside		Not Covered		

Code	Description	Limitations	Pre-Authorization Required (ADULT)	Pre-Authorization Required (PREGNANT WOMAN)	Documentation/ X-Rays Required
D5740	Reline maxillary partial denture, chairside	1 of (D5710-D5761) every 36 month(s) per arch. Not covered within 12 months of placement.	Not Covered		
D5741	Reline mandibular partial denture, chairside		Not Covered		
D5750	Reline complete maxillary denture, laboratory		Not Covered		
D5751	Reline complete mandibular denture, laboratory		Not Covered		
D5760	Reline maxillary partial denture, laboratory		Not Covered		
D5761	Reline mandibular partial denture, laboratory		Not Covered		
D5820	Interim partial denture, maxillary	1 of (D5820, D5821) in a Lifetime. Not covered within 24 months of (D5211, D5212, D5213, D5214, D5225 or D5226).	Not Covered		Pre-op x-ray with claim submission
D5821	Interim partial denture, mandibular		Not Covered		
D5850	Tissue conditioning, maxillary	1 of (D5850, D5851) every 60 months. Prior to new denture impressions only.	Not Covered		
D5851	Tissue conditioning, mandibular		Not Covered		
Fixed Prosthodontic Services					
D6549	Resin retainer for resin bonded fixed prosthesis		Not Covered		Pre-op x-ray and narrative of medical necessity with claim submission
D6930	Re-cement or re-bond fixed partial denture	1 (D6930) every 60 month(s). Not covered within 6 months of placement	Not Covered		
D6980	Fixed partial denture repair, restorative material failure	1 (D6980) in a Lifetime per site	Not Covered		Pre-op x-ray and narrative of medical necessity with claim submission
Oral & Maxillofacial Services					
D7111	Extraction, coronal remnants, primary tooth				

Code	Description	Limitations	Pre-Authorization Required (ADULT)	Pre-Authorization Required (PREGNANT WOMAN)	Documentation/ X-Rays Required
D7140	Extraction, erupted tooth or exposed root				
D7210	Extraction, erupted tooth requiring removal of bone and/or sectioning of tooth	Removal of asymptomatic tooth not covered			Pre-op x-ray with claim submission
D7220	Removal of impacted tooth, soft tissue	Removal of asymptomatic tooth not covered.	Yes	Yes	Pre-op x-ray
D7230	Removal of impacted tooth, partially bony		Yes	Yes	
D7240	Removal of impacted tooth, completely bony		Yes	Yes	
D7241	Removal impacted tooth, complete bony, complication	Unusual complications such as nerve dissection, separate closure of the maxillary sinus or aberrant tooth position. Removal of asymptomatic tooth not covered.	Yes	Yes	Pre-op x-ray
D7250	Removal of residual tooth roots (cutting procedure)				Pre-op x-ray with claim submission
D7260	Oroantral fistula closure		Yes	Yes	Pre-op x-ray and narrative of medical necessity
D7261	Primary closure of a sinus perforation		Yes	Yes	Narrative of medical necessity
D7270	Tooth reimplantation and/or stabilization, accident		Not Covered	Yes	Pre-op x-ray and narrative of medical necessity
D7285	Incisional biopsy of oral tissue, hard (bone, tooth)				Pathology Report with claim submission
D7286	Incisional biopsy of oral tissue, soft				Pathology Report with claim submission

Code	Description	Limitations	Pre-Authorization Required (ADULT)	Pre-Authorization Required (PREGNANT WOMAN)	Documentation/ X-Rays Required
D7290	Surgical repositioning of teeth		Not Covered		Pre-op x-ray and narrative of medical necessity with claim submission
D7291	Transseptal fiberotomy/supra crestal fiberotomy, by report		Not Covered		Pre-op x-ray and narrative of medical necessity with claim submission
D7296	Corticotomy – one to three teeth or tooth spaces, per quadrant	1 of (D7296, D7297) in a Lifetime per quadrant			Pre-op x-ray and narrative of medical necessity with claim submission
D7297	Corticotomy – four or more teeth or tooth spaces, per quadrant				
D7310	Alveoloplasty with extractions, four or more teeth per quadrant	1 of (D7310, D7320) in a Lifetime per quadrant	Not Covered		Pre-op x-ray and narrative of medical necessity with claim submission
D7320	Alveoloplasty, w/o extractions, four or more teeth per quadrant		Not Covered		
D7410	Excision of benign lesion, up to 1.25cm		Yes	Yes	Pathology Report
D7411	Excision of benign lesion greater than 1.25 cm		Not Covered	Yes	Pathology Report
D7412	Excision of benign lesion, complicated		Not Covered	Yes	Pathology Report
D7413	Excision of malignant lesion up to 1.25 cm		Not Covered	Yes	Pathology Report
D7414	Excision of malignant lesion greater than 1.25 cm		Not Covered	Yes	Pathology Report
D7415	Excision of malignant lesion, complicated		Not Covered	Yes	Pathology Report
D7471	Removal of lateral exostosis, maxilla or mandible	1 (D7471) in a Lifetime	Not Covered	Yes	Pre-op x-ray and narrative of medical necessity

Code	Description	Limitations	Pre-Authorization Required (ADULT)	Pre-Authorization Required (PREGNANT WOMAN)	Documentation/ X-Rays Required
D7472	Removal of torus palatinus		Not Covered	Yes	Pre-op x-ray and narrative of medical necessity
D7473	Removal of torus mandibularis		Not Covered	Yes	Pre-op x-ray and narrative of medical necessity
D7485	Surgical reduction of osseous tuberosity		Not Covered	Yes	Pre-op x-ray and narrative of medical necessity
D7510	Incision & drainage of abscess, intraoral soft tissue	Not payable on same date as extraction.			Narrative of medical necessity with claim submission
D7511	Incision and drainage of abscess -intraoral soft tissue - complicated (includes drainage of multiple fascial spaces)				Narrative of medical necessity with claim submission
D7520	Incision & drainage of abscess, extraoral soft tissue				Narrative of medical necessity with claim submission
D7521	Incision and drainage of abscess -extraoral soft tissue - complicated (includes drainage of multiple fascial spaces)				Narrative of medical necessity with claim submission
D7871	Non-arthroscopic lysis and lavage		Not Covered		Pre-op x-ray and narrative of medical necessity with claim submission
D7960	Frenulectomy (frenotomy or frenotomy), separate procedure	1 (D7960) in a Lifetime	Not Covered		Narrative of medical necessity with claim submission
D7970	Excision of hyperplastic tissue, per arch	1 (D7970) in a Lifetime per arch	Not Covered		Narrative of medical necessity with claim submission
D7971	Excision of pericoronal gingiva		Not Covered		Narrative of medical necessity with claim submission
D7972	surgical reduction of fibrous tuberosity		Not Covered		Pre-op x-ray and narrative of medical necessity with claim submission

Code	Description	Limitations	Pre-Authorization Required (ADULT)	Pre-Authorization Required (PREGNANT WOMAN)	Documentation/ X-Rays Required
Adjunctive General Services					
D9110	Palliative (emergency) treatment, minor procedure				
D9212	Trigeminal division block anesthesia	Injection for diagnosis purposes. It is not to be used for a second division block.	Not Covered		Narrative of medical necessity with claim submission
D9222	Deep sedation/general anesthesia, first 15-minute increment	1 (D9222) per day. Not allowed on same day as (D9230, D9239, D9243, D9248).	Not Covered		Narrative of medical necessity with claim submission
D9223	Deep sedation/general anesthesia, each subsequent 15-minute increment	Additional sedation units covered in the minimum amount necessary to complete the treatment plan. Not to be billed with (D9230, D9239, D9243 or D9248)	Not Covered		Narrative of medical necessity with claim submission
D9230	Inhalation of nitrous oxide/analgesia, anxiolysis	1 (D9230) per day. Not allowed on the same day as (D9222, D9223, D9239, D9243, or D9248)			Narrative of medical necessity with claim submission
D9239	Intravenous moderate (conscious) sedation/analgesia, first 15-minute increment	1 (D9239) per day. Not allowed on same day as (D9222, D9223, D9230 or D9248)			Narrative of medical necessity with claim submission
D9243	Intravenous moderate (conscious) sedation/analgesia, each subsequent 15-minutes increment	Additional sedation units covered in the minimum amount necessary to complete the treatment plan. Not to be billed with (D9222, D9223, D9230 or D9248)			Narrative of medical necessity with claim submission
D9248	Non-intravenous conscious sedation,	Not allowed on the same day as (D9222, D9223, D9230, D9239 or D9243)			Narrative of medical necessity with claim submission

Code	Description	Limitations	Pre-Authorization Required (ADULT)	Pre-Authorization Required (PREGNANT WOMAN)	Documentation/ X-Rays Required
D9310	Consultation - diagnostic service provided by dentist or physician other than requesting dentist or physician	Only payable to specialists. Not covered with any other services other than radiographs on the same day.	Not Covered		
D9420	Hospital or ambulatory surgical center call		Yes	Yes	Narrative of medical necessity
D9610	Therapeutic parenteral drug, single administration				Narrative of medical necessity with claim submission
D9612	Therapeutic drug injection - 2 or more medications by report				Narrative of medical necessity with claim submission
D9910	Application of desensitizing medicament	Emergency treatment only	Not Covered		
D9930	Treatment of complications (post-surgical) - unusual circumstances, by report				Narrative of medical necessity with claim submission
D9995	Teledentistry – synchronous; real-time encounter				
D9996	Teledentistry – asynchronous; information stored and forwarded to dentist for subsequent review				