



PROVIDER REFERENCE GUIDE



www.libertydentalplan.com

SECTION 1 – LIBERTY DENTAL PLAN INFORMATION	5
INTRODUCTION	5
OUR MISSION	5
PROVIDER CONTACT AND INFORMATION GUIDE	6
SECTION 2 – PROFESSIONAL RELATIONS.....	7
NETWORK MANAGERS	7
SECTION 3 – ONLINE SERVICES.....	8
ON-LINE ACCOUNT ACCESS	8
SECTION 4 – ELIGIBILITY	9
How to Verify Eligibility	9
MONTHLY ELIGIBILITY ROSTERS (CAPITATION PROGRAMS ONLY)	9
MEMBER IDENTIFICATION CARDS	10
SECTION 5 – SUMMARY OF PLAN OFFERINGS	11
DHMO (CAPITATION).....	11
DHMO (COPAYMENT ONLY)	11
EPO	11
BENEFIT COPAYMENT SCHEDULES	11
SECTION 6 – CLAIMS AND BILLING	12
ELECTRONIC SUBMISSION – SUBMISSION OF CLAIMS, ENCOUNTERS, PRE-ESTIMATES AND REFERRALS	12
PAPER SUBMISSION – SUBMISSION OF CLAIMS, ENCOUNTERS, PRE-ESTIMATES AND REFERRALS.....	13
CLAIMS SUBMISSION REQUIREMENTS.....	13
CLAIMS STATUS INQUIRY	13
CLAIMS STATUS EXPLANATIONS	13
CLAIMS RESUBMISSION.....	14
CLAIMS OVERPAYMENT.....	14
NOTICE OF OVERPAYMENT OF A CLAIM	14
PROVIDER CONTESTS THE OVERPAYMENT NOTICE	14
PROVIDER DOES NOT CONTEST THE OVERPAYMENT NOTICE	14
OFFSETS TO CURRENT AND/OR FUTURE PAYMENTS.....	14
SECTION 7 – COORDINATION OF BENEFITS.....	15
IDENTIFY THE PRIMARY CARRIER	15
SCENARIOS OF COBS:	18

SECTION 8 – PROFESSIONAL GUIDELINES AND STANDARDS OF CARE	20
SPECIALTY CARE PROVIDERS RESPONSIBILITIES AND RIGHTS.....	21
NATIONAL PROVIDER IDENTIFIER (“NPI”)	21
HOW TO APPLY FOR AN NPI	21
VOLUNTARY TERMINATION OF THE PROVIDER CONTRACT.....	21
STANDARDS OF ACCESSIBILITY AND AVAILABILITY	21
AFTER HOURS AND EMERGENCY SERVICES AVAILABILITY	22
FACILITY PHYSICAL ACCESS FOR THE DIASBLED – AMERICANS WITH DISABILITIES ACT	22
APPOINTMENT RESCHEDULING	22
LANGUAGE ASSISTANCE PROGRAM – INTERPRETER SERVICES	22
TREATMENT PLAN GUIDELINES.....	23
SECOND OPINIONS	23
RECALL, FAILED OR CANCELLED APPOINTMENTS	23
CONTINUITY AND COORDINATION OF CARE.....	23
MEMBER RIGHTS AND RESPONSIBILITIES	24
SECTION 9 – CLINICAL DENTISTRY PRACTICE PARAMETERS	26
CONTINUITY OF CARE.....	27
INFECTION CONTROL.....	27
DENTAL RECORDS AVAILABILITY	28
LANGUAGE ASSISTANCE PROGRAM (LAP).....	28
HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA)	29
RADIOGRAPHS	30
PREVENTIVE.....	31
TREATMENT PLANNING.....	32
PROGRESS NOTES	35
ENDODONTICS.....	35
ORAL SURGERY	38
PERIODONTICS.....	41
RESTORATIVE.....	46
CROWNS AND FIXED BRIDGES.....	49
REMOVABLE PROSTHODONTICS	53
SECTION 10 – SPECIALTY CARE REFERRAL GUIDELINES	58

NON-EMERGENCY SPECIALTY REFERRAL SUBMISSION AND INQUIRIES.....	58
EMERGENCY REFERRAL	59
ENDODONTICS.....	59
REFERRAL GUIDELINES FOR THE ENDODONTIST:.....	59
ORAL SURGERY	62
ORTHODONTICS.....	65
REFERRAL GUIDELINES FOR THE ORTHODONTIST:	66
PEDIATRIC DENTISTRY	67
PERIODONTICS.....	69
PROSTHODONTIST	74
SECTION 11 – QUALITY MANAGEMENT	75
PROGRAM DESCRIPTION	75
QMI PROGRAM POLICY	75
QMI PROGRAM SCOPE	75
QMI PROGRAM GOALS AND OBJECTIVES.....	75
QUALITY MANAGEMENT OVERSIGHT COMMITTEES	76
PROGRAM STANDARDS AND GUIDELINES	78
PROVIDER QMI Program RESPONSIBILITIES	79
CREDENTIALING / RECREDENTIALING	79
RECORDS REVIEW	80
ELEMENTS OF RECORD REVIEW	80
GRIEVANCES, PROVIDER CLAIM DISPUTES AND APPEALS	80
MEMBER GRIEVANCES	80
MEMBER APPEALS.....	80
PROVIDER CLAIM DISPUTES	81
ACKNOWLEDGMENT OF CONTRACTED PROVIDER DISPUTES.....	82
CONTRACTED PROVIDER DISPUTE INQUIRIES.....	82
SECTION 12 – FRAUD, WASTE AND ABUSE	83
REPORTING FRAUD, WASTE AND ABUSE	84
TRAINING	85
SECTION 13 – ALTERNATIVE TREATMENT	86
DEFINITION OF ALTERNATIVE TREATMENT.....	86

UPGRADED TREATMENT	87
SECTION 14 – FORMS	88
ALTERNATE TREATMENT FORM	88
REFERRAL FORM	88

SECTION 1 – LIBERTY DENTAL PLAN INFORMATION



INTRODUCTION

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

The intent of this Provider Reference Guide is to aid each Participating Provider and their staff members in becoming familiar with the administration of LIBERTY's dental plans. Please note that this Provider Reference Guide serves only as an addendum to the terms of the Provider Agreement between you (or the contracting dental office/facility) and LIBERTY Dental Plan and that additional terms and conditions of the Provider Agreement apply. In the event of a conflict between this Provider Reference Guide and the Provider Agreement, the Provider Agreement shall prevail, unless the applicable statement in this Provider Reference Guide specifically indicates that it prevails over the Provider Agreement. You received a copy of the fully executed Provider Agreement at the time of your activation on LIBERTY Dental Plan's network or your LIBERTY orientation; however, you may also obtain a copy of the Provider Agreement at any time by submitting a request to pinquiries@libertydentalplan.com or by contacting **Professional Relations** at (888) 352-7924.

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

OUR MISSION

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

PROVIDER CONTACT AND INFORMATION GUIDE

PROVIDER CONTACT and INFORMATION GUIDE			
Important Phone Numbers & General Information	Eligibility & Benefits Verification	Claims Inquiries	Provider Web Portal (i-Transact)
<p>LIBERTY Provider Service Line 888.352.7924</p> <p>Eligibility & Benefits: option 1 Claims: option 2 Pre-estimates: option 3 Specialty Referrals: option 4</p> <p>Hours: Live representatives are available M-F, 5 am PST to 5 pm PST</p> <p>Professional Relations Department 888.352.7924 800.268.0154 (fax)</p> <p>LIBERTY Dental Plan ATTN: Professional Relations P.O. Box 26110 Santa Ana, CA 92799-6110</p> <p>email: prinquiries@libertydentalplan.com</p>	<p>Provider Portal (i-Transact) www.libertydentalplan.com</p> <p>or</p> <p>Telephone 888.352.7924 option 1</p>	<p>Provider Portal (i-Transact) www.libertydentalplan.com</p> <p>or</p> <p>Telephone 888.352.7924 option 2</p>	<p>www.libertydentalplan.com</p> <p>LIBERTY Dental Plan offers 24/7 real-time access to important information and tools through our secure online system</p> <ul style="list-style-type: none"> • Electronic Claims Submission • Claims Inquiries • Real-time Eligibility Verification • Member Benefit Information • Referral Submission • Referral Status <p>Please visit: www.libertydentalplan.com to register as a new user and/or login.</p> <p>Your “Access Code” can be found on your LIBERTY Welcome Letter. If you cannot locate your access code, or need help with the login process, please call: 888.352.7924 for assistance, or email: support@libertydentalplan.com</p>
	<p>Referral Submission & Inquiries</p> <p>Provider Portal (i-Transact) www.libertydentalplan.com</p> <p>Telephone 888.352.7924 option 2</p> <p>Regular Referrals by Mail: LIBERTY Dental Plan ATTN: Referral Department PO Box 401086 Las Vegas, NV 89140</p> <p>*Emergency Referrals* All requests for emergency specialty care should be made by calling: 888.352.7924 option 4</p>	<p>Claims Submissions</p> <p>Provider Portal (i-Transact) www.libertydentalplan.com</p> <p>EDI Payer ID #: CX083</p> <p>Paper Claims By Mail: LIBERTY Dental Plan ATTN: Claims Department P.O. Box 26110 Santa Ana, CA 92799-6110</p>	

SECTION 2 – PROFESSIONAL RELATIONS






NETWORK MANAGERS

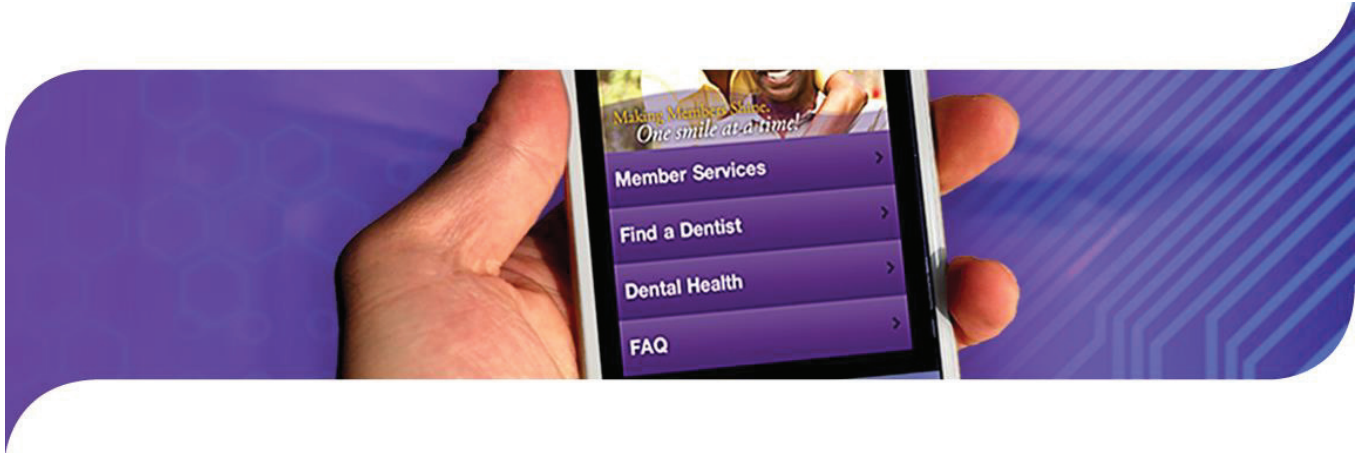
LIBERTY’s team of Network Managers is responsible for recruiting, contracting, servicing and maintaining our network of Providers. We encourage our Providers to communicate directly with their designated Network Manager for assistance with the following:

- Plan Contracting
- Escalated Claim Payment Issues
- Education on LIBERTY Members and Benefits
- Opening, Changing, Selling or Closing a Provider Location
- Adding or Terminating Associates
- Credentialing Inquiries
- Change in Name or Ownership
- Tax Payer Identification Number (TIN) Change

To ensure that your information is displayed accurately and claims are processed efficiently, please submit all changes 30 days in advance and in writing to the following P.O. Box or email. If necessary, you may also call the Professional Relations Team at the phone number shown below.

	LIBERTY Dental Plan ATTN: Professional Relations P.O. Box 26110 Santa Ana, CA 92799-6110		Professional Relations Team M-F from 8 am – 5 pm PST (888) 352-7924, press option 4
	Email at pinquiries@libertydentalplan.com		

SECTION 3 – ONLINE SERVICES



LIBERTY Dental Plan is dedicated to meeting the needs of our providers by utilizing leading technology to increase your office's efficiency. Online tools are available for billing, eligibility, claim inquiries, referrals and other transactions related to the operation of your dental practice. We offer 24/7 real-time access to important information and tools through our secure online Provider Portal. Registered users will be able to:

- Submit Electronic Claims
- Verify Member 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

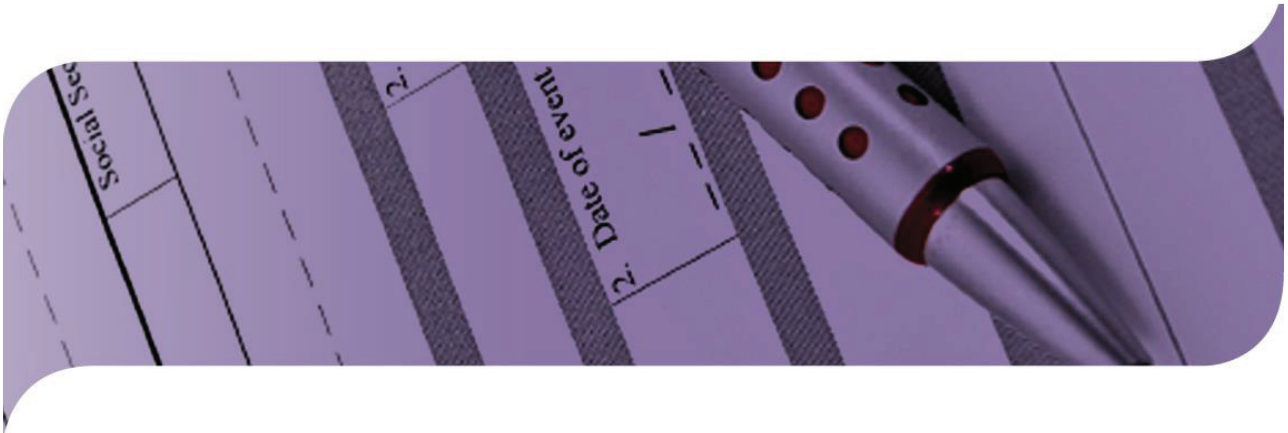
ON-LINE ACCOUNT ACCESS

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

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

If you are unable to locate your Office Number and/or Access Code, please contact our **Professional Relations Department** at (888) 352-7924 or email support@libertydentalplan.com for assistance. For more detailed instructions on how to utilize the Provider Portal, please reference the Online Provider Portal User Guide.

SECTION 4 – ELIGIBILITY



Providers are responsible for verifying member eligibility before each visit. The member ID card does not guarantee eligibility. Checking eligibility will allow you to complete the necessary pre-authorizations and reduce the risk of denied claims.

HOW TO VERIFY ELIGIBILITY

There are several options available to verify eligibility:

- **Provider Portal:** www.libertydentalplan.com - The Member's Last Name, First Name and any combination of Member Number, Policy Number, or Date of Birth will be required (DOB is recommended for best results)
- **Telephone:** Speak with a live Representative from 5 a.m. to 5 p.m. PST, Monday through Friday by contacting our Provider Service Line at (888) 352-7924, press option 1

MONTHLY ELIGIBILITY ROSTERS (CAPITATION PROGRAMS ONLY)

At the beginning of each month, your office will receive an updated *Eligibility Roster* (eligibility list) of LIBERTY Dental Plan members who have selected your office for their primary dental care. This *Eligibility Roster* will provide your office with the following information:

- Member name
- Dependent(s) name(s) or number of dependents covered
- Member Identification Number
- Member date of birth
- Group name (if through employer group, name of employer)
- Type of coverage (Plan number/name)
- Effective date of coverage

The Roster is in alphabetical order and the dependents are listed individually. Dependents include spouse and eligible children. In most cases, eligible children are those who are unmarried and financially dependent upon

the member for full support. Dependents include natural children, stepchildren, and foster children under the age of 19. Children may continue to be eligible up to age of 26, if they are full time students.

In the event a patient does not appear on the monthly Roster please contact LIBERTY Dental Plan's **Member Services Department** at (888) 352-7924. Upon verification of eligibility, LIBERTY will fax confirmation of member's eligibility to your office.

MEMBER IDENTIFICATION CARDS

Members should present their ID card at each appointment; which can be printed from LIBERTY'S website. Providers are encouraged to confirm the identity of the person presenting an ID card by requesting photo ID. The presentation of an ID card does not guarantee eligibility and/or LIBERTY's payment of benefits. Not all LIBERTY plans provide printed ID Cards. In such cases, providers should check a photo ID and the Eligibility Roster, contact Member Services or the online web portal for verification of eligibility.



SECTION 5 – SUMMARY OF PLAN OFFERINGS

DHMO (CAPITATION)

Dental Health Maintenance Organization Network (DHMO): Dentist compensation consists of fixed monthly payments (capitation), patient charges (copayments) and procedural guarantee payments for specific plans. Monthly capitation payments are issued on the 20th day of each month of coverage and will reflect the members listed on the monthly roster. Members can select any contracted participating provider in the DHMO network as their primary care dentist. A referral from the member's primary care dentist will be required to see a specialist, unless specifically noted otherwise. Providers are required to submit claim forms for all services rendered so that the plan can log and track the utilization of services by each member and for each covered group.

DHMO (COPAYMENT ONLY)

Dental Health Maintenance Organization Network (DHMO): Dentist compensation consists of patient charges (copayments). Depending on member's plan benefits, additional supplemental reimbursement payments from LIBERTY Dental Plan may be available for specific services. Providers are required to submit claim forms for all services rendered so that the plan can log and track the utilization of services by each member and for each covered group.

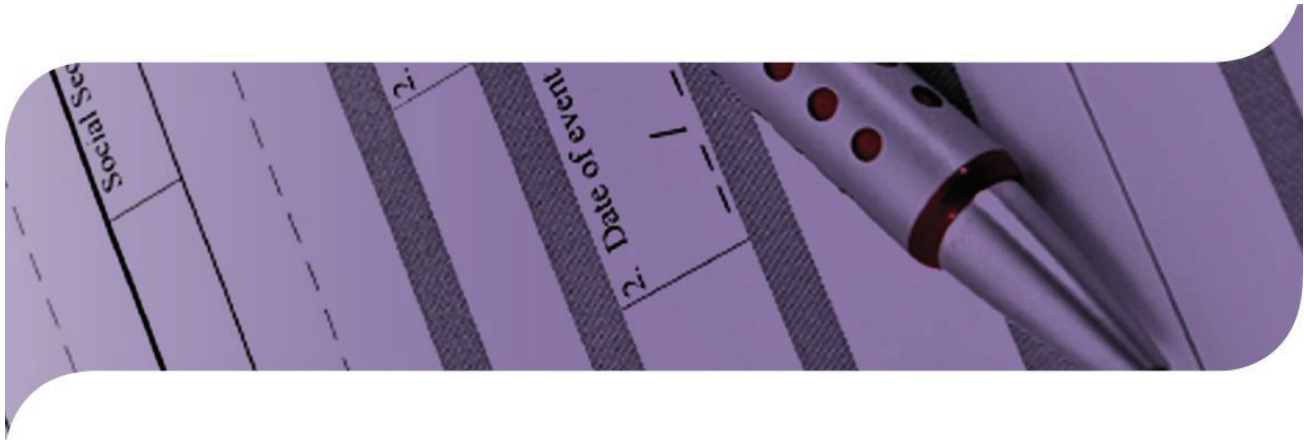
EPO

Exclusive Provider Organization (EPO): Network dentists are compensated on a contracted fee schedule, less applicable member's copayment. Offices are required to submit claims for all services rendered. It is recommended that claims be submitted each month or each visit to ensure timely payment.

BENEFIT COPAYMENT SCHEDULES

Benefit Copayment Schedules are available by logging into the Provider Portal or by contacting the **Provider Service Line** at **(888) 352-7924**.

SECTION 6 – CLAIMS AND BILLING



At LIBERTY, we are committed to efficient and accurate claims processing. It is imperative that all submitted information be accurate and in the correct format. Providers are encouraged to submit clean claims within 45 days of completing each procedure. Your office can submit claims, encounters, pre-estimates and referrals electronically (highly recommended), or by mail (not recommended, but acceptable).

LIBERTY may require Prior Authorization for certain dental benefit programs. When Prior Authorization is not required, you may still request Prior Authorization for extensive treatment plans to help clarify any patient financial obligations before treatment is rendered.

ELECTRONIC SUBMISSION – SUBMISSION OF CLAIMS, ENCOUNTERS, PRE-ESTIMATES AND REFERRALS

LIBERTY strongly encourages the electronic submission of pre-estimates, referrals and claims. This convenient feature assists in streamlining claims administration, reducing turnaround times and expediting claim payments for providers. There are two options to submit electronically - directly through the Provider Portal or by using a clearinghouse.

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

LIBERTY accepts electronic submissions from providers through the clearinghouses listed below. If you do not submit claims, encounters, pre-estimates and referrals through a clearinghouse, please contact DentalXchange, Emdeon or Tesia:

LIBERTY EDI VENDOR	PHONE NUMBER	WEBSITE	PAYER ID
DentalXchange	(800) 576-6412	www.dentalxchange.com	CX083
Emdeon	(877) 469-3263	www.emdeon.com	CX083
Tesia	(800) 724-7240 x 6	www.tesia.com	CX083

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

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

PAPER SUBMISSION – SUBMISSION OF CLAIMS, ENCOUNTERS, PRE-ESTIMATES AND REFERRALS

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

CA, TX, MO ONLY:	FL ONLY:	ALL OTHER STATES:
LIBERTY Dental Plan P.O. Box 26110 Santa Ana, CA 92799-6110 Attn: Claims Department	LIBERTY Dental Plan P.O. Box 15149 Tampa, FL 33684 Attn: Claims Department	LIBERTY Dental Plan P.O. Box 401086 Las Vegas, NV 89140 Attn: Claims Department

CLAIMS SUBMISSION REQUIREMENTS

The following is a summary of claim submission timeframes, supplemental information and documentation required by LIBERTY.

1. All claims must be submitted to LIBERTY for payment no later than 180 days after the date of service unless applicable laws provide for a longer or shorter timeframe.
2. The treating dentist's and billing entity's National Provider Identifier (NPI) numbers and tax ID are required on all claims. Claims submitted without these NPIs will be rejected. All health care providers, health plans and clearinghouses are required to use the NPI as the ONLY identifier in electronic health care claims and other transactions.
3. All submissions must include the name of the program under which the member is covered and all necessary information and documentation to adjudicate the claim.

For emergency services, please submit a standard claim form which includes all the necessary information, including pre-operative x-rays and a detailed explanation of the emergency circumstances. If applicable, the LIBERTY Specialty Care Referral Request Form should be completed and submitted with the Emergency box checked.

CLAIMS STATUS INQUIRY

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

	(888) 352-7924, press option 3		Provider Portal: www.libertydentalplan.com
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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 and is being reviewed for benefit determination

CLAIMS RESUBMISSION

Providers have 365 days from the original 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 a claim has been overpaid, LIBERTY will notify the provider in writing, 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.

PROVIDER CONTESTS THE OVERPAYMENT NOTICE

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

PROVIDER DOES NOT CONTEST THE OVERPAYMENT NOTICE

If the provider does not contest LIBERTY's notice of a claim overpayment, the provider must reimburse LIBERTY within 30 working days of the provider's receipt of LIBERTY's notice of claim overpayment. In the event that the provider does not contest the overpayment notice and fails to reimburse LIBERTY within 30 working days of the receipt of LIBERTY's notice of claim overpayment, LIBERTY may offset the amount of the overpayment from any amounts due the provider for current and/or future claim submissions as described below.

OFFSETS TO CURRENT AND/OR FUTURE PAYMENTS

LIBERTY may only offset an uncontested notice of claim overpayment against a provider's current and/or future claim submission when: (1) the provider fails to reimburse LIBERTY within the timeframe set forth above, and (2) LIBERTY's contract with the provider specifically authorizes LIBERTY to offset an uncontested notice of claim overpayment from the provider's current and/or future claims submissions. In the event that an overpayment of a claim or claims is offset against the provider's current and/or future claim or claims pursuant to this section, LIBERTY will provide the provider with a detailed written explanation of the offset.

SECTION 7 – COORDINATION OF BENEFITS



Coordination of Benefits (“COB”) applies when a member has more than one source of dental coverage. The purpose of COB is to allow members to receive the highest level of benefits up to 100% of the cost of covered services. COB also ensures that providers do not collect more than the actual cost of the member’s dental expenses.

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

IDENTIFY THE PRIMARY CARRIER

When determining the order of benefits (making payment) between two coordinating plans, the effective date refers to the first date the plan actively covers a member.

When there is a break in coverage LIBERTY will be primary based on LIBERTY effective date versus the new group effective date. The table below is a guide to assist your office in determining the primary carrier

PATIENT IS THE MEMBER	PRIMARY
Member has dental coverage through employer	Member coverage is always primary
Member has dental coverage as an active employee and through the spouse	Member coverage is primary
Member has two active insurance carriers, both provide dental coverage	The carrier with the earliest effective date is primary
Member has dental coverage through a group plan and COBRA coverage	Group plan is primary
Member has dental coverage through a group plan and individual or supplemental coverage through another carrier Note: Supplemental/Individual plans are purchased by the member for added coverage Examples:	Group plan is primary

PATIENT IS THE MEMBER	PRIMARY
Student Accident Plans Supplemental Plans (Western Dental) Prepaid Trust Plans Individual Plan (AFLAC) Reimbursement Plans Discount/Reduced Fee Plan	
Member has dental coverage as an active employee of one plan and as retired employee of another plan	The active coverage is primary
Member has two retiree plans	The plan that covered the member longer is primary
Member has a retiree plan and spouse holds a group plan	Spouse's group plan is primary
Member has a government funded plan and individual or supplemental coverage through another carrier	Individual/Supplemental coverage is primary
Member has two government funded plans. One is Federal (Medicare) and the other is State (Medicaid, Medi-Cal or Value Add)	Federal coverage is primary
Member has dental coverage through a group plan and a government funded plan	Group plan is primary
Member has dental coverage through a retiree plan and a government funded plan	Government funded plan is primary
Member has two Medicare plans	The Plan with the earliest effective date is considered primary
Dependent Child and the Birthday Rule	<p>The plan of the parent whose birthday falls earlier in the calendar year (month and day only) holds the primary coverage for dependent children.</p> <p>If both parents have the same birthday, the plan that has covered either of the parents the longest is the primary plan. However, if the other plan follows the "gender rule" with male coverage always primary, LIBERTY will follow the rules of that plan.</p> <p>These rules may be superseded by a court order that establishes the responsible party for the child's coverage. When determining the primary carrier for dependents with dual coverage, verify that both parents are the biological parents before applying the birthday rule.</p> <p>Coverage through the biological parent is primary.</p>

PATIENT IS THE DEPENDENT	PRIMARY
If coverage is through a biological parent and a step-parent residing in the same household	The biological parent's plan is primary
If parents are divorced or separated and there are two dental plans	The parent with custody to be the primary
If coverage is through both biological parents and stepparent, in absence of a court order, if the biological parents are legally separated or divorced	<p>The plan covering the parent with custody or with whom the child resides is primary.</p> <p>The plan covering the stepparent residing in the same household is secondary.</p> <p>The plan covering the other biological parent's coverage is third (tertiary).</p> <p>The plan covering the other stepparent's coverage is fourth.</p>
<p>If child has a government funded plan and group plan through child's parent</p> <p>Examples of Government Funded Plans:</p> <ul style="list-style-type: none"> • Healthy Families • Denti-Cal • Medicaid • Medi-Cal • MediCare • Healthy Kids • Viva • Scan • Coventry • TRICARE (see note below) <p>Note: TRICARE is a self-funded government plan and does not follow the Active vs. Retiree guidelines. TRICARE follows the effective date regardless of the plan's active or retiree status. The plan with the earliest effective date is considered prime. If enrollee has a group plan and TRICARE; the group plan will be primary</p>	Group plan through parent is primary

SCENARIOS OF COBS:

1. When Member has two Managed Care Plans (DHMO-cap program)

When the member is eligible under two managed care programs and assigned to the same contracted dentists, the member would be responsible for the copayment of the plan with the lesser copayment for the covered benefit. The member can be charged for copayment under one program only. If the treatment is a benefit under one program only, the applicable copay for that program applies.

Examples:

Procedure Code	Carrier	Copayment	Member's Portion	Determination
D7240	Plan #1	\$150	\$125	The plan with the lesser copayment
	Plan #2	\$125		
D7240	Plan #1	\$100	\$100	The plan with the covered benefit
	Plan #2	Not Covered		

2. When LIBERTY is Primary Carrier

When LIBERTY is the primary carrier, payment is made for covered services without regard to what the other plan might pay. The secondary carrier, then, depending upon its particular provisions and limitations, may pay the amounts not covered by LIBERTY.

Because LIBERTY's participating dentists have agreed to accept LIBERTY's allowance as payment in full for covered services, they should bill the secondary carrier for the patient's coinsurance, any amounts exceeding the annual or lifetime maximums and/or any amounts applied towards the patient's deductible or non-covered services.

3. When LIBERTY is Secondary Carrier

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

When LIBERTY is secondary, payment is based on the lesser of either the amount that it would have paid in the absence of any other dental benefit coverage, or the enrollee's total out-of-pocket cost payable under the primary carrier for benefits covered under the secondary carrier (according to AB895). That means whatever amount remains on the member's bill that was not paid by the member's primary carrier is now the responsibility of the secondary carrier to pay with the following conditions:

The remaining amount is for procedures that are benefits of the secondary plan

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

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

When LIBERTY is secondary and the service was performed at a specialist, the member will need an authorization from the primary carrier and from LIBERTY, only if the group requires pre-authorization.

Example #1:

Standard Calculation (before COB)				
	Submitted Fee	Allowed Fee	Member's Portion	Plan Pays Office
Primary Carrier	\$325.00	\$137.00	\$67.40	\$69.60 (\$137 - \$67.40)
LIBERTY	\$325.00	\$81.00	\$55.00	\$26.00 (\$81 - \$55.00)

After applying COB:

- Member's Portion is reduced = \$ 41.40 (\$67.40 - \$26.00)
- LIBERTY pays office = \$26.00

Example #2:

Standard Calculation (before COB)				
	Submitted Fee	Allowed Fee	Member's Portion	Plan Pays Office
Primary Carrier	\$325.00	\$137.00	\$67.40	\$69.60 (\$137 - \$67.40)
LIBERTY	\$325.00	\$150.00	\$55.00	\$95.00 (\$150 - \$55.00)

After applying COB:

- Member's Portion is reduced = \$0 (since member's primary liability is less than LIBERTY's portion - \$67.40 < \$95.00)
- LIBERTY pays office = \$67.40 (LIBERTY pays the lesser of either the amount that it would have paid in the absence of any other dental benefit coverage or the member's total out-of-pocket liability under the primary carrier)

SECTION 8 – PROFESSIONAL GUIDELINES AND STANDARDS OF CARE



General Dentist Provider Responsibilities

All dental services, including those proposed, recommended and/or performed, must be documented and /or provided consistent with professionally recognized standards of dental practice.

- Provide and/or coordinate all dental care for members
- Perform an initial dental assessment
- Upon request from member, provide to member a written treatment plan identifies covered services, optional and/or non-covered services, and clearly identifies the costs associated with each option. The treatment plan should be understandable by a prudent layperson with general knowledge of oral health issues
- Provide an informed consent discussion and supporting materials for all dental services and procedures for which the member has questions or concerns
- Treatment plans and informed consent documents must be signed by the member or responsible party demonstrating an understanding of the treatment plan and an agreement with a treatment plan and the associated financial terms
- Work closely with specialty care provider to promote continuity of care
- Maintain adherence to LIBERTY's Quality Management and Improvement Program
- Identify dependent children with special health care needs and notify LIBERTY of these needs
- Notify LIBERTY of a member death
- Arrange coverage by another provider when away from the dental facility
- Ensure that emergency dental services are available and accessible 24 hours a day, 7 days a week through primary care dentist
- Maintain scheduled office hours
- Maintain dental records for a period of ten years
- Provide LIBERTY with updated credentialing information upon request
- Provide requested information upon receipt of patient grievance/complaint within the timeframe specified by LIBERTY on the written request
- Provide claim or encounter data on standard ADA claim form in a timely manner (for capitation plans)

- Notify LIBERTY of any changes regarding his or her practice, including location name, telephone number, address, associate additions / terminations, change of ownership, plan terminations, etc.
- Provide dental services in accordance with generally accepted clinical principles, criteria, guidelines and any published parameters of care

SPECIALTY CARE PROVIDERS RESPONSIBILITIES AND RIGHTS

- All the Responsibilities of the General Dentist listed above
- Provide specialty care to members
- Work closely with primary care dentists to ensure continuity of care
- Submit claims to LIBERTY Dental Plan for all dental services that were authorized

NATIONAL PROVIDER IDENTIFIER (“NPI”)

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

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

HOW TO APPLY FOR AN NPI

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

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

VOLUNTARY TERMINATION OF THE PROVIDER CONTRACT

Providers are required to provide to LIBERTY at least 90 days advance written notice of their intent to terminate a provider contract. Providers must continue to treat members until the last day of the month following the date of termination. Impacted members are given advance written notification informing them of their transitional rights. Certain contractual rights survive termination, such as the agreement to furnish patient records in response to a grievance or claims review. Please consult your provider contract for your responsibilities after the date of termination.

STANDARDS OF ACCESSIBILITY AND AVAILABILITY

LIBERTY is committed to ensuring our members receive timely access to care. Providers are required to schedule appointments for eligible members in compliance with standards of accessibility and availability as defined in the applicable program orientation brochure.

AFTER HOURS AND EMERGENCY SERVICES AVAILABILITY

The provider's after-hours response system must enable members to reach an on-call dentist 24 hours a day, seven days a week. In the event the primary care provider is not available to see an emergency for a patient of record within 24 hours, it is his/her responsibility to make arrangements to ensure that emergency services are available. Members requiring after-hours emergency dental services must receive an assessment by telephone from the provider within one hour of the time the member contacts the provider's "after hours" telephone service. Member must be scheduled within 24 hours and should be informed that only the emergency treatment will be provided at that time. If the patient is unable to access emergency care within these guidelines and must seek services outside of your facility, provider may be held financially responsible for the total costs of such services. Additionally, if your office is unable to meet LIBERTY Dental Plan guidelines, LIBERTY Dental Plan has the right to transfer some or all capitation programs enrollment to another provider or close your office to new enrollment.

FACILITY PHYSICAL ACCESS FOR THE DISABLED – AMERICANS WITH DISABILITIES ACT

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

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

The Americans with Disabilities Act sets requirements for new construction of and alterations to buildings and facilities, including health care facilities. In addition, all buildings, including those built before the ADA went into effect, are subject to accessibility requirements for existing facilities. Detailed service and facility requirements for disabled individuals can be found by visiting www.ada.gov.

APPOINTMENT RESCHEDULING

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

LANGUAGE ASSISTANCE PROGRAM – INTERPRETER SERVICES

LIBERTY provides professional language assistance services as required by CLAS standards. In some cases telephone interpretation is adequate. If telephone interpretation is not appropriate, a professional translator may be provided. Any such request for language assistance services may be arranged by contacting and discussing the need for such services with our Member Services Representative 48 hours prior to member appointment.

Compliance with the Standards of Accessibility and Availability

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

TREATMENT PLAN GUIDELINES

All members must be presented with an appropriate, written treatment plan including an explanation of the benefits, alternatives, recommendations and financial implications of the treatment recommended and/or proposed. If there are alternate treatments available, the treating dentist must also present those options and the related costs for both covered and/or non-covered services.

Alternate and/or Elective/Non-Covered Procedures and Treatment Plans: LIBERTY Dental members cannot be denied appropriate plan benefits if they do not choose “alternative or elective/non-covered” procedures. All accepted or declined treatment plans must be signed and dated by the patient or his/her guardian and the treating dentist. Refer to the Members’ benefit plans to determine covered, alternate and elective procedures.

Note: Most LIBERTY commercial (non-governmental) plans allow for an upgrade in materials to noble or high noble metal and for porcelain on molar teeth with a signed treatment plan and informed consent by the Member.

SECOND OPINIONS

Members may request a consultation with another network dentist for a second opinion to confirm a diagnosis and/or treatment plan. Providers should refer these members to the **Member Services Department** at (888) 352-7924, Monday through Friday, 5 a.m. to 5 p.m. PST.

RECALL, FAILED OR CANCELLED APPOINTMENTS

Contracted dentists are expected to have an active recall system for established patients who fail to keep or who cancel scheduled appointments. Failed appointment charges may apply; copayments will vary based on the members’ plan benefits. Refer to the Schedule of Benefits form or contact Member Services or the LIBERTY website for more information. Missed or cancelled appointments should be noted in the patient’s record.

CONTINUITY AND COORDINATION OF CARE

LIBERTY Dental Plan ensures appropriate and timely continuity and coordination of care for all plan members.

All care rendered to LIBERTY members must be properly documented in the patient’s dental charts according to established documentation standards. Communication between the primary care dentists (Provider) and dental specialists shall occur when members are referred for specialty dental care. LIBERTY expects General Dentistry providers to follow-up with the Member and with the Specialist to ensure that referrals are occurring consistent with the best interests of the Member. Specialist providers are encouraged to send treatment reports back to the referring General Dentist providers to ensure that continuity of care occurs consistent with generally accepted standards of practice.

LIBERTY Dental Plan enforces Quality Management and Improvement (QMI) Program policies and procedures that will ensure:

- An enrollment packet contains a list of Providers that shall be given to all members upon enrollment

- A current list of Providers is maintained on LIBERTY's web site at www.libertydentalplan.com
- If a member has not selected Provider within 30 days of enrollment, a reminder postcard notifying the member of their "automatic assignment" shall be sent 10 days after assignment of his/her Provider **(for capitation plans)**
- Members who do not select a Provider shall be assigned one, based on the member's geographic location **(for capitation plans)**
- Dental chart documentation standards are included in this provider guide
- Dental chart audits will verify compliance to documentation standards
- Guidelines for adequate communications between the referring and receiving providers when members are referred for specialty dental care are included in this provider guide
- During facility on-site audits, LIBERTY Dental monitors compliance with continuity and coordination of care standards
- When a referral to a Specialist is authorized, the General Dentist provider is responsible for evaluating the need for follow-up care after specialty care services have been rendered and schedule the member for any appropriate follow-up care
- When a specialty care referral is denied, the General Dentist provider is responsible for the evaluation of the need to perform the services directly, and schedule the member for appropriate treatment
- The results of site audits shall be reported to the Peer Review and QMI Committees, and corrective action shall be ordered when deficiencies are identified

MEMBER RIGHTS AND RESPONSIBILITIES

LIBERTY Dental Plan members have specific rights and responsibilities when it comes to their care. The member rights and responsibilities are provided to each member in the member's Evidence of Coverage booklet and are outlined below.

Members have the right to:

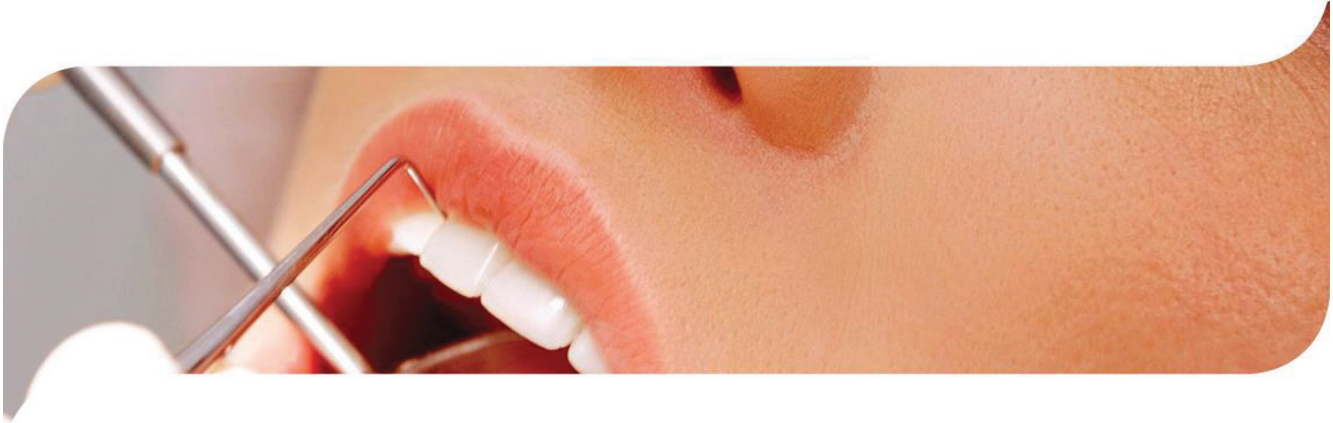
- Have information provided in a way they are able to understand, including information that is available in alternate languages and formats
- Be treated with fairness, respect, and dignity
- See LIBERTY Dental Plan providers, receive appropriate Covered Services, and have their prescriptions filled in a timely manner
- Privacy and to have their protected health information ("PHI") protected
- Information about LIBERTY, its network of providers, Covered Services, and their rights and responsibilities
- Know their treatment choices and participate in decisions about their health care
- Use Advance Directives (such as a living will or a durable health care power of attorney)
- Make complaints about LIBERTY Dental Plan or the care provided and feel confident it will not affect the way they are treated
- Appeal medical or administrative decisions LIBERTY Dental Plan has made by using the grievance process
- Make recommendations about LIBERTY Dental Plan's policies regarding member rights and responsibilities; and

- Talk openly about care needed for their health, regardless of cost or benefit coverage, as well as the choices and risks involved. Provider must provide the information to members in a way they understand

Members also have certain responsibilities. These include the responsibility to:

- Become familiar with their coverage and the rules they must follow to get care as a member;
- Tell LIBERTY Dental Plan and providers if they have any additional health insurance coverage or prescription drug coverage;
- Tell their dentists and other health care providers that they are enrolled in LIBERTY Dental Plan; Give their dentist and other providers complete and accurate information to care for them, and to follow the treatment plans and instructions that they and their providers agree upon;
- Understand their dental health problems and help set treatment goals that they and their dentist agree to;
- Ask their dentist and other providers questions about treatment if they do not understand;
- Make sure their doctors know all of the drugs they are taking, including over-the-counter drugs, vitamins, and supplements;
- Act in a way that supports the care given to other patients and helps ensure the smooth running of their doctor's office, hospitals, and other offices
- Pay their plan premiums and any co-payments or coinsurance they owe for the Covered Services they receive. Members must also meet their other financial responsibilities as described in the Evidence of Coverage booklet;
- Inform LIBERTY Dental Plan if they move; and
- Inform LIBERTY Dental Plan of any questions, concerns, problems or suggestions by calling the Member Services Department listed in their Evidence of Coverage booklet.

SECTION 9 – CLINICAL DENTISTRY PRACTICE PARAMETERS



LIBERTY expects contracted dentists to adhere to common record-keeping as per generally accepted clinical guidelines and requirements. All dental services, including those proposed, recommended and/or performed, must be documented and/or consistent with professionally recognized standards of dental practice.

New Patient Information

Registration information should minimally include:

- Name, sex, birth date, address and telephone number, cell phone number, e-mail address, name of employer, work address and telephone number, other contact information such as social media addresses
- Name and telephone number of person(s) to contact in an emergency
- For minors, name of parent(s) or guardian(s) and telephone numbers, if different from above
- Pertinent information relative to the patient's chief complaint and dental history, including problems or complications with previous dental treatment

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

- Patient's current health status
- Name and telephone number of physician and date of last visit
- History of hospitalizations and/or surgeries
- History of abnormal (high or low) blood pressure
- Current medications, including dosages and indications
- History of drug and medication use (including Fen-Phen/Redux and bisphosphonates)
- Allergies and sensitivity to medications or materials (including latex)
- Adverse reaction to local anesthetics
- 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 conditions, including the location and date of placement of any prosthetic joints
- Pregnancy
 - Document the name of the patient's obstetrician and estimated due date.
 - Follow current guidelines in the ADA publication, Women's Oral Health Issues.
- History of cancer, including radiation or chemotherapy
- The medical history form must be signed and dated by the patient or patient's parent or guardian.

Dentist's notes following up patient comments, significant medical issues and/or consultation with a physician should be documented on the medical history form or in the progress notes.

Medical alerts for significant medical conditions must be uniform and conspicuously located on a portion of the chart used and visible during treatment and should reflect current conditions.

The dentist must sign and date all baseline medical histories after review with the patient.

The medical history should be updated at appropriate intervals, dictated by the patient's history and risk factors, and must be done at least annually and signed by the patient and dentist.

Dental History:

- Reason for seeking current dental care (Chief Complaint)
- History of previous oral surgery, orthodontics, periodontics, etc.
- Problems with previous dental treatment
- Complications from local anesthesia
- Previous Risk Assessments
- Member's dental goals

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.

INFECTION CONTROL

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

DENTAL RECORDS AVAILABILITY

Member dental records must be kept and maintained in compliance with applicable state and federal regulations. Complete dental records of active or inactive patients must be accessible for a minimum of 10 years, even if the facility is no longer under contract with a LIBERTY network. Dental records for children should be maintained up to 10 years beyond the age of majority.

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 or for state and/or 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 current enrollment and/or closure to new enrollment. Continued non-compliance may result in termination by the Plan.

LANGUAGE ASSISTANCE PROGRAM (LAP)

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

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

- In compliance with state law and/or a LIBERTY's client group requirements, interpreting services, including American Sign Language, are available to members 24 hours a day, 7 days a week at no cost by contacting LIBERTY's Member Services Department at (888) 352-7924.
- If member is entitled to this service: When the member is ready to receive interpretation services, please call (888) 352-7924. The member's LIBERTY Dental ID number, full name and date of birth will be needed to confirm eligibility and access interpretation services. It is not necessary to arrange for these services in advance.
- LIBERTY discourages the use of family or friends as interpreters and expressly prohibits the use of minors as interpreters for members except in an emergency situation, and only if the minor demonstrates the ability to interpret complex dental information.
- Providers must also fully inform the member that he or she has the right not to use family, friends or minors as interpreters.
- Whether in a provider setting, or the member's administrative file (call tracking record) in the Member Services setting, if a member prefers not to use the interpretation services after she/he has been told that a trained interpreter is available free of charge, the member's refusal to use the trained interpreter shall be documented in the member's dental record.
- Member's language preferences will be available to directly contracted dentists upon request through telephone inquiries. This is made available only to members who are entitled to receive such services by virtue of state requirement or client group requirement.

- Written Member Informing Materials in threshold languages and alternative formats such as Braille and large font are available to members at no cost and can be requested by contacting LIBERTY's Member Services Department at (888) 352-7924.
- Assistance in working effectively with members using in-person and telephonic interpreters and other media such as TTY/TDD and remote interpreting services can be obtained by contacting LIBERTY's Member Services Department at (888) 352-7924.

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA)

LIBERTY takes pride in administering our dental plan in an effective and innovative manner while safeguarding our members' Protected Health Information (PHI). We are committed to complying with the requirements and standards of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

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

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

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

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

Baseline Clinical Evaluation and Diagnostic Documentation

- Observations of the initial evaluation are to be recorded in writing and charted graphically where appropriate, including missing or impacted teeth, existing restorations, and prior endodontic treatment, fixed and removable appliances.
- Assessment of TMJ status (necessary for adults) and/or classification of occlusion (especially necessary for minors) should be documented.
- Periodontal screening is required for all members. Full mouth periodontal probing and diagnosis must be documented, including an evaluation of bone levels, gingival recession, inflammation, etiologic factors (e.g., plaque and calculus), mobility, and furcation involvements for all members where periodontal services is being prescribed.

- A soft tissue/oral cancer examination of the lips, cheeks, tongue, gingiva, oral mucosal membranes, pharynx and floor of the mouth must be documented.
- 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.
- Risk Assessment for caries is recommended. Risk Assessment forms are available from the American Dental Association and the American Academy of Pediatric Dentistry at www.ada.org and www.aapd.org. Risk assessments are also available and highly recommended for periodontal disease and oral cancer.

RADIOGRAPHS

- An attempt should be made to obtain any recent radiographs from the previous dentist.
- An adequate number of initial radiographs should be taken to make an appropriate diagnosis and treatment plan, per current FDA/ADA radiographic guidelines.
- D0210 Intraoral – complete series (including bitewings)

Note: As per the ADA's CDT, 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.

Clinical / Coverage Guideline:

[X1]: LIBERTY covers D0210 complete series of radiographs only when the number of images meets the ADA definition, or some other combination of panoramic images with additional images taken on the same day. Despite the fact that a provider may itemize radiographs, LIBERTY may group radiographic images taken on the same day (or nearby in dates) as a complete series benefit, and apply pertinent limitations or exclusions to this group of radiographic images.

Benefits for this procedure are determined within each plan design.

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

Clinical / Coverage Guideline:

[X2]: Any panoramic film taken in conjunction with periapical and/or bitewing radiograph(s) will be considered as a complete series, for benefit purposes only.

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

- Diagnostic radiographs should reveal contact areas without cone cuts or overlapping, and periapical films should reveal periapical areas and alveolar bone.
- Radiographs should exhibit good contrast
- Diagnostic digital radiographs should be printed on photographic quality paper and exhibit good clarity and brightness.
- Recent radiographs must be mounted, labeled left/right and dated
- Any patient refusal of radiographs should be documented
- When a patient 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, the patient may not be charged any X-ray duplication fees.
- If the transfer is initiated by the patient, many plans allow the provider to charge for the actual cost of copying the X-rays. Generally a fee of \$25 or the actual cost of duplication is allowable.

Clinical / Coverage Guideline:

[X3]: Narratives that are contradictory to radiographic or photographic presentation are ambiguous. In such cases, the radiographic presentation will be the determining factor in the determination of coverage

PREVENTIVE

Preventive dentistry may include risk assessments for caries, periodontal disease and oral cancer, clinical tests, dental health education and other appropriate procedures to prevent caries, periodontal disease, oral cancer or injury to the mouth, teeth and related oral structures.

Caries prevention may include the following procedures where appropriate:

- Patient education in oral hygiene and dietary instruction
- 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
- Oral hygiene and dietary instructions
- Prophylaxis procedures on a regular basis
- Occlusal evaluation
- Correction of malocclusion and malposed teeth
- Restoration and/or replacement of broken down, missing or deformed teeth

D1110 and D1120 – prophylaxis procedures

- Plan policy- Procedure D1110 applies to patients who are 14 years old and older.
- Plan Policy - Procedure D1120 applies to patients who are 13 years old and younger.

D1206 and D1208 Topical Fluoride Treatment (Office Procedure)

- Plan Policy Procedure D1206 topical fluoride varnish
- Plan Policy Procedure D1208 topical application of fluoride applies to patients up to their 18th birthday

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

TREATMENT PLANNING

- Treatment plans should be comprehensive and documented in ink.
- Treatment plans should be consistent with the clinical evaluation findings and diagnosis.
- Treatment plans should be consistent with the level of risk assessed. Large invasive restorative treatment plans may not be appropriate for a member with high risk for caries and periodontal disease. Conversely, conservative treatment such as fluoride and monitoring may be appropriate for incipient non-cavitated caries in low-risk members.
- Treatment plans should be signed by the member demonstrating an understanding and accepting the proposed treatment. Treatment plans must be clear and concise and must be understandable by a prudent layperson with a normal general public knowledge of the procedures involved.

Clinical / Coverage Guideline:

[TP1]: The resolution of a grievance in which the patient has not signed a treatment plan (and appropriate financial consent) that is clear concise and understandable will be ruled in favor of the member. Exceptions may be made for routine diagnostic, preventive and routine non-complex restorative treatment, or when other documented evidence is present showing a reasonable clinical and financial presentation was made to the Member.

Clinical / Coverage Guideline:

[TP2]: Treatment proposed or rendered that is not consistent with the written or apparent diagnosis should not be benefited.

Sequencing: 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. Treatment sequencing may vary to accomplish particular functional goals of the patient.

Clinical / Coverage Guideline:

[TP3]: Treatment proposed or rendered that appears to be inconsistent with generally accepted professional standards of treatment sequencing (based on radiographs, photographs, narrative or other information provided) may not be benefited.

Informed Consent Process:

- 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, and the total financial responsibilities for all proposed procedures.
- In addition, the patient should be advised of the likely results of not doing the treatment or of doing no treatment whatsoever.
- Appropriate informed consent documentation must be signed and dated by the patient and dentist for the specific treatment plan that was accepted.
- If a patient refuses recommended procedures, the patient must sign a specific “refusal of care” document.

Clinical / Coverage Guideline:

[TP4]: Treatment rendered without a signed consent form is considered to be inconsistent with generally accepted professional standards of practice. The resolution of a grievance that involves treatment rendered in which the patient has not signed an informed consent (signed treatment plan, financial arrangement and/or clinical consent) will be ruled against the rendering provider. Exceptions may be made for routine diagnostic, preventive and routine non-complex restorative treatment, or when other documented evidence is present showing a reasonable clinical presentation was made to the Member.

- Poor Prognosis

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

Clinical / Coverage Guideline:

[TP5]: Procedures recommended for teeth with a guarded or poor prognosis (endodontic, periodontal or restorative) are not covered. Poor prognosis is deemed to be an expected longevity of less than 3 years in full function based on clinical presentation and experience of treating clinician and/or reviewing clinician.

Clinical / Coverage Guideline:

*[TP6]: Endodontic treatment should not be benefited for teeth that will require crown lengthening surgery UNLESS the crown lengthening will improve the prognosis of the tooth and is expected to have a successful outcome.*Clinical / Coverage Guideline:

[TP7]: Endodontic treatment should not be benefited on teeth with severe bone loss of 50% or more of the bone support. To do so would not be consistent with documentation of medical necessity.

LIBERTY's licensed dental consultants adjudicate prognosis determinations for the above procedures on a case-by-case basis.

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

- Upgrades: Some upgraded procedures (i.e. metals and porcelain on molars) may not be covered.
- Multiple Options: If more than one procedure would be considered appropriate in treating a dental condition, the Alternate Treatment Plan Formula should be utilized and presented: This Formula credits the patient's benefited procedure against the cost of the alternative procedure and the patient's responsibility is calculated as follows: The provider's usual total cost of the alternate treatment minus (–) the provider's usual cost of the covered procedure plus (+) any listed copayment for the covered procedure.
- If the dentist recommends two covered procedures as “needed” services, either of the chosen procedure would be covered. Example: if an extraction is agreed to instead of an endodontic procedure, the extraction would be covered.
- Right to Extraction over Treatment: A Member always has the right to an extraction over any simple, routine, or complex restorative, endodontic or periodontal procedures. Providers may not inform Members of complex procedures and then present the extraction as “optional”. If Provider feels that an extraction is not appropriate, it should not be offered, or the Member should be redirected to Member Services for re-assignment to another office.
- Member Indication of Choice of Treatment Option: Alternative treatment plans and options should be documented with a clear and concise indication of the treatment the patient has chosen. In such cases, the Alternate Treatment Plan Formula should be presented and documented. Members should sign the treatment plan, informed consent and/or financial consent indicating they have chosen the presented course of treatment. Presentation should be understandable so that a prudent layperson would understand the treatment and choices made.

Clinical / Coverage Guideline:

[TP8]: The resolution of a grievance that involves treatment rendered that does not have evidence of a signed informed consent (signed treatment plan, financial arrangement and/or clinical consent) will be ruled against the rendering provider. Exceptions may be made for routine diagnostic, preventive and routine non-complex restorative treatment, or when other documented evidence is present showing a reasonable clinical presentation was made to the Member.

- Provider Disagreement of Member Request: Should a dentist not agree with a procedure requested by a patient, the dentist may decline to provide the procedure and request that the patient be transferred. In such cases, the dentist is responsible for completion of treatment-in-progress and emergencies until the transfer request is effective.
- Consultations, second opinions, referrals and their results must be documented in the clinical record.

PROGRESS NOTES

- Progress notes constitute a legal record and must be detailed, legible and in ink.
- All entries must be signed or initialed and dated by the person licensed to provide treatment.
- Entries may be corrected, modified or lined out, but require the name of the person making any such changes and the date.
- 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.
- 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.
- Copies of all lab prescriptions should be kept in the chart.
- For paperless dental records, computer entries cannot be modified without identification of the person making the modification and the date of the change.

Clinical / Coverage Guideline:

[PN1]: Federal HIPAA laws require practitioners to use current CDT codes to report dental procedures. LIBERTY may reject/deny coverage for procedures not reported using current CDT codes. Clinical Dental Consultant reviewers may correct, alter or re-code the procedure that is apparently being submitted to the proper code at their discretion.

ENDODONTICS

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

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

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

- Strategic importance of the tooth or teeth

- Prognosis – endodontic procedures for teeth with a guarded or poor (less than 3-year prognosis (endodontic, periodontal or restorative) are not generally covered
- Presence and severity of periodontal disease
- Restorability and tooth fractures – Teeth that require crown-lengthening procedures due to caries at or below the osseous crest are not generally benefited
- 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 member is responsible for the dentist's usual fee. The dentist should have the member sign appropriate informed consent documents and financial agreements. See documentation requirements for non-covered services to avoid grievances or refunds.
- Teeth that are predisposed to fracture following endodontic treatment should be protected with an appropriate restoration and removed from occlusion pending the final restoration. Most posterior teeth should be restored with a full coverage restoration, unless access opening is small.
- Occlusion – endodontic treatment of teeth that are not in occlusion is not generally benefited

Clinical Performance Considerations:

- 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 (via radiograph 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.
- Endodontic referral necessity

If 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.

- Endodontic irrigation

Providers are contractually obligated to perform the root canal treatments with the materials they choose as adequate and appropriate. Providers may not charge for the materials used in the procedure such as BioPure (MTAD), diluted bleach, saline, sterile water, local anesthetic and/or any other acceptable alternative to irrigate the canal. Filling materials such as Thermo-Fil, or other brand name files or filling materials and posts may not be charged. The compensation for the root canal treatment includes all materials involved.

Providers may not unbundle dental procedures in an attempt to charge enrollees for intraoperative materials. The provider agreement and plan addenda determine what enrollees are to be charged for covered dental procedures. Charging for BioPure as an alternative to diluted bleach is not allowed on LIBERTY's dental plans.

Clinical / Coverage Guideline:

[E1]: LIBERTY's policy does not allow charging for the use of irrigants or materials as part of root canal treatment, whether or not a choice is presented to the Member.

Note regarding inappropriate unbundling/coding for endodontic irrigation:

D9630 – Providers should not use this procedure code when reporting endodontic irrigation (BioPure).

This procedure code is primarily used to report material dispensed for home use, not to report drugs or medicaments used in the dental office.

- Treatment of root canal obstruction; non-surgical access (D3331)

LIBERTY acknowledges that procedure D3331 is a separate, accepted procedure code. This procedure should not be submitted with endodontic retreatment procedures D3346, D3347 or D3348.

LIBERTY will not approve a benefit for this procedure when submitted as part of a pre-determination request, prior to actual treatment.

Note: It is not generally known that a canal obstruction is present until the time of the root canal treatment.

Clinical Guideline:

[E2]: As per the ADA CDT, at least 50% of the canal must be obstructed to be eligible for this code.

However, LIBERTY's licensed dental consultants will evaluate all available documentation on a case-by-case basis when this procedure is submitted for payment. Providers should submit brief narratives or copies of the patient's progress notes, in order to document that this additional treatment was needed and performed.

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

- 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.

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 capping (re-mineralization) is indicated to attempt to minimize the possibility of pulp exposure in very deep caries in vital teeth

Apical Surgery: Endodontic apical surgical treatment 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

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
- Caries at or below the osseous crest

Clinical / Coverage Guideline:

[E3]: Endodontic treatment will only be benefited for teeth that have decay at or below the alveolar bone crest if caries can be successfully restored and tooth prognosis improved by crown lengthening.

Clinical / Coverage Guideline:

[E4]: Endodontic treatment will not be benefited on teeth with a crown/root ratio of less than 50%.

ORAL SURGERY

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

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

- Uncomplicated extractions
- Routine surgical extractions
- Incision and drainage of intra-oral abscesses
- Minor surgical procedures and postoperative services

Clinical / Coverage Guideline:

[OS1]: LIBERTY expects contracting general dentists to provide all services within their scope of practice, experience and clinical comfort including routine and surgical extractions. LIBERTY does not benefit referral of routine exactions to a specialist except when documented as complex or outside of the experience or scope of the primary care general dentist.

- 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 which provide compelling justification to eliminate existing or potential sources of oral infection.
- 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.
- Local anesthesia is preferred in the absence of specific indications for the use of general anesthesia.
- Minor contouring of bone and soft tissues, and routine closure of the socket during a single tooth extraction (D7140) and surgical extraction (D7210) are considered to be a part of and included in the extraction process.
- Bone grafting (D7953) for ridge preservation may be indicated in preparation for implant placement or where alveolar contour is critical to planned prosthetic reconstruction.
- Documentation of a surgical procedure should include: recording the tooth number, tissue removed and 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.

Clinical / Coverage Guideline:

[OS2]: LIBERTY will not benefit a procedure code unless the documentation justifies it and the diagnostic information demonstrates the appropriateness of a particular procedure.

- Third molar extractions & benefit determinations

LIBERTY's licensed dental consultants adjudicate benefits on a case-by-case basis.

It is appropriate to report procedure D7220, D7230, D7240 or D7241 for the removal of an impacted tooth, with active pathology or symptomatology.

Note: Impacted tooth is defined in the ADA CDT as: "An unerupted or partially erupted tooth that is positioned against another tooth, bone, or soft tissue so that complete eruption is unlikely."

Clinical / Coverage Guideline:

[OS3]: The prophylactic removal of a tooth or teeth that appear to exhibit an unimpeded path of eruption and/or exhibit no active pathology or current symptomatology is not covered on most LIBERTY dental benefit plans.

Clinical / Coverage Guideline:

[OS4]: 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.

Clinical / Coverage Guideline:

[OS5]: The removal of asymptomatic, unerupted, third molars in the absence of active pathology may not be covered.

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

Clinical / Coverage Guideline:

[OS6]: Narratives describing the presence of pericoronitis on a fully erupted tooth are ambiguous. In such cases, the radiographic presentation will be the determining factor in the determination of coverage.

- All suspicious lesions should be biopsied and examined microscopically.
- Deep sedation / general anesthesia (D9220/D9221)

When D9220/21 is listed as covered procedures, benefits may be approved in conjunction with the following approved impaction extractions: D7230, D7240 and D7241.

Licensed dental consultants adjudicate D9220/21 benefits for other, simpler extractions on a case-by-case basis, with consideration for:

- Medical conditions affecting the ability of the patient to tolerate an extraction such as special needs patients (autism, developmental disability, complex medical conditions, etc.)
- The extent and/or number of infected teeth
- Alveoloplasty and/or procedures involving the excision of bone or extensive, invasive or surgical procedures requiring a sufficient length of time so that performing such procedures without alteration of consciousness would be difficult or impossible.
- Bone replacement graft for ridge preservation – per site (D7953)

Clinical / Coverage Guideline:

[OS7]: Osseous auto graft, allograft or non-osseous graft may be placed in an extraction site at the time of the extraction to preserve ridge integrity (e.g., clinically indicated in preparation for implant reconstruction or where alveolar contour is critical to planned prosthetic reconstruction) as a covered service.

Clinical / Coverage Guideline:

[OS8]: Grafting may be reported under a variety of codes. Reviewing Dental Consultants may alter or correct the code for grafting when the identified use of the code submitted appears to not be consistent with the definition or the apparent clinical application of the code. CDT 2011/2012, page 67

Note: Code D7953 should be reported when the bone graft “is placed in an extraction site at the time of the extraction . . .” to preserve ridge integrity.

- Bone replacement graft – first site in quadrant (D4263)

“This procedure involves the use of osseous auto grafts, osseous allografts or non-osseous grafts to stimulate periodontal regeneration when the disease process has led to a deformity of the bone...”

Code D4263 is primarily used to report a bone graft performed to stimulate periodontal regeneration when the disease process has led to deformity of the bone around an existing tooth. This code should not be used in conjunction with extractions and/or ridge preservation.

Note: Benefits for bone graft procedures are based on individual plan designs, including limitations and exclusions.

PERIODONTICS

Periodontal Screening and Examination:

All children, adolescents and adults should be evaluated for evidence of periodontal disease. If pocket depths do not exceed 3 mm and there is no bleeding on probing or evidence of radiographic bone loss, it is appropriate to document the patient’s periodontal status as being “within normal limits” (WNL).

In many cases, a periodontal screening activity such as visual inspection, PSR® (Periodontal Screening and Recording) evaluation of each sextant or other mechanism may provide sufficient information to make a diagnosis or treatment plan.

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

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

Periodontal treatment sequencing:

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

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.

Note, this procedure:

- must be supported by radiographic evidence of heavy calculus
- is not a replacement code for procedure D1110
- is not appropriate on the same day as procedure D0150 or D0180

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

- Treatment follows a periodontal evaluation usually conducted at the examination appointment. The Treatment involves the instrumentation of the crown and root surfaces of the teeth to remove plaque, calculus, biofilm and stains from these surfaces. The absence of calculus should be evident on post treatment radiographs. These procedures are:
- Considered to be within the scope of a general dentist or a dental hygienist
- Supported when full mouth periodontal pocket charting demonstrates at least 4 mm pocket depths. It is common for radiographs to reveal evidence of bone loss of attachment and/or the presence of interproximal calculus.
- 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. In the interim, any localized scaling and root planning would be included within periodontal maintenance procedure D4910.

Clinical / Coverage Guideline:

[PR1]: Perform no more than 2 quadrants of SRP at the same visit (or, in most cases, on the same date of service) unless a medical or other condition is present that would justify such AND there is demonstration of sufficient clinical treatment time to adequately perform judicious scaling and root planing of the submitted quadrants. Per clinical review, in the absence of such information, LIBERTY may limit the approval to no more than 2 quadrants on any given date of service.

Clinical / Coverage Guideline:

[PR2]: Scaling and Root Planing (SRP) should not be reported for an enhanced prophylaxis. Rather, it is the judicious removal of deposits on the root surface in the presence of periodontal disease. In most cases some form of local anesthesia would be indicated to properly render the SRP procedure.

Definitive or Pre-Surgical scaling and root planing:

- For early stages of periodontal disease, this procedure is used as definitive non-surgical treatment and the patient may not need to be referred to a periodontist based upon tissue response and the patient’s oral hygiene.
- 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 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 is arduous and time consuming, involving instrumentation of the crown and root surfaces of the teeth to remove plaque, calculus, and stains from these surfaces.

Clinical / Coverage Guideline:

[PR3]: 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 in the patient's records and/or progress notes.

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

D1110 and D4341

- It is usually not appropriate to perform D1110 and D4341 on the same date of service. LIBERTY's licensed dental consultants may review documented rationale for any such situations on a case-by-case basis.
- Periodontal maintenance at regular intervals should be instituted following scaling and root planing if the periodontal condition has improved to a controllable level. Periodontal pocket depths and gingival status should be recorded periodically.
- The patient's homecare compliance and instructions should be documented.

D4921 Gingival Irrigation – per quadrant

- If a patient elects not to have elective irrigation with other procedures (i.e. D1110, D4355, D4341, D4342 or D4910), contracted dentists may not limit the patient's access to other benefited procedures.
- A patient's refusal of irrigation does not constitute grounds for requesting a patient transfer.

Note regarding the use of CDT D9630 – Medicaments, by report: The American Dental Association implies that providers should not use this procedure code when reporting irrigation. LIBERTY Dental plans may have included language in the EOC indicating the acceptability of D9630 for irrigation techniques. Plan documentation supersedes the code definition for these Members.

D4381 Localized delivery of antimicrobial agents via a controlled release vehicle into diseased crevicular tissue, per tooth, by report

- Benefits are not available when D4381 is performed with D4341 or D4342 in the same quadrant on the same date of service.

Clinical / Coverage Guideline:

[PR4]: Locally-delivered antimicrobials are defined by ADA as adjunctive to periodontal therapy and were intended for use in refractory or non-responsive periodontal pockets. It would not be considered within the standard application of D4381 to provide this service until after a clinical area was determined to be refractory or non-responsive to standard surgical or non-surgical pocket reduction techniques. Therefore, LIBERTY will not benefit this procedure on the same day as D4341 or D4342 or as surgical periodontal therapy.

- Dentists may consider the appropriate use of local delivery antimicrobials for chronic periodontitis patients as an adjunct to procedures D4341/D4342 (scaling and root planing) AFTER the following steps¹:
- A clinician has completed D4341/D4342 and allowed a minimum 4-week healing period. Then, the patient's pockets are re-probed and re-evaluated to determine the clinical response to the scaling and root planing.
- Re-evaluation confirms that several teeth were non-responsive to scaling and root planing, with localized residual pocket depths of 5 mm's or deeper plus inflammation.

Clinical / Coverage Guideline:

[PR5]: LIBERTY dental consultants may approve D4381 benefits for non-responsive cases following scaling and root planing on a 'by report' basis:

- In such cases, benefits may be approved for two teeth per quadrant in any twelve month period
- Other procedures, such as systemic antibiotics² or surgery, should be considered when multiple teeth with 5 mm pockets or deeper exist in the same quadrant.

Treatment alternatives such as systemic antibiotics² or periodontal surgery instead of procedure D4381 should be considered when:

- Multiple teeth with pocket depths of 5 mm's or deeper exist in the same quadrant
- Procedure D4381 was completed at least 4-weeks after D4341 but a re-evaluation of the patient's clinical response confirms that D4381 failed to control periodontitis (i.e. a reduction of localized pocket depths)
- Anatomical defects are present (i.e. infrabony defects)
- Periodontal Surgical Procedures (D4240/41, D4260/61 and related surgical procedures)

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

¹ American Academy of Periodontology Statement on Local Delivery of Sustained or Controlled Release Antimicrobials as Adjunctive Therapy in the Treatment of Periodontitis. May, 2006

² American Academy of Periodontology Position Paper, Systemic Antibiotics in Periodontics. November, 2004

WARNINGS/PRECAUTIONS: This procedure may be contra-indicated during pregnancy.

"May cause fetal harm during pregnancy." ADA/PDR Guide to DENTAL THERAPEUTICS, Fourth Edition

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

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

- Pocket depths are 4 mm's or less and appear to be maintainable by non-surgical means (i.e. periodontal maintenance and root planing)
- Patients are smokers or diabetics who's disease is not being adequately managed
- Periodontal pocket reduction surgical procedures should result in the removal of residual calculus and granulation tissue with improved physiologic form of the gingival tissues.
- Osseous surgery and regenerative procedures should also correct and reshape deformities in the alveolar bone where indicated.
- Soft tissue gingival grafting should be done to correct gingival deficiencies where appropriate.
- D4249 clinical crown lengthening – hard tissue

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

Clinical / Coverage Guideline:

[PR6]: LIBERTY will not benefit a periodontal surgical procedure on the same tooth on the same date of service as a final impression for a fixed or removable prosthesis, as healing has not occurred, which could change the architecture substantially affecting the outcome of the prosthesis.

Clinical / Coverage Guideline:

[PR7]: LIBERTY considers the management or alteration of soft tissues performed during a restorative procedure or crown preparation with final impressions to be a part of and included in the fee for the related procedure. Providers may not charge LIBERTY or the patient a separate fee for D4249 if it is performed on the same tooth on the same day as preparation and final impressions for a crown.

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

Clinical / Coverage Guideline:

[PR8]: Periodontal Maintenance D4910 is allowable for 3 years (or even longer) when there is a history of periodontal therapy evident in the patient's treatment record (by report, by LIBERTY record, or by narrative).

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.

Restorative treatment must be identified using valid procedure codes as found in the current edition of the American Dental Association's Current Dental Terminology (CDT). This source includes nomenclature and descriptors for each procedure code.

Sequencing of treatment must be appropriate to the needs of the patient.

Clinical / Coverage Guideline:

[R1]: Treatment results, including margins, contours and contacts, should be clinically acceptable. The long-term prognosis should be good.

- Restorative dentistry includes the restoration of hard tooth structure lost as a result of caries, fracture, erosion, attrition, or trauma.
- Restorative procedures in operative dentistry include silver amalgam; resin-based composites; direct or indirectly fabricated inlays, onlays and crowns of various materials; certain pre-fabricated restorations (i.e. stainless steel or polycarbonate type crowns), as well as the use of various temporary materials.

Amalgam fillings, safety & benefits

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

"WASHINGTON, July 28, 2009—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...

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 several decades, including two large clinical trials published in the April 2006 Journal of the American Medical Association, indicate dental amalgam is a safe, effective cavity-filling material for children and others. And, in its 2009 review of the scientific literature on amalgam safety, the ADA's Council on Scientific Affairs reaffirmed that the scientific evidence continues to support amalgam as “a valuable, viable and safe choice for dental patients...”

Clinical / Coverage Guideline:

[R2]: Amalgam free dental offices - If a dentist chooses not to provide amalgam fillings, alternative posterior fillings must be made available for LIBERTY patients. Any listed amalgam copayments would still apply.

Clinical / Coverage Guideline:

[R3]: Any alleged “allergies” to silver 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.

- 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.
- 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.
- The procedures of choice for treating caries or the replacement of an existing restoration not involving or undermining the incisal edges of an anterior tooth is composite. Decay limited to the Incisal edge only, may be a candidate for a filling restoration if little to no other surfaces manifests caries or breakdown.
- Restorations for chipped teeth may be covered. Providers should not use an exclusion for “treatment of an accident” to deny coverage for a chipped tooth that occurs through normal function and wear of the tooth over time. “Treatment of an accident” exclusion is reserved for traumatic accidents such as automobile collisions, serious external trauma to the face, etc. requiring complex dental reconstructive procedures.

Clinical / Coverage Guideline:

[R4]: The replacement of clinically acceptable amalgam fillings with alternative materials (composite, crown, etc.) is considered cosmetic and is not covered unless decay or fracture is present.

Clinical / Coverage Guideline:

[R5]: 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. (see clinical guidelines in Restorative section)

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

- For posterior primary teeth showing 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.
- When incisal edges of anterior teeth are undermined due to caries or replacement of a restoration undermining the incisal edges or a fracture, the procedures of choice may be veneers or crowns, either porcelain fused to metal or porcelain/ceramic substrate.
- An onlay should be considered when there is sufficient tooth structure, but cusp support is needed.
- An inlay is an intracoronal restoration and should have the same indications as a filling. It may not be practical to use an inlay due to the cost and limited use in current clinical dentistry practices

Other resin restorations:

- D1351 sealant – per tooth

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

Clinical / Coverage Guideline:

[R6]: If the resin restoration does not penetrate dentin, D1351 is appropriate.

Clinical / Coverage Guideline:

[R6]: If the pits and/or fissures are prepared, but remain in enamel, D1352 preventive resin restoration is appropriate

Clinical / Coverage Guideline:

[R7]: D2990 resin infiltration of incipient smooth surface lesions is appropriate for smooth surface lesions with some or no minor enameloplasty

- D2330, D2391 or D2392 - Resin-based composites

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

- D9910/D9911 - Desensitizing

Appropriate reporting of these procedures is clearly detailed below.

Clinical / Coverage Guideline:

[R8]: 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.

- D9910 – application of desensitizing medicament

Clinical / Coverage Guideline:

[R9]: Includes in-office treatment for root sensitivity. Typically reported on a “per visit” basis for application of topical fluoride. As per the ADA’s CDT, this code is not to be used for bases, liners or adhesives under restorations.

- D9911 – application of desensitizing resin for cervical and/or root surface, per tooth

Clinical / Coverage Guideline:

[R10]: As per the ADA’s CDT, this code is not to be used for bases, liners, or adhesives used under restorations.

CROWNS AND FIXED BRIDGES

Note: Providers should report the date of delivery for crowns and bridges. However, in special circumstances, providers may document the date of service for these procedures to be the date when final impressions are completed, in special circumstances. Provider would be subject to review.

Clinical / Coverage Guideline:

[CR1]: Providers must complete any irreversible procedure started regardless of payment or coverage.

- Upgrades

Plan designs limit the total maximum amount chargeable to a member for any combination of upgrades to \$250 per unit.

Typical upgrades include:

- Choice of metal – noble, high noble, titanium alloy or titanium
- porcelain on molar teeth
- porcelain margins, by report

Note: porcelain margin upgrades may be reported as D2999 for single crowns or as D6999 for abutment crowns

- Based on the particular plan design, porcelain margins may be charged separately. A reasonable charge should be made (\$100 or less per unit). Signed informed consent accepting the optional nature of this feature must be present.

Clinical / Coverage Guideline:

[CR2]: Grievances involving charges for upgrades will be found in favor of the Provider’s right to charge for upgraded features only when a signed informed consent or treatment plan is present that meets the “prudent layperson” requirement for clear disclosure of the proposed upgraded features. Members must have access to their covered benefit as well as any upgraded procedures.

- Single Crowns

Clinical / Coverage Guideline:

[CR3]: When bicuspid and anterior crowns are covered, the benefit is generally porcelain fused to a base metal crown or a porcelain/ceramic substrate crown.

Clinical / Coverage Guideline:

[CR4]: When molar crowns are indicated due to caries, an undermined or fractured off cusp or the necessary replacement of a restoration due to pathology, the benefit is usually a base metal crown.

Clinical / Coverage Guideline:

[CR5]: Porcelain/ceramic substrate crowns and porcelain fused to metal crowns on molars may be susceptible to fracture during occlusal function; therefore porcelain/ceramic restorations on molar teeth should not be routinely used.

Clinical / Coverage Guideline:

[CR6]: When anterior teeth have incisal edges/corners that are undermined or missing because of caries, a defective restoration or are fractured off, a labial veneer may not be sufficient. The treatment of choice may then become porcelain fused to a base metal crown or porcelain/ceramic substrate crown.

Clinical / Coverage Guideline:

[CR7]: Final 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%. See sequencing-related clinical / coverage guidelines earlier in this document.

Clinical / Coverage Guideline:

[CR8]: Crown services must be documented using valid procedure codes as found in the American Dental Association's Current Dental Terminology (CDT).

Enamel "craze" lines or "imminent" or "possible" fractures: Anterior or posterior teeth that show a discolored line in the enamel indicating a non-decayed defect in the surface enamel, and are not a through-and-through fracture should be monitored for future breakdown. Crowns may be benefited only when there is evidence of true decay undermining more than 50% of the remaining enamel surface, or when there is a through-and-through fracture identified radiographically, or when a portion of the tooth has actually fractured off and is missing. Otherwise, there is no benefit provided for crown coverage of a tooth due to a "suspected future or possible" fracture.

- Brand name dental materials/alternatives

Contracts, plan designs and benefit determinations are all based upon the CDT procedure codes, not on Brand Names. LIBERTY makes no distinction in payment for variations of material brand or quality within the same procedure code. It is the determination of the treating dentist as to what materials work best in each clinical situation. Benefit, plan payment and member copayment is per code

Benefit determination protocols utilized by LIBERTY's licensed Dental Consultants:

- Verify what procedure(s) a provider is recommending, regardless of any submitted Brand Name
- Apply the most accurate CDT code(s) to describe the verified procedure(s)

Refer to the specific, applicable plan design to determine if the verified procedure:

- is listed as covered
- would be considered some type of upgrade compared to a basic covered procedure
- is not covered at all

It is the responsibility of the provider to complete an adequate/accurate informed consent/financial disclosure process including:

- Benefits - the procedure code(s) for the member's basic benefit(s)
- Alternatives – the procedure code(s) for any recommended alternate, upgraded or non-covered service and the member's responsibility based on the application of the alternative treatment formula. Presentation of options must be clear and evident, so that a prudent layperson would understand the basic differences and the cost differences. Best practice would be for the member to sign the treatment plan sheet showing a clear indication of the choice selected, and to sign a separate financial consent indicating the agreement to pay for any alternative, optional or non-covered services. Adoption of these practices is aimed at preventing grievances after the fact, and minimizing refunds ordered by LIBERTY on the treating provider.
- Risks – the risks of treatment as well as the risks of doing nothing

It is expressly understood that "no treatment" is a viable option for various conditions and situations. Monitoring an area for further development is also a viable option and should be noted in the treatment plan.

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 pins and report it separately from either of these procedures for the same tooth during the same course of treatment.

Clinical / Coverage Guideline:

[CR9]: D2950 is generally not appropriate on an endodontically treated tooth receiving a post as the code D2954 post and core includes the core build up. LIBERTY will not benefit both codes on the same tooth on the same date of service.

- Outcomes
- Margins, contours and contacts must be clinically acceptable
- Prostheses should be designed with a minimum life expectancy or service life of 3- 5 years or more.

Clinical / Coverage Guideline:

[CR10]: Based on the submitted materials, if the requested single crown does not appear to have sufficient periodontal support, or sufficient tooth structure to retain a crown for an expected life of 5 or more years. Radiographic images indicate that the tooth may be mobile and be lost during normal function sooner than a 5-year life expectation.

- Fixed Bridges
- When a single posterior tooth is missing on one side of an arch and there are clinically adequate abutment teeth on each side of the missing tooth, the general choices to replace the missing tooth would be a fixed bridge or an implant.
- If it is also necessary to replace teeth on the opposite side of the same arch, the benefit would be a removable partial denture instead of a fixed bridge. In general, a removable partial denture would be the benefit in cases where there are multiple edentulous areas, when none of them have a bridge replacement in place.
- If an existing fixed bridge is present replacing one or more edentulous areas, the benefit is generally to replace like for like.
- If a bridge is failing, and must be replaced, and there are other edentulous areas, the dental consultant may consider the benefit to be replacement of both/all edentulous areas with a removable appliance.
- This consideration may be altered for a young person with periodontal stability. In such cases consideration may be given to replacing “like for like”; e.g. replacing a defective bridge with another one, even in the presence of other edentulous areas.
- Dental Consultants may deny the replacement bridge and may ask for additional information regarding the treating dentist’s plans for the other edentulous areas.
- Bridge abutments should generally be full coverage crowns.
- A distal cantilevered pontic is generally inappropriate for the replacement of a missing posterior tooth. However, a mesial cantilevered pontic but may be acceptable for the replacement of a maxillary lateral incisor when an adequate adjacent cuspid can be used for the abutment crown. Supporting narrative should be provided for any proposed cantilever bridge.
- Replacement of Third molars is not a benefit unless other molars are also missing and the placement of an implant approximating the third molar location would provide anchorage for prosthesis. Routine replacement of non-functional third molars is not a benefit.

Clinical / Coverage Guideline:

[BR1]: When a requested fixed bridge appliance does not meet plan guidelines for missing tooth replacement due to the presence of other missing teeth in the same arch, consideration should be given for a removable appliance to replace all areas of missing teeth.

Clinical / Coverage Guideline:

[BR2]: Fixed bridges are not covered benefits in the presence of untreated moderate to severe periodontal disease, as evidenced in x-rays, or when a proposed abutment tooth or teeth have poor crown/root ratios.

Clinical / Coverage Guideline:

[BR3]: Fixed bridges are not a benefit or considered clinically acceptable by LIBERTY in the presence of evidence of possible active periodontal disease indicating the likelihood of tooth mobility when remaining tooth structure does not provide sufficient crown/root ratio of 50% or greater; or sufficient tooth structure to properly retain the prosthesis on one or more teeth involved. Consideration should be given to a removable prosthesis.

Clinical / Coverage Guideline:

[BR4]: When up to all four incisors are missing in an arch, the potential abutment teeth are clinically adequate and implants are not appropriate, possible benefits for a fixed bridge will be evaluated on a case-by-case basis. Evaluation and diagnosis of any patient's periodontal status or active disease should be documented with recent full mouth periodontal probing and submitted with any benefit determination.

- Margins, contours and contacts should be clinically acceptable
- Prognosis should be good for long term longevity
- Guidelines for the Assessment of Clinical Quality and Professional Performance of the California Dental Association shall apply.

REMOVABLE PROSTHODONTICS

Note: Providers should document the date of service for these procedures to be the date when prosthetic appliances are delivered. In some extenuating cases, LIBERTY may allow final impression date for cases where there was a difficulty in delivering the case. Any such submission must contain a narrative explanation of the complications, and is subject to review for partial payment or denial by LIBERTY.

Clinical / Coverage Guideline for all Removable Prosthodontic appliances:

[RM1]: If you did not plan for a denture or other appliance to be temporary or interim, and you find that a new denture is now necessary due to case complications including but not limited to, healing, shrinkage, appliance design, patient discomfort, occlusion errors, non-refractory sore areas, etc. LIBERTY is responsible only for the coverage as listed in the dental plan benefit schedule, and may provide no additional coverage. Further, members are not responsible for paying for services that have a non-optimal substandard outcome.

- Removable Partial Dentures

Clinical / Coverage Guideline:

[RM2]: A removable partial denture is normally not indicated for a single tooth replacement of non-functional second or third molars (i.e. no opposing occlusion).

Clinical / Coverage Guideline:

[RM3]: Partial dentures are covered when posterior teeth require replacement on both sides of the same arch or multiple edentulous areas (missing but un-replaced natural teeth spaces) are present.

Clinical / Coverage Guideline:

[RM4]: Full or partial dentures are not covered for replacement if an existing appliance can be made satisfactory by relining or repair.

Clinical / Coverage Guideline:

[RM5]: Full or partial dentures are not a covered benefit 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.

- LIBERTY considers “Best Practice” to replace unilateral missing teeth with a fixed bridge or implant. Unilateral removable partial dentures are rarely appropriate.
- LIBERTY considers “Best Practice” that abutment teeth should be restored with crown or filling prior to the fabrication of a removable appliance. LIBERTY provides coverage for the abutment teeth if the teeth meet the same standalone benefit requirements of a single crown.
- Partials should be designed so that they do not harm the remaining teeth.
- Materials used for removable of partial dentures must be strong enough to resist breakage during normal function, nonporous, color stable, esthetically pleasing, non-toxic and non-abrading to the opposing or supporting dentition or adjacent soft tissues.
- Appliances should be designed to cause no damage to abutment teeth and/or periodontal tissues, and to facilitate oral hygiene.
- Flexible partial dentures (D5225/D5226) include the following brands: Valplast, Thermoflex, Flexite, etc.
- Partial dentures with acrylic clasps (such as Valplast or others, also known as “Combo Partials”) are considered under the coverage for D5213/D5214.
- Proper patient education and orientation to the use of removable partial dentures should be part of the diagnosis and treatment plan.
- Educational materials regarding these prostheses are highly encouraged at the treatment planning phase as well as at the delivery of the appliance to avoid misunderstandings and grievances, and to manage patient expectation.

Complete Dentures

- Complete dentures are the appliances of last resort, particularly in the mandibular arch. Patients should be fully informed of their significant limitations.
- Establishing vertical dimension is considered to be a part of and included in the fee/process for fabricating a complete denture (standard, interim or immediate). Therefore, benefits for a complete denture are not limited or excluded in any way simply because of the necessity to establish vertical dimension.
- Proper patient education and orientation on how to the use of removable partial dentures should be part of the diagnosis and treatment plan.

- Educational materials regarding these prostheses are highly encouraged at the treatment planning phase as well as at the delivery of the appliance to avoid misunderstandings and grievances, and to manage patient expectation.

“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. Benefit may not exist for both an interim and definitive (final or “permanent”) complete denture.
- Discussion of coverage and benefits for any interim appliances that are planned to be interim or temporary should be clearly discussed and agreed by the member before proceeding with optional, elective, upgraded or non-covered service. Evidence of such a discussion would be member signature on informed consent forms, treatment plan documents, chart progress notes and/or financial consent forms.

Immediate Complete Dentures

- These covered dentures are inserted immediately after a patient’s remaining teeth are removed. While immediate dentures offer the benefit of never having to be without teeth, in many cases, immediate dentures are discarded and replaced after full healing with standard complete dentures within the first six months. Often these second dentures are not covered or have limited coverage. See Clinical / Coverage Guideline at the beginning of this section.
- Discussion of coverage and benefits for interim appliances that are planned to be interim or temporary should be clearly discussed and agreed by the member before proceeding with any optional, elective, upgraded or non-covered service. Evidence of such a discussion would be member signature on informed consent forms, treatment plan documents, chart progress notes and/or financial consent forms.

Clinical / Coverage Guideline:

[RM6]: LIBERTY understands that Immediate Denture(s) may be designed to be the permanent set of dentures, or are planned to be interim/temporary for the post-extraction healing phase only. Clear understanding of the intent of the provider regarding whether or not the immediate denture(s) will be the final definitive dentures or just used as an interim appliance should be clearly stated in the treatment plan that is signed by the member. The provider and member shall work together to create a treatment plan that is mutually acceptable.

Proper patient education and orientation to the use of removable partial dentures should be part of the diagnosis and treatment plan. Educational materials regarding these prostheses are highly encouraged to avoid misunderstandings and grievances, and to manage patient expectation.

Adjustments, Repairs and Relines

- Adjustment, repair or reline of a partial or complete denture (or any appliance) should result in a serviceable functional appliance.

- The coverage of Repairs and Relines may be subject to various limitations, such as early follow-up repairs or relines after recent delivery.
- Supporting soft tissues and bone shrink over time, resulting in decreased retention and/or stability of a removable appliance. A reline of a partial or complete denture would be covered (subject to plan limitations if the procedure would result in a serviceable appliance.)

Clinical / Coverage Guideline:

[RM7]: LIBERTY discourages the performance of relines of recently placed appliances in an attempt to treat pain or dissatisfaction with the recently delivered appliance. A reline or rebase should only be placed when there is a definitive reason for altering the fit and retention of the flanges. If there has been no shrinkage or other identified problems with the appliance, the reline or rebase should not be performed and may not be a benefit. A narrative demonstrating medical necessity for the procedure along with other documentation should be provided for any reline or rebase of a standard appliance within 6 months of initial placement.

Clinical / Coverage Guideline:

[RM8]: Reline or rebase of an immediate denture after 12 months of initial placement is generally indicated and would be covered without need for narrative. Any needed reline or rebase prior to 12 months will be considered with inclusion of documentation of medical necessity for the procedure(s).

IMPLANTS

General Guidelines

A thorough history and clinical examination leading to the evaluation of the patient's general health and diagnosis of his/her oral condition must be completed prior to the establishment of an appropriate treatment plan.

A conservative treatment plan should be considered prior to providing a patient with one or more implants. Crown(s) and fixed partial prosthetics for dental implants may be contraindicated for the following reasons:

- Adverse systemic factors such as diabetes and history of recent smoking habit
- Poor oral hygiene and tissue management by the patient
- Inadequate osseointegration of the dental implant(s) (mobility)
- Excessive para-function or occlusal loading
- Poor positioning of the dental implant(s)
- Excessive loss of bone around the implant prior to its restoration
- Mobility of the implant(s) prior to placement of the prosthesis
- Inadequate number of implants or poor bone quality for long span prostheses
- Need to restore the appearance of gingival tissues in high esthetic areas
- When the patient is under 16 years of age, unless unusual conditions prevail

Restoration

- The restoration of dental implants differs in many ways from the restoration of teeth, and as such, the restoration of dental implants has separate guidelines.
- Care must be exercised when restoring dental implants so that the occlusal and lateral loading of the prosthesis does not damage the integration of the dental implant system to the bone or affect the integrity of the implant system itself.
- Care must also be exercised when designing the prosthesis so that the hardness of the material used is compatible with that of the opposing occlusion.
- Jaw relationship and inter-arch vertical distance should be considered in the initial treatment plan and selection of retentive and restorative appliances.

Outcomes

- The appearance of fixed prosthetic appliances for implants may vary considerably depending on the location, position and number of implants to be restored.
- The appearance of the appliances must be appropriate to meet the functional and esthetic needs of the patient.
- The appearance and shape of the fixed prosthesis must exhibit contours that are in functional harmony with the remaining hard and soft tissues of the mouth.
- They must exhibit good design form to facilitate good oral hygiene, even in cases where the prosthesis may have a ridge lap form.
- Fixed implant prostheses must incorporate a strategy for removal of the appliance without damage to the implant, or adjacent dentition, so that the implant can be utilized in cases where there is further loss of teeth, or where repair of the appliance is necessary.
- Multiple unit fixed prostheses for implants must fit precisely and passively to avoid damage to the implants or their integration to the bone.
- It is a contra-indication to have a fixed dental prosthesis abutted by both dental implant(s) and natural teeth (tooth) without incorporating a design to alleviate the stress from an osseo-integrated (non-movable) abutment to a natural tooth supported by the periodontal ligament allowing slight movement.
- It is the responsibility of the restoring dentist to evaluate the initial acceptability of the implants prior to proceeding with a restoration.
- It is the responsibility of the restoring dentist to instruct the patient in the proper care and maintenance of the implant system and to evaluate the patient's care initially following the final placement of the prosthetic restoration.
- Fixed partial prostheses, as well as a single unit crowns, are expected to have a minimum life expectancy or service life of 5-years.

SECTION 10 – SPECIALTY CARE REFERRAL GUIDELINES






The following guidelines outline the specialty care referral process. Failure to follow these guidelines may result in financial penalties against provider's office such as through capitation adjustment or financial recoupment processes from future claims or other means.

*All codes listed in this section may not be covered under all benefit plans. Referrals are subject to a member's plan-specific benefits, limitations and exclusions. Please refer to the Patient Copayment Schedule for plan-specific details regarding procedure codes and specialty referral protocols.

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

NON-EMERGENCY SPECIALTY REFERRAL SUBMISSION AND INQUIRIES

General Dentist must submit a referral request to the Plan for prior approval. There are three options to submit a specialty care referral:

	LIBERTY Dental Plan ATTN: Referral Department P.O. Box 26110 Santa Ana, CA 92799-6110		888.352.7924, press option 2
	Provider Portal: www.libertydentalplan.com		

If there is no contracted LIBERTY specialist available within a reasonable proximity to the General Dentist's office, provider's office staff may contact LIBERTY's Member Services office who will provide assistance to refer the patient to a non-contracted Specialist.

If a referral is made to a non-LIBERTY specialist by the patient's assigned General Dentist without prior approval, the referring office may be held financially responsible for any additional costs. Failure to use the proper forms and submit accurate information may cause delays in processing or claim payment.

The LIBERTY Specialty Care Referral Request Form or an Attending Dentist Statement must be completed and used when making a referral. The form may be photocopied and duplicated in provider's office as needed.

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

Provider must include a narrative statement as to the reasons for the specialty referral may be of great assistance to LIBERTY in processing the specialty referral.

EMERGENCY REFERRAL

If emergency specialty care is needed, the Referral Unit can issue an emergency authorization number to the General Dentist by calling **LIBERTY's Referral Unit** (888) 352-7924 press option 2.

ENDODONTICS

Referral Guidelines for the General Dentist

Confirm the need for a referral and that the Referral Criteria listed below are met.

Complete a LIBERTY Specialty Care Referral Request Form and provide the:

- Patient's name, the Primary Member's name, LIBERTY identification number, group name and group number
- Name, address and telephone number of the contracted LIBERTY network Endodontist. If provider and provider's staff are unfamiliar with network Endodontists, contact LIBERTY's Member Services for specialty referral assistance
- Procedure code(s), tooth number(s) and member copayments for the covered endodontic treatment, which requires referral

Inform the member that:

- Referral is only approved for services listed on the request from the referring General Dentist
- The member will be financially responsible for non-covered and non-approved services provided by the Endodontist, as well as the copayment for the covered services
- Payment by the Plan is subject to eligibility at the time services are rendered

For non-emergency referrals, submit referral to LIBERTY Dental Plan with appropriate documentation/x-rays through i-Transact or via standard mail service.

The Plan's Dental Consultant (a licensed dentist) will review referral to ensure requested procedures meet referral guidelines and plan benefits.

REFERRAL GUIDELINES FOR THE ENDODONTIST:

Obtain the LIBERTY Specialty Care Authorization and pre-operative periapical radiograph(s) from LIBERTY Dental Plan, General Dentist or member.

For any services, other than those listed on the original authorization form from LIBERTY Dental Plan, you must submit a preauthorization request to the Plan with a copy of pre-operative periapical radiograph(s) and justifying narrative, as well as the member's LIBERTY Specialty Care Authorization.

If an emergency endodontic service is needed, but has not been listed on the original authorization form, the Endodontist should contact **LIBERTY's Referral Unit** at (888) 352-7924, press option 2 for an emergency authorization number. This will provide tentative authorization. However, any such service added to an existing pre-authorization by virtue of phoning the Referral Unit, will require pre-operative x-ray and narrative when Specialist submit for payment. Any emergency service must qualify for authorization and will receive clinical review by a LIBERTY Dental Consultant at the time it is reviewed for payment.

After completion of treatment, submit claim for payment with post-operative periapical radiographs. (To avoid delays in claim payment, please always attach a copy of the member's Authorization Form.) **X-rays and other supporting documentation will not be returned. Please do not submit original x-rays. X-ray copies of diagnostic quality or paper copies of digitized images, are acceptable.**

Your office is responsible for the collection of any applicable copayments from the patient.

Endodontic Referral Guidelines					
Endodontic Referrals General Dentist Specialty Care Guidelines (Subject to plan Benefits)		Procedures Usually Approved For Referral	Referral Criteria (teeth must have a good prognosis & be restorable)	Emergency Referral Criteria	Qualifies for Emergency Referrals
D0220	Intraoral - periapical first film	No	N/A	Swelling, bleeding and/or pain and the General Dentist has attempted palliative treatment	If no diagnostic PA x-ray is available
D3310	Root canal - anterior (excluding final restoration)	No	When excessive root curvature or calcification evident on x-rays precludes General Dentist from treating		Extraordinary circumstances considered on a case-by-case basis
D3320	Root canal - bicuspid (excluding final restoration)	No			Extraordinary circumstances considered on a case-by-case basis
D3321	Pulpal Debridement	No	This procedure would only be covered for General Dentists who then refer to an Endodontist to continue treatment		No
D3330	Root canal - molar (excluding final restoration)	Yes	Attending General Dentist documents procedure to be "outside the scope" of his or her skills		Yes
D3331	Treatment of root canal obstruction; non-	No	Endodontic claims for this procedure		No

Endodontic Referral Guidelines					
Endodontic Referrals General Dentist Specialty Care Guidelines (Subject to plan Benefits)		Procedures Usually Approved For Referral	Referral Criteria (teeth must have a good prognosis & be restorable)	Emergency Referral Criteria	Qualifies for Emergency Referrals
	surgical access		evaluated on a case-by-case. Canal must be 50% in length obstructed		
D3332	Incomplete endodontic therapy; inoperable, non-restorable or fractured tooth	No	N/A		No
D3333	Internal root repair of perforation defects	B/R	Case-By-Case	Swelling, bleeding and/or pain and the General Dentist has attempted palliative treatment.	Yes
D3346	Retreatment of previous root canal therapy - anterior	Yes			Yes
D3347	Retreatment of previous root canal therapy - bicuspid	Yes			Yes
D3348	Retreatment of previous root canal therapy - molar	Yes			Yes
D3351	Apexification/recalcification - initial visit (apical closure/calific repair of perforations, root resorption, etc.)	Yes			Extraordinary circumstances considered on a case-by-case basis
D3410	Apicoectomy/periradicular surgery - anterior	Yes			
D3421	Apicoectomy/periradicular surgery - bicuspid (first root)	Yes			
D3425	Apicoectomy/periradicular surgery - molar (first root)	Yes			
D3426	Apicoectomy/periradicular surgery (each additional root)	Yes			
D3430	Retrograde filling - per	Yes			

Endodontic Referral Guidelines					
Endodontic Referrals General Dentist Specialty Care Guidelines (Subject to plan Benefits)		Procedures Usually Approved For Referral	Referral Criteria (teeth must have a good prognosis & be restorable)	Emergency Referral Criteria	Qualifies for Emergency Referrals
	root				
D3450	Root Amputation - per root	Yes			
D3910	Surgical procedure for isolation of tooth with rubber dam	No			
D3920	Hemisection (including any root removal), not including root canal therapy	No			
D9310	Consultation - diagnostic service provided by dentist or physician other than requesting dentist or physician	Yes	Not payable when rendered on the same day as other services		Yes

ORAL SURGERY

Referral Guidelines for the General Dentist:

Confirm the need for a referral and that the Referral Criteria listed below are met.

Complete a LIBERTY Specialty Care Referral Request Form and provide the:

- Patient's name, the Primary Member's name, LIBERTY identification number, group name and group number;
- Name, address and telephone number of the contracted LIBERTY network Oral Surgeon. If you are unfamiliar with network Oral Surgeons, contact LIBERTY's Member Services for specialty referral assistance.
- Procedure code(s) and, tooth number(s)/quadrant(s), which require referral.

Inform the member that:

- Referral is only approved for services listed on the request from the referring General Dentist;
- The member will be financially responsible for non-covered and non-approved services provided by the Oral Surgeon, as well as any copayment for the covered services.
- Payment by the Plan is subject to eligibility at the time services are rendered.

For non-emergency referrals, submit referral to LIBERTY Dental Plan with appropriate documentation/x-rays through i-Transact or via standard mail service.

The Plan Dental Consultant (a licensed dentist) will review referral to ensure requested procedures meet referral guidelines and plan benefits.

Referral Guidelines for the Oral Surgeon:

Obtain the LIBERTY Specialty Care Authorization and appropriate radiograph(s) from LIBERTY Dental Plan, General Dentist or member.

For any services, other than those listed on the referral form the patient's General Dentist, you must submit a preauthorization request to the Plan with a copy of pre-operative periapical radiograph(s) or panoramic radiograph, and any justifying narrative, as well as the member's LIBERTY Specialty Care Authorization.

If an emergency oral surgery service is needed, but has not been listed by the General Dentist on the LIBERTY Specialty Care Authorization, the Oral Surgeon should contact LIBERTY's Referral Unit at (888) 352-7924, Option 2 for an emergency authorization number. Any such services added to the Referral via telephone will be subject to clinical review at the time of submission for payment. Enclose any narrative and supportive pre-operative x-rays for these services to the claim form.

After completion of treatment, submit your claim for payment. To avoid delays in claim payment, please attach a copy of the member's LIBERTY Specialty Care Authorization or the Plan's authorization form. If emergency care was provided after obtaining a Plan emergency authorization number, print that number on the claim form and attach the radiograph(s). For a biopsy, also attach a copy of the laboratory's report. **X-rays and other supporting documentation will not be returned. Please do not submit original x-rays. X-ray copies of diagnostic quality or paper copies of digitized images are acceptable.**

Your office is responsible for the collection of any applicable copayments from the patient.

Oral Surgery Referral Guidelines				
Oral Surgery Referrals		Procedures Usually Approved For Referral	Referral Criteria	Qualified for Emergency Referral
D0220	Intraoral - periapical first film	B/R	Non-diagnostic x-rays sent by referring dentist	B/R
D0330	Panoramic film	B/R	Non-diagnostic x-ray(s) sent by General Dentist	B/R
D7111	Extraction, coronal remnants - deciduous tooth	No	N/A	No
D7140	Extraction, erupted tooth or exposed root (elevation and/or	No	N/A	No

Oral Surgery Referral Guidelines				
Oral Surgery Referrals		Procedures Usually Approved For Referral	Referral Criteria	Qualified for Emergency Referral
	forceps removal)			
D7210	Surgical removal of erupted tooth requiring elevation of mucoperiosteal flap & removal of bone and/or section of tooth	B/R	General Dentist's x-ray(s) supports the procedure to be "outside the scope" of his or her skills and/or five (5) or more teeth to be extracted.	B/R
D7220	Removal of impacted tooth - soft tissue	Yes	Most plans only allow a benefit with documented active pathology	Yes
D7230	Removal of impacted tooth - partially bony	Yes	Most plans only allow a benefit with documented active pathology	Yes
D7240	Removal of impacted tooth - completely bony	Yes	Most plans only allow a benefit with documented active pathology	Yes
D7241	Removal of impacted tooth - completely bony, with unusual surgical complications	Yes	Most plans only allow a benefit with documented active pathology	Yes
D7250	Surgical removal of residual tooth roots (cutting procedure)	B/R	X-ray must support the use of this code	Yes
D7280	Surgical access of an unerupted tooth	Yes		Yes
D7282	Mobilization of erupted or malpositioned tooth to aid eruption	Yes	Not covered under most plans	Yes
D7283	Placement of device to facilitate eruption of impacted tooth	Yes		Yes
D7285	Biopsy of oral tissue - hard (bone, tooth)	Yes		Yes
D7286	Biopsy of oral tissue - soft	Yes		Yes
D7310	Alveoloplasty in conjunction with extractions - 4 or more teeth or tooth spaces, per quadrant	B/R	May be included in multiple extractions	Yes
D7311	Alveoloplasty in conjunction	B/R		Yes

Oral Surgery Referral Guidelines				
Oral Surgery Referrals		Procedures Usually Approved For Referral	Referral Criteria	Qualified for Emergency Referral
	with extractions - 1 to 3 teeth or tooth spaces, per quadrant			
D7320	Alveoloplasty not in conjunction with extractions - 4 or more teeth or tooth spaces, per quadrant	B/R	B/R	Yes
D7321	Alveoloplasty not in conjunction with extractions 1 to 3 teeth or tooth spaces, per quadrant	B/R	B/R	Yes
D7471	Removal of lateral exostosis (maxilla or mandible)	Yes	B/R	Yes
D7960	Frenulectomy (frenectomy or frenotomy) - separate procedure	Yes	B/R	Yes
D7970	Excision of hyperplastic tissue - per arch	Yes	B/R	Yes
D9310	Consultation - diagnostic service provided by dentist or physician other than requesting dentist or physician	Yes	Not payable when rendered on the same day of other services	Yes

ORTHODONTICS

Referral Guidelines for the General Dentist:

Confirm the need for a referral and that the Referral Criteria listed below are met.

Complete a LIBERTY Specialty Care Authorization and provide the:

- Patient's name, the Primary Member's name, LIBERTY identification number, group name and group number
- Name, address and telephone number of the contracted LIBERTY network Orthodontist. If you are unfamiliar with network Orthodontists, contact LIBERTY's Member Services for specialty referral assistance
- Comments concerning the member's malocclusion

Inform the member that:

- Referrals are subject to an member's plan-specific benefits, limitations and exclusions
- The member will be financially responsible for non-covered services provided by the Orthodontist as well as any copayments for the covered services
- Payment by the Plan is subject to eligibility at the time services are rendered

REFERRAL GUIDELINES FOR THE ORTHODONTIST:

Obtain the LIBERTY Specialty Care Authorization from LIBERTY Dental Plan, the General Dentist or member.

Contact the Plan's Membership Service department at (888) 352-7924 to obtain member's copayments and plan-specific benefits, limitations and exclusions for:

- Limited orthodontic treatment (D8020-40)
- Interceptive orthodontic treatment (D8050-60)
- Comprehensive orthodontic treatment (D8070-90)

After the pre-treatment visit, arrangements for initial records should be made. If the patient requires further general dentistry prior to banding, refer them back to the assigned General Dentist.

After patient is banded, submit your claim to the Plan for payment. Net payable claim amounts in excess of \$300.00 will be paid over the period of active orthodontic treatment.

Orthodontic Referral Guidelines			
Orthodontic Referrals General Dentist Specialty Care Guidelines (subject to Plan Benefits)		Generally Approved For Referral	Referral Criteria
D8010	Limited orthodontic treatment of the primary dentition	Yes	General Dentist screens for appropriateness of orthodontic treatment and makes necessary referral Some benefit programs may only covered "medically necessary" orthodontic treatment and must be qualified for coverage by a required score of the various conditions present in the malocclusion
D8020	Limited orthodontic treatment of the transitional dentition	Yes	
D8030	Limited orthodontic treatment of the adolescent dentition	Yes	
D8040	Limited orthodontic treatment of the adult dentition	Yes	
D8050	Interceptive orthodontic treatment of the primary dentition	Yes	
D8060	Interceptive orthodontic treatment of the transitional dentition	Yes	
D8070	Comprehensive orthodontic treatment of the transitional dentition	Yes	
D8080	Comprehensive orthodontic treatment of the	Yes	

Orthodontic Referral Guidelines			
Orthodontic Referrals General Dentist Specialty Care Guidelines (subject to Plan Benefits)		Generally Approved For Referral	Referral Criteria
	adolescent dentition		
D8090	Comprehensive orthodontic treatment of the adult dentition	Yes	
D8210	Removable appliance therapy	Yes	
D8220	Fixed appliance therapy	Yes	
D8660	Pre-orthodontic treatment visit	Yes	
D8670	Periodic orthodontic treatment visit (as part of contract)	Yes	
D8680	Orthodontic retention (removal of appliances, construction and placement of retainer(s) - to age 18	Yes	
D8690	Orthodontic treatment (alternative billing to a contract fee)	Yes	
D8691	Repair of orthodontic appliance	Yes	
D8692	Replacement of lost or broken retainer	Yes	
D8693	Rebonding or recementing; and/or repair, as required, of fixed retainers	Yes	
D0210	Intraoral - complete series	Yes	
D0330	Panoramic Film	Yes	
D0340	Cephalometric Film	Yes	
D0350	Oral / facial photographic images	Yes	
D0470	Diagnostic casts	Yes	

PEDIATRIC DENTISTRY

Referral Guidelines for the General Dentist:

Confirm the need for a referral and that the Referral Criteria listed below are met.

Complete a Specialty Care Authorization and provide the:

- Patient's name, the Primary Member's name, LIBERTY identification number, group name and group number

- Name, address and telephone number of the contracted LIBERTY network Pediatric Dentist. If you are unfamiliar with network Pediatric Dentists, contact LIBERTY's Member Services for specialty referral assistance
- Procedure code, tooth number/quadrant and member copayments for each service, which require referral

If the General Dentist is unable to perform an adequate examination due to limited patient cooperation, the procedure codes for an examination and radiographs should be listed.

Inform the member that:

- Referral is only approved for services listed on the request from the referring General Dentist
- The member will be financially responsible for non-covered and non-approved services provided by the Pediatric Dentist, as well as any copayment for covered services
- Payment by the Plan is subject to eligibility at the time services are rendered

For non-emergency referrals, submit referral to LIBERTY Dental Plan with appropriate documentation/x-rays through i-Transact or via standard mail service.

The Plan Dental Consultant (a licensed dentist) will review the referral to ensure requested procedures meet referral guidelines and plan benefits.

Referral Guidelines for the Pediatric Dentist:

Obtain the LIBERTY Specialty Care Authorization and appropriate radiograph(s) from LIBERTY Dental Plan, General Dentist or member.

For any services, other than those listed on the referral from the patient's assigned General Dentist, you must submit a preauthorization request to the Plan with a copy of pre-operative periapical radiograph(s) and any justifying narrative and of the member's LIBERTY Specialty Care Authorization.

If an emergency pediatric service is needed, but has not been listed by the General Dentist on the LIBERTY Specialty Care Authorization, the Pediatric Dentist should contact the LIBERTY's **Referral Unit** at **888.352.7924**, press option 2 for an emergency authorization number. Any such services added to the Referral via telephone will be subject to clinical review at the time of submission for payment. Enclose any narrative and supportive pre-operative x-rays for these services to the claim form.

After completion of treatment, submit your claim for payment with justifying narrative and radiographs for any treatment that has not been pre-authorized. To avoid delays in claim payment, please always attach a copy of the LIBERTY Specialty Care Authorization or the Plan's authorization for treatment when applicable. **X-rays and other supporting documentation will not be returned. Please do not submit original x-rays. X-ray copies of diagnostic quality, including paper copies of digitized images, are acceptable.**

Your office is responsible for the collection of any applicable copayments from the patient.

Pediatric Referral Guidelines				
Pediatric Referrals General Dentist Specialty Care Guidelines (Subject to Plan Benefits)		Procedures Usually Approved For Referral	Criteria for Referral	Qualifies for Emergency Referral
D0145	Oral evaluation for a patient under 3 years of age	Yes	General Dentist has attempted to see child: Children 0-4 minimum of one attempt made by General Dentist. Children 4-7 two attempts made by General Dentist. Pediatric Referrals are limited to Children under the age of 7, unless the qualify under Americans with Disabilities Act "ADA"	
D0150	Comp oral evaluation - new/= or established patient	Yes		Yes
D0210	Intraoral - complete series	Yes		
D0220	Intraoral - periapical first film	Yes		Yes
D0230	Intraoral - periapical each additional film	Yes		Yes
D1120	Prophylaxis – child	Yes		Yes
D1203	Topical application of fluoride – child	Yes		Yes
D3110	Pulp Cap – direct	Yes		Yes
D3120	Pulp Cap – indirect	Yes		Yes
D3220	Therapeutic pulpotomy	Yes		Yes
D3221	Pulpal debridement primary and permanent teeth	Yes		Yes
D3230	Pulpal therapy - anterior primary tooth	Yes		Yes
D3240	Pulpal therapy - posterior primary tooth	Yes		Yes
D7140	Extraction erupted tooth or exposed root	Yes		Yes
D9310	Consultation - diagnostic service provided by dentist or physician other than requesting dentist or physician	Yes		Yes

PERIODONTICS

Referral Guidelines for the General Dentist:

Confirm the need for a referral and that the Referral Criteria listed below are met.

Complete a LIBERTY Specialty Care Authorization and provide the:

- Patient's name, the Primary Member's name, LIBERTY identification number, group name and group number
- Name, address and telephone number of the contracted LIBERTY network Periodontist. If you are unfamiliar with network Pediatric Dentists, contact LIBERTY's Member Services for specialty referral assistance

- Procedure code(s), tooth number/quadrant(s) and member copayments for the covered periodontal treatment, which require referral

Inform the member that:

- Referral is only approved for services listed on the request from the referring General Dentist
- The member will be financially responsible for non-covered and non-approved services provided by the Periodontist, as well as any copayment for the covered services
- Payment by the Plan is subject to eligibility at the time services are rendered
- Submit referral to LIBERTY Dental Plan with appropriate documentation/x-rays through i-Transact or via standard mail service
- The Plan's Dental Consultant (a licensed dentist) will review referral to ensure requested procedures meet referral guidelines and plan benefits

Referral Guidelines for the Periodontist:

Obtain the LIBERTY Specialty Care Authorization and appropriate radiograph(s) from LIBERTY Dental Plan, General Dentist or member.

For any services, other than those listed on the referral from the patient's assigned General Dentist, submit a preauthorization request to the Plan with copies of:

- Pre-operative radiographs
- Complete periodontal charting showing six-point probing of each natural tooth and any furcation involvements, abnormal mobility, areas of little-to-no attached gingiva or areas of recession. Submit x-rays that were enclosed with original authorization form (or copies) and any justifying narrative
- The member's LIBERTY Specialty Care Authorization.

If an unforeseen periodontic service is needed, but has not been listed by the General Dentist on the LIBERTY Specialty Care Authorization, the Periodontist should contact the LIBERTY's **Referral Unit** at (888) 352-7924, press option 2 for an emergency authorization number. Any such services added to the Referral via telephone will be subject to clinical review at the time of submission for payment. Enclose any narrative and supportive pre-operative x-rays for these services to the claim form.

After completion of treatment, submit your claim for payment with a copy of the Plan's authorization for treatment.

Your office is responsible for the collection of any applicable copayments from the patient.

Periodontic Referral Guidelines				
Periodontal Referrals General Dentist Specialty Care Guidelines (subject to Plan Benefits)		Procedures Usually Approved For Referral	Referral Criteria	Items to be sent to LDP and specialist
D0180	Comprehensive periodontal evaluation	Yes	General Dentist has completed non-surgical services + follow-up evaluation, patient exhibits good motivation & oral hygiene habits	Diagnostic Full Mouth x-rays & Full Mouth periodontal probings
D0210	Intraoral - complete series (including bitewings)	No	No	Yes
D4210	Gingivectomy or gingivoplasty - 4 or more contiguous teeth or bounded teeth spaces per quadrant	B/R	Diagnostic Full Mouth x-rays & Full Mouth periodontal probings	Diagnostic Full Mouth x-rays & Full Mouth probings
D4211	Gingivectomy or gingivoplasty - 1 to 3 contiguous teeth or bounded teeth spaces per quadrant	B/R		
D4240	Gingival flap procedure, including root planing - 4 or more contiguous teeth or bounded teeth spaces per quadrant	B/R		
D4241	Gingival flap procedure, including root planing - 1 to 3 contiguous teeth or bounded teeth spaces per quadrant	B/R		
D4245	Apically positioned flap	B/R		
D4249	Clinical crown lengthening - hard tissue	B/R	PA x-ray confirms necessity to retain a crown on a restorable tooth	PA x-ray showing entire root
D4260	Osseous surgery (including flap entry & closure) - 4 or	B/R	When approved, limited to no more	Full Mouth x-rays, Full mouth

Periodontic Referral Guidelines				
Periodontal Referrals General Dentist Specialty Care Guidelines (subject to Plan Benefits)		Procedures Usually Approved For Referral	Referral Criteria	Items to be sent to LDP and specialist
	more contiguous teeth or bounded teeth spaces per quadrant		than two quadrants on the same date of service	periodontal probing's, dates of SRP's & follow-up evaluation
D4261	Osseous surgery (including flap entry & closure) - 1 to 3 contiguous teeth or bounded teeth spaces per quadrant	B/R	B/R	
D4263	Bone replacement graft - first site in quadrant	B/R	B/R	
D4264	Bone replacement graft - each additional site in quadrant	B/R	B/R	
D4270	Pedicle soft tissue graft procedure	B/R	Most plans do not benefit this procedure	
D4271	Free soft tissue graft procedure (including donor site surgery)	B/R	B/R	
D4274	Distal or proximal wedge procedure (when not performed in conjunction with surgical procedures in the same anatomical area)	B/R	B/R	
D4341	Periodontal scaling & root planing - 4 or more teeth per quadrant	No	For moderate to severe periodontitis, "may" be considered for referral	If approved, limited to no more than two quadrants on the same date of service
D4342	Periodontal scaling & root planing - 1 to 3 teeth per quadrant	No	For moderate to severe periodontitis, "may" be considered for referral	
D9310	Consultation - diagnostic service provided by dentist or physician other than requesting dentist or	Yes	Not payable when rendered on the same day of other procedures	B/R

Periodontic Referral Guidelines			
Periodontal Referrals General Dentist Specialty Care Guidelines (subject to Plan Benefits)	Procedures Usually Approved For Referral	Referral Criteria	Items to be sent to LDP and specialist
physician			

Referral Coverage Based on Diagnosis

Gingivitis

- Sulcus depths of 1 – 3 mm with the possibility of an occasional 4 mm pseudo pocket
- Some bleeding upon probing
- No abnormal tooth mobility, no furcation involvements and no radiographic evidence of bone loss (i.e., the alveolar bone level is within 1 – 2 mm of the cemento-enamel junction area)

Referral to a Periodontist covered only for a problem-focused evaluation and hard tissue clinical crown lengthening or soft tissue grafting.

Slight Chronic/Aggressive Periodontitis (localized or generalized)

- 4 - 5 mm pockets and possibly an occasional 6 mm pocket with 1 - 2 mm of clinical attachment loss
- Moderate bleeding upon probing, which is more generalized than in gingivitis
- Normal tooth mobility with possibly some Class 1 (+/- 1.0 mm) mobility
- No furcation involvement or an isolated Grade 1 involvement (i.e., can probe into the concavity of a root trunk)
- Radiographic evidence of localized loss crestal lamina dura and early to very moderate (10% - 20%) bone loss, which is usually localized

Referral to a Periodontist covered only for a problem-focused evaluation and hard tissue clinical crown lengthening, soft tissue grafting or, if there are isolated 5 mm pockets, periodontal surgery.

Moderate Chronic/Aggressive Periodontitis, (localized or generalized)

- Pocket depths of 4 – 6 mm with the possibility of localized greater pocket depths with 3 - 4 mm of clinical attachment loss
- Generalized bleeding upon probing
- Possible Class 1 to Class 2 (1 – 2 mm) tooth mobility
- Class I furcation involvement with the possibility of some early Class II (i.e., can probe between the roots)
- Radiographic evidence of moderate (20%-40%) bone loss, which is usually horizontal in nature

Referral to a Periodontist covered for a problem-focused examination and possible periodontal surgery.

Moderate Chronic/Aggressive Periodontitis may be eligible for direct specialty referral.

Referral to a Periodontist covered, after scaling and root planing by the General Dentist, for a problem-focused examination and possible periodontal surgery.

Severe Chronic/Aggressive Periodontitis (localized or generalized)

- Pocket depths are generally greater than 6 mm with 5 mm or greater clinical attachment loss
- Generalized bleeding upon probing
- Possible Class 1, Class 2 or Class 3 (>2 mm or depressibility) tooth mobility
- Grades I and II furcation involvements with possibly Grade III involvement (i.e., “through and through” access between the roots)
- Radiographic evidence of severe (over 40%) bone loss, which may be horizontal and vertical in nature

Severe Chronic/Aggressive Periodontitis is eligible for direct specialty referral.

Referral to a Periodontist covered for a problem-focused evaluation, scaling and root planing and possible periodontal surgery.

Refractory Chronic/Aggressive Periodontitis

Defined as a periodontitis case that treatment fails to arrest the progression of periodontitis – whatever the thoroughness or frequency – as well as patients with recurrent disease at single or multiple sites.

Refractory Chronic/Aggressive Periodontitis is eligible for direct specialty referral.

Referral to a Periodontist covered to confirm the diagnosis of Refractory Chronic/Aggressive Periodontitis and to advise you on the patient’s management and care.

PROSTHODONTIST

Referrals for this type of specialist are not covered under LIBERTY Dental Capitation, DHMO-EPO and Discount Programs. Consult individual Schedule of Benefits of Evidence of Coverage to determine if prosthodontic referrals are available.

SECTION 11 – QUALITY MANAGEMENT



PROGRAM DESCRIPTION

LIBERTY Dental Plan's Quality Management and Improvement (QMI) Program is organized to ensure the quality of dental care provided is being reviewed by dentists, quality of care problems are identified and corrected, and follow-up is planned when indicated. LIBERTY Dental Plan's QMI Program addresses essential elements including quality of care, accessibility, availability and continuity of care. The provision and utilization of services are closely monitored to ensure professionally recognized standards of care are met.

QMI PROGRAM POLICY

The purpose of LIBERTY Dental Plan's QMI Program is to ensure the highest quality and cost effective dental care for our members, with emphasis on dental prevention and the provision of exceptional customer service to all involved in the program; our providers, our clients and their members.

QMI PROGRAM SCOPE

The scope of the QMI Program activities includes continuous monitoring and evaluation of primary and specialty dental care provided throughout the dental network. In addition, the scope includes systematic processes for evaluating and monitoring all clinical and non-clinical aspects of dental care delivery.

QMI PROGRAM GOALS AND OBJECTIVES

The LIBERTY Dental Plan QMI Program goals and objectives are comprehensive and support the overall organizational goal of providing the highest quality dental care to LIBERTY members in a cost effective manner. LIBERTY's QMI Program focuses on a proactive problem solving and continuous monitoring and improvement approach to ensure access to quality dental care. The program includes:

- Standards and criteria development
- Problem and trend identification and assessment
- Development and implementation of QMI Program studies, performance measure monitoring and member/provider surveys
- Credentialing and Re-credentialing of providers
- Monitoring of dental office staff and provider performance
- Infection control monitoring
- Facility review audits

- Dental chart audits
- Utilization management and monitoring of over- and under-utilization
- Monitoring of member and provider grievance/appeals and follow-up
- Disenrollment, enrollment, and primary care dentist transfer request tracking
- Provider/member education
- Staff orientation
- Corrective action plan development, implementation and monitoring effectiveness, including disciplinary actions and terminations of any provider for serious quality deficiencies and reporting the same to the appropriate authorities
- Other QMI Program activities identified during monitoring process

QUALITY MANAGEMENT OVERSIGHT COMMITTEES

Oversight of the QMI Program is provided through a committee structure, which allows the flow of information to and from the Board of Directors. The QMI Program employs various Committees to ensure that the dental care delivery decisions are made independent of financial and administrative decisions. They are the:

- Quality Management & Improvement Committee
- Credentialing Committee
- Culture & Linguistics Committee
- Network Access and Availability Committee
- Peer Review Committee
- Utilization Management Committee
- Potential Quality Issues (PQI) and Potential Fraud, Waste and Abuse (PFWA) Committee

The **Quality Management and Improvement Committee** reviews, formulates, and approves all aspects of dental care provided by LIBERTY Dental Plan's Network Providers, including the structure of care, the process and outcome of care, utilization and access to care, availability, referrals to specialists, continuity of care, safety, appropriateness, and problem resolution in the dental delivery system identified by the Peer Review, Utilization Management or PQI Committees.

The QMI Committee's oversight responsibilities include monitoring the activities of other QMI components and participants to assure that approved policies and procedures are followed and those policies and procedures are effective in meeting the needs of LIBERTY Dental Plan and its members.

The **Credentialing Committee** is responsible for reviewing, accepting, or rejecting the professional credentials of each applicant dentist and contracted dental provider. This committee follows the approved policies and procedures of the QMI Committee in determining whether a provider will be approved or denied as a participant in LIBERTY's provider network.

Dentists are re-credentialed on a three-year cycle and as needed. Sixty days before the provider's assigned re-credentialing date, the dentist will receive a written request to submit required documents to LIBERTY's Credentialing Verification Organization (CVO). If the dentist does not respond, a report is generated by the CVO

for LIBERTY to assist in obtaining the missing or expired information. Failure to comply with re-credentialing requests will result in provider's termination from the network.

The **Cultural and Linguistic Committee** ensures quality dental care and dental services through the provision of translation or interpreter services, cultural and linguistic service training, and identification of linkages to community appropriate agencies. The Committee's oversight helps ensure that the needs of enrollees with limited English proficiency or other physical conditions limiting ability to understand spoken or written English are being addressed in a culturally and linguistically appropriate manner.

The **Network Access and Availability Committee** is responsible for monitoring the number and distribution of primary care and specialty care dentists to ensure an adequate network of providers. Quarterly, this committee reports on the geographic distribution and members to dentist ratio as well as the analysis of data regarding appointment availability, wait times for appointments, in-office wait times to be seated, and related grievances/appeals to determine shortcomings in the network and submits the finding to the QMI Committee for review.

The **Peer Review Committee (PRC)** ensures that dental care is rendered in accordance with the policies, procedures and standards set by the QMI Committee.

The PRC is responsible for:

- Provider quality of care issues identified through various means, including but not limited to, member grievances and on-site audits and chart reviews
- Potential or pending malpractice issues, National Practitioner's Data Bank reports and Dental Board of the specified State reports, when requested by the QMI Committee
- Provider appeals (i.e., grievance resolution, terminations, denial for panel participation)
- Member appeals as they relate to grievances or other dental care issues
- Annual review and updates of the Specialty Referral Criteria and Guidelines

The **Utilization Management Committee (UMC)** is responsible for reviewing the utilization data as reported by network providers and the subsequent analytical reports to ensure proper utilization and delivery of care.

The UMC evaluates a summary of treatments provided by the entire contracted General Dentist network. The analysis is intended to provide an indication of the numbers of members seeking treatment and the types of treatment they receive. Further evaluation of specific provider offices allows a determination of how those offices compare to the overall experience of the entire network and how individual provider offices compare to the established network norms.

The Dental Director assesses over- and under-utilization of specialty referral trends and reports the findings to the UMC. With the data in these reports, the committee is able to monitor trends in specialty referral denials and make recommendations to the QMI Committee.

The UMC also reviews access and availability and continuity of care issues by reviewing reports of appointment availability, wait time and the number of actual appointments kept by the members. This also includes evaluation of the number and location of the general and specialty dentist providers. The committee addresses

negative trends in these areas and makes recommendations for improvements that are forwarded to the QMI Committee.

The **PQI-PFWA Committee** monitors and reviews potential quality issues from grievance details, grievances ruled against the provider, provider onsite assessments (structural/facility and process assessments/chart audits) with a failed score, onsite assessments with a deficient critical indicator, aberrant utilization pattern, significant departure of expected contractual behavior and non-compliance of LIBERTY's provider policies and procedures. Potential fraud, waste and abuse cases are also researched by this committee and forwarded to the proper authorities.

PROGRAM STANDARDS AND GUIDELINES

LIBERTY understands and supports that high quality dental care is dependent, in part, on the ability of both the Primary Care Dentist (Provider) and specialty care providers to see patients promptly when they need care, and to spend a sufficient amount of time with each of their patients.

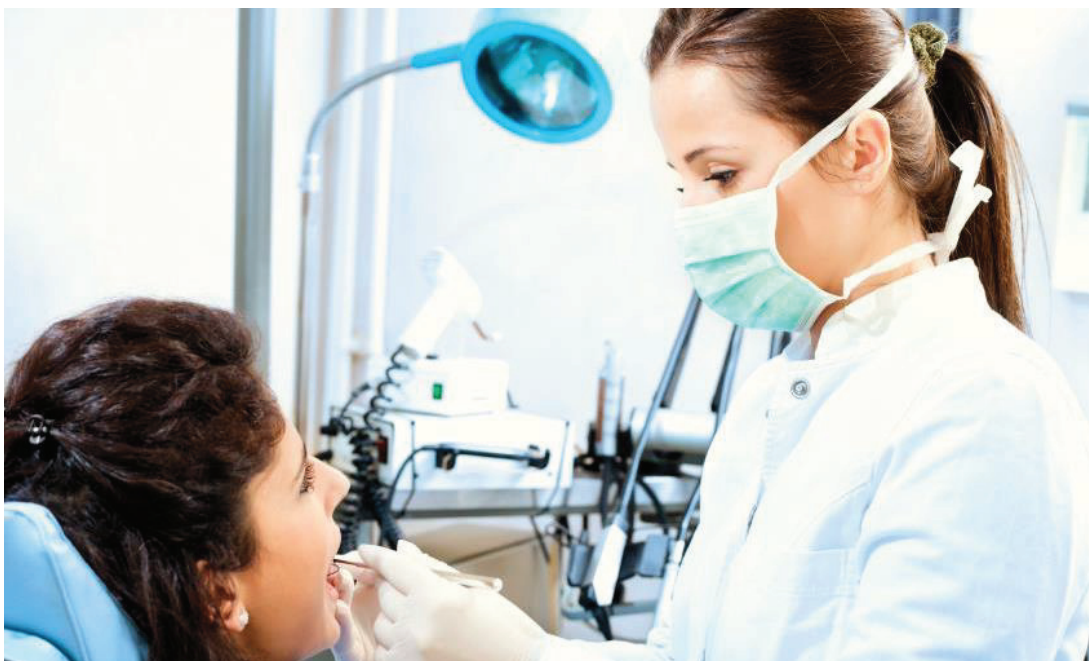
- Surveys

Provider Access Surveys:

For all Provider offices, LIBERTY Dental Plan conducts quarterly random office contacts to assess availability of appointments

Member Satisfaction Surveys:

Surveys can be generated to members in response to trending information, reports or potential access problems with specific dental offices.



Grievance System:

The Grievance Committee reports the summary of the quarterly findings of access issue reports by member's grievances or member transfers to alternate facilities.

Corrective Action:

Negative findings resulting from the above activities may trigger further investigation of the provider facility by the Dental Director or his/her designee. If an access to care problem is identified, corrective action must be taken including, but not limited to, the following:

- Further education and assistance to the provider
- Provider counseling
- Closure to new membership enrollment
- Transfer of patients to another provider
- Contract termination
- Investigation results from subcommittees must be reported to QMI.

PROVIDER QMI PROGRAM RESPONSIBILITIES

Typically, when a member enrolls with LIBERTY Dental Plan, they select a Provider from the network who is responsible for providing or coordinating all dental care for that member, including referrals to participating specialty care providers. In order to ensure that the care provided to members is given under the appropriate requirements, including covered benefits and referrals, provider's and participating specialty care providers have certain responsibilities.

CREDENTIALING / RECREDENTIALING

Prior to acceptance in the LIBERTY Dental 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 license/credential expiration from LIBERTY Dental Plan's delegated Certified Verification Organization (CVO), 60 days prior to expiration to allow time to submit current copies.

For all accepted providers, the local Network Manager presents a provider orientation within 30 days after activation at which time the provider receives a copy of LIBERTY's Provider Reference Guide. The 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. 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 Dental Plan maintains two separate and distinct files for each provider. The first is the provider's quality improvement file, which is maintained with restricted access by the Quality Management Department. This file includes confidential credentialing information. The second file is the provider's facility file that is maintained by the Professional Relations Department, which also includes audit results. The latter contains copies of signed agreements, addenda, and related business correspondence.

RECORDS REVIEW

LIBERTY Dental Plan has established guidelines for the delivery of dental care to Plan members. To generalize, all providers are expected to render dental care in accordance with community standards. The guidelines begin below and conclude with the form that our dental consultants use to evaluate patient records.

Chart Selection: A minimum of 10 randomly selected patient charts shall be reviewed.

ELEMENTS OF RECORD REVIEW

The criteria used for dental records review is detailed in the Forms Section of this Reference Guide. The criteria described shall apply to all reviews completed by LIBERTY Dental Plan.

GRIEVANCES, PROVIDER CLAIM DISPUTES AND APPEALS

MEMBER GRIEVANCES

The LIBERTY member grievance process encompasses investigation, review, and resolution of member issues submitted to LIBERTY and/or contracted providers. Members may file a grievance following any incident or action that is the subject of their dissatisfaction. LIBERTY members, as well as members of some of LIBERTY's Health Plan partners, may submit grievances by telephone by calling LIBERTY's Member Services Department toll-free at (888)352-7924. All members have the option to submit a grievance in writing; either by composing a letter or completing a grievance form (available in this Provider Reference Guide). LIBERTY offers members whose primary language is not English with language assistance services by contacting the Member Services Department. We currently provide interpretation services in 150 languages. Members can obtain a grievance form from LIBERTY's Member Service Department, from a dental provider facility, or from the LIBERTY website. All contracted provider facilities are required to display member complaint forms.

MEMBER APPEALS

Members may appeal any adverse decision made by LIBERTY. The timeframe for members to submit an appeal to LIBERTY varies by state. The Grievance Analyst will compile all the information used in the initial determination and any additional information received and forwarded by the member or the provider to coordinate a fair, timely decision to uphold or overturn the Plan's initial determination. LIBERTY personnel involved in determining a member's appeal, must have had no prior involvement in the initial decision. This rule

extends to both the Grievance Analyst coordinating the appeal, and to the licensed dentist rendering any clinical determination on the case.

LIBERTY’s grievance and appeals system also addresses the linguistic and cultural needs of all members, as well as the needs of those members with disabilities. The system is designed to ensure that all Plan members have equal access to, and can fully participate in, the grievance system. For members with linguistic, cultural or communicative impairments, participation in the grievance system is facilitated through LIBERTY’s coordination of translation, interpretation and other communication services to assist in communicating the procedures, processes and findings of the grievance system.

PROVIDER CLAIM DISPUTES

Definition: A contracted or non-contracted provider dispute is a provider’s written notice challenging, appealing or requesting reconsideration of a claim (or a bundled group of substantially similar multiple claims that are individually numbered) that has been denied, adjusted or contested. A provider dispute may also be a written notice seeking resolution of a billing determination or other contract dispute or disputing a request for reimbursement of an overpayment of a claim.

Each contracted provider dispute must contain, at a minimum, the following information:


- provider’s name
- provider’s license number
- provider’s contact information

If the contracted provider dispute relates to a claim or a request for reimbursement of a claim overpayment from LIBERTY to a contracted provider a clear identification of the disputed item, the date of service and a clear explanation of the basis upon which the provider believes the payment amount, request for additional information, request for reimbursement for the overpayment of a claim, contest, denial, adjustment or other action is incorrect.

If the contracted provider dispute is not about a claim, a clear explanation of the issue and the provider’s position on the issue must be provided.

LIBERTY will resolve provider disputes submitted on behalf of a member through LIBERTY’s Member Grievance Process. A provider dispute submitted on behalf of a member will not be resolved through LIBERTY’s Provider Dispute Resolution Process.

Provider Disputes must be submitted in writing to the attention of the Provider Dispute Resolution Mechanism Department at the following address:

	<p>LIBERTY Dental Plan ATTN: Provider Dispute Resolution Mechanism Department P.O. Box 26110 Santa Ana, CA 92799-6110</p>
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ACKNOWLEDGMENT OF CONTRACTED PROVIDER DISPUTES

LIBERTY will acknowledge and respond to all Provider Disputes within the applicable statutory guidelines.

LIBERTY resolves all Provider Disputes within 30 calendar days of receipt.

CONTRACTED PROVIDER DISPUTE INQUIRIES

All inquiries regarding the status of a contracted provider dispute or about filing a contracted provider dispute must be directed to the Provider Dispute Resolution Mechanism Department at: (800) 268-9012.

SECTION 12 – FRAUD, WASTE AND ABUSE



LIBERTY is committed to the prevention, detection and reporting of health care fraud and abuse according to applicable federal and state statutory, regulatory and contractual requirements. LIBERTY has developed an aggressive, proactive fraud and abuse program designed to collect, analyze and evaluate data in order to identify suspected fraud and abuse. Detection tools have been developed to identify patterns of health care service use, including over-utilization, unbundling, up-coding, misuse of modifiers and other common schemes.

The civil provisions for the FCA (False Claims Act) make a person liable to pay damages to the Government if he or she knowingly:

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

Federal and state regulatory agencies, law enforcement, and LIBERTY vigorously investigate incidents of suspected fraud and abuse. Providers are cautioned that unbundling, fragmenting, up-coding, and other activities designed to manipulate treatment codes as a means of increasing reimbursement may be considered an improper billing practice and may be a misrepresentation of the services actually rendered.

In addition, providers are reminded that medical records and other documentation must be legible and support the level of care and service indicated on claims. Providers engaged in fraud and abuse may be subject to disciplinary and corrective actions, including but not limited to, warnings, monitoring, administrative sanctions, suspension or termination as an authorized provider, loss of licensure, and/or civil and/or criminal prosecution, fines and other penalties.

LIBERTY has adopted the CMS Fraud, Waste and Abuse training as part of our FWA Program. Participating providers must be in compliance with all CMS FWA rules and regulations. This includes the CMS requirement that all employees who work for or contract with a managed care organization meet annual compliance and education training requirements with respect to Fraud Waste and Abuse. To meet federal regulation standards specific to Fraud, Waste and Abuse (§ 423.504) providers and their employees must complete an annual FWA

training. Dental office staff are required to complete CMS FWA training within 10 days of the contract effective date with LIBERTY and annually thereafter.

“Fraud” means, but is not limited to, knowingly making or causing false or fraudulent claim for payment of a health care benefit program.

Examples of fraud may include:

- Knowingly billing for unnecessary services, for services not performed, or for more expensive services than were provided;
- Soliciting, offering or receiving a kickback, bribe or rebate

“Waste” is a misuse of resources: the extravagant, careless or needless expenditure of healthcare benefits or services that result from deficient practices or decisions.

Examples of waste may include:

- Over-utilization of services
- Misuse of resources

“Abuse” describes practices that, either directly or indirectly, result in unnecessary costs. Abuse includes any practice that is not consistent with the goals of providing patients with services that are medically necessary, meet professionally recognized standards, and are fairly priced.

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.

REPORTING FRAUD, WASTE AND ABUSE

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

LIBERTY’s Special Investigation Unit
SIU Hotline (888) 704-9833
Email hotline@libertydentalplan.com

U.S. Mail
LIBERTY Dental Plan
ATTN: Special Investigations Unit
P.O. Box 26110
Santa Ana, CA 92799-6110

U.S. Government Recovery Board
Fraud Hotline (877) 392-3375

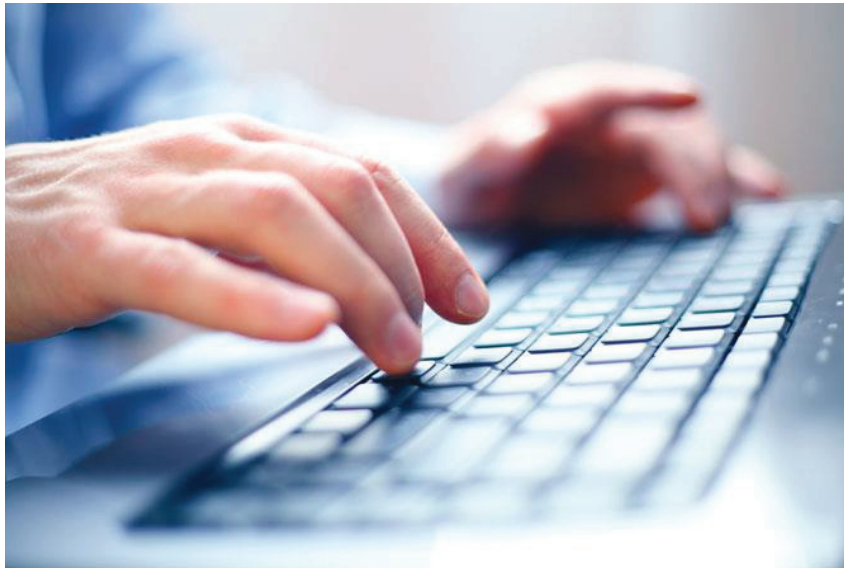
U.S. Mail
Recovery Accountability and Transparency Board
ATTN: Hotline Operators
P.O. Box 27545
Washington, D.C. 20038-7958

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

TRAINING

LIBERTY provides, free of charge, Fraud, Waste and Abuse Prevention Training for all contracted providers and any other downstream entity with whom provider has contract to provide health, and/or administrative services on behalf of LIBERTY. This training is available on-line by visiting www.libertydentalplan.com. Upon completion, providers and their staff will be able to print out a certificate/attestation that will satisfy the CMS the requirements.

If a provider and their personnel have already completed a Fraud, Waste and Abuse training that meets CMS requirements, LIBERTY will accept documentation of that training. Organizations must retain a copy of all documentation related to this training for a period of no less than 10 years – including methods of training, dates, materials, sign-in sheets, etc.



On-line training www.libertydentalplan.com

SECTION 13 – ALTERNATIVE TREATMENT



When a member has more than one dental treatment option, it is the responsibility of the provider to advise the member of treatment alternatives that are within professionally accepted standards of care, including procedures that are and are not covered by the member's dental benefits plan. By thoroughly explaining the treatment options to the member, he/she can select the treatment that is most appropriate for him/her. The provider can make professional recommendations as to the treatment option; however the decision remains that of the member.

LIBERTY requires that any alternative, upgraded and/or elective treatment(s) be presented to the member in writing during the informed consent process, with the statement of fact that the service is not-covered. In addition, the member's signature of approval should be documented prior to initiating treatment. This process will alleviate potential member disputes. Any member covered by a Medicare or Medicaid plan must have a clear statement that the service is not-covered. Statements to the effect that "any service not covered by your plan is your responsibility" are not adequate for benefit plans that are part of Medicare or Medicaid plans.

DEFINITION OF ALTERNATIVE TREATMENT

LIBERTY considers treatments to be alternative when more than one treatment plan is recommended for the same condition(s). In most cases, the least expensive, professionally acceptable covered alternative treatment is covered at the member's copayment. Alternative treatments should be presented to the member using the alternative treatment plan formula, as demonstrated in the sample below. Documentation must verify that all treatment alternatives were presented and which specific treatment was accepted by the member, with a signature of approval.

When a member selects an alternative treatment plan, LIBERTY will allow the applicable benefit for the covered treatment. The member is responsible for the entire remainder of the provider's fee (the difference between alternative treatment and the covered treatment) plus the copayment for the covered treatment.

For Example:

Provider's usual fee for the alternative treatment (i.e., fixed bridge)	\$2,100.00
Provider's usual fee for the covered treatment (i.e., partial denture)	\$975.00
Difference between alternative treatment and covered treatment (\$2,100.00 - \$975.00)	\$1,125.00
Copayment for the covered treatment	\$125.00
Total member's responsibility* (\$1,125.00 + \$125.00)	\$1,250.00

*this does not include any upgraded treatment

UPGRADED TREATMENT

LIBERTY considers treatment to be an upgrade when similar, more expensive procedures or materials are recommended.

When a member selects an upgraded treatment or material, they are responsible for the cost of the upgrades. Cost of upgraded materials should be based on the actual lab or material costs of such materials.

For Example:

Provider's usual fee for the alternative treatment (i.e., fixed bridge)	\$2,100.00
Provider's usual fee for the covered treatment (i.e., partial denture)	\$975.00
Difference between alternative treatment and covered treatment (\$2,100.00 - \$975.00)	\$1,125.00
Copayment for the covered treatment	\$125.00
Total member's responsibility* (\$1,125.00 + \$125.00)	\$1,250.00

*Please refer to specific benefit plan designs for additional information

SECTION 14 – FORMS



ALTERNATE TREATMENT FORM

REFERRAL FORM



LIBERTY Dental Plan Informed Consent for Alternative Treatment

Patient Name	Member ID
Subscriber (if different than Patient)	Plan Number

Description of Alternative services and reason for recommendation:

Tooth/ Area	Covered Services		Alternative Treatment*			Patient's Responsibility for Procedure Elected	Patient's Acceptance (Please initial)
	CDT Code	Procedure Description	Copayment	Accept	Decline		

*"Alternative Treatment" means an alternative or upgrade treatment that has been proposed or recommended for the same tooth or condition(s) as the corresponding "Covered Service." The Covered Service is listed as covered by your plan whereas the Alternative Treatment is not covered by your plan (meaning that if you elect the Alternative Treatment, you will incur the "Alternative Cost" specified). You have the option to choose between the two services and will be responsible for the specified "Patient's Responsibility for Procedure Elected." Formula for Alternative Cost = usual cost of Alternative Treatment minus (-) the usual cost of the Covered Service plus (+) any listed copayment for the Covered Service.

Total patient responsibility for procedure(s) elected: \$ _____

I have explained to the patient: his/her treatment options, the risks and benefits of (and alternatives to) each, and that although Alternative Treatment is being proposed that those services covered under his/her benefit plan would nonetheless also meet the relevant dental standards of care.

☐ Yes ☐ No

Dentist Signature _____ Dentist Name _____ Date _____

By signing below, I acknowledge the following: (i) the dentist named above has explained to me the proposed alternative or upgraded treatment specified above ("Alternative Treatment") and the additional costs associated with such treatment ("Alternative Costs"); (ii) I understand that I have the right to choose either the Covered Service or the Alternative Treatment outlined above and I understand the risks, benefits and costs of each; (iii) if I have elected any Alternative Treatment specified above, I consent to such treatment and I understand: that I am solely responsible for the cost of the Alternative Treatment, that such treatment is not covered by LIBERTY Dental Plan, and that the Covered Service(s) I am declining would have also met the relevant dental standards of care; (iv) I understand that while there may be financing options available, I am under no obligation to select a specific financing option or to use one at all; and (v) if I have any questions or concerns about my dental treatment plan, copayments or additional costs, I will have contacted LIBERTY Dental Plan at 800-268-9012 or 888-700-0643 (Nevada) before signing below.

Patient Signature (Parent or Guardian) _____ Patient Name _____ Date _____



LIBERTY Dental Plan Specialty Care Referral Request

P.O. Box 401086
Las Vegas, NV 89140
Phone: 888-359-1087 Fax: 888-401-1129

Eligibility Verified:	Yes	No
Verifiers Initials:		
Date & Time:		

☐ Specialty Referral (Mail to LDP with x-ray & documents) ☐ Emergency Referral (Call 888-359-1087)

Provider		Referring Specialist	
Name:		Specialist Name:	
Phone:	ID#:	Phone:	ID#:
Address:		Address:	
City, State, Zip:		City, State, Zip:	

Member		
Member Name:	ID #:	Eligibility Verified: <input type="checkbox"/> Yes <input type="checkbox"/> No
Patient Name:	DOB:	Verifiers Initials:
Address:	Phone:	Date & Time:
City, State, Zip:		

Treatment Request			
CDT Code	Procedure Code Description	Tooth #	Surface

PLEASE CHECK ALL THAT APPLY IN EACH SPECIALTY CATEGORY:

Endodontics (must submit PA & BWX)	<input type="checkbox"/> Prognosis (circle one): good / poor <input type="checkbox"/> Reason for referral Additional Information _____
Oral Surgery (must submit PA or Pano)	<input type="checkbox"/> Reason for Referral _____ Additional Information _____ *In absence of Pathology extractions of impacted teeth and roots are not a benefit
Pediatric Dentistry	<input type="checkbox"/> Reason for Referral (Please document behavioral problems occurring at initial exam): Date(s) _____ <input type="checkbox"/> Age of Child _____ Additional Information _____
Periodontics	Referral limited to D9310 Consultation – diagnostic service provided by dentist or physician other than requesting dentist or physician (circle one) Case Type I, II, III, IV Dates of Root Planing UR _____ UL _____ LR _____ LL _____ Additional Information _____
Orthodontics	Notes: _____

I hereby certify that the above noted treatment request has met the criteria for specialty referral and acknowledge that the final claim for payment is subject to clinical review.

Dentist Signature: _____ Date: _____

Dental plan use only ☐ Approve ☐ Deny ☐ Pend Dental Consultant Signature _____

Comments _____