GROW YOUR BUSINESS

UTILIZATION REVIEW

PROVIDER DIRECTORY VALIDATION

LIBERTY DENTAL PLAN

VOLUME 4 Q1 | SPRING 2018

LQ

LIBERTY QUARTERLY PROVIDER NEWS

Better Care, Better Incentives...

Coming May 2018 California Providers:

Please be on the look-out for an announcement with details about our Provider Incentive Program for the Medi-Cal LA PHP Program.

LIBERTY pays more

LIBERTY will pay the highest reimbursements in the Managed Care Program, and higher than the Denti-Cal Program!

...Be prepared to grow your business!

LIBERTY DENTAL PLAN

LIBERTY QUARTERLY PROVIDER NEWS VOLUME 4 Q1 | SPRING 2018

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If you have comments or questions, please contact:

LIBERTY Dental Plan Professional Relations
340 Commerce, Suite 100
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INTERNET ACCESS

libertydentalplan.com

- Verify Member Eligibility
- View Member Claims Submission
- Review Member Benefit Plans
- Submit Claims, Pre-Estimates and Referrals

PROFESSIONAL SERVICES

- Contracting
- Provider Education

TOLL FREE TELEPHONE:

California:	800.268.9012
Florida:	888.352.7924
Nevada:	888.700.0643
All other States:	888.352.7924

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California:	800.268.0154
Florida:	888.334.6034
Nevada:	888.401.1129
All other States:	888.401.1129

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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 Directory Validation

Recent changes to state and federal law require LIBERTY Dental Plan (LIBERTY) to actively verify and maintain the accuracy of our provider directories which are available to members and the general public.

Accordingly, we ask you to verify every quarter that the information we have on file for you is accurate so you can be included in our provider directories.

Not only is it important to keep provider data as current as possible; it's the law.

Notify LIBERTY immediately when:

- **A new dentist joins or leaves your office**
- **Your office has an address change**
- **Your office has a TIN change**
- **Your office has any billing address changes**

Quarterly verifications include:

- **Your office hours**
- **Confirmation of the treating dentists working in each office**
- **Languages spoken**
- **Confirm that you are accepting new members**
- **Plans or programs that your office is currently accepting**

If you have any questions or need to update your provider profile, please contact LIBERTY's Professional Relations Department via fax at **714.389.3520** or email us at: directoryupdate@libertydentalplan.com.

iTRANSACT Provider Portal

To better serve you, LIBERTY has simplified the claim, pre-estimate and referral submissions into a single navigation screen. Our **iTransact Online Provider Portal User Guide** has been updated with step-by-step instructions on how your office can submit claims, pre-estimates and referrals. This user guide is available at www.libertydentalplan.com in the Resource section of the web portal.

log on

We encourage you to log on to our web portal page where you can quickly do the following:

- **Verify member eligibility**
- **View member claim history**
- **Review member benefit plans**

If you have any questions or need further information on how to register or use our web portal, please view our Online Provider Portal User Guide. LIBERTY appreciates your participation, partnership and our mutual goal to provide your patients and our members the highest quality oral health care.

Billing Bulletin

Protect your dental practice from government scrutiny - watch for Medicare and Medicaid overpayments (False Claims Act)

Here's a stern warning for dentists: Do NOT keep overpayments from Medicare or Medicaid. This could lead to False Claims Act liability and lawsuits, and no one wants to face the wrath of the U.S. government. Lea Courington is an attorney who specializes in these matters. She explains how you can protect your practice.

Under the Affordable Care Act, health-care providers must report and return Medicare or Medicaid overpayments within 60 days after an overpayment is identified, or the date a corresponding cost report is due, whichever is later. But it can be challenging to figure out what constitutes an "identified" overpayment. Does the 60-day clock start when a health-care provider actually knows there is an overpayment, or is suspicion about a possible overpayment enough to start the 60-day clock?

> **"Do NOT keep overpayments from Medicare or Medicaid. This could lead to False Claims Act liability and lawsuits."**

It's an important question. If a health-care provider misses the 60-day deadline, particularly if the government can demonstrate that the provider did not investigate a suspicion or concern about possible overpayment, the government can assert that an identified overpayment has been "knowingly concealed" or "knowingly and improperly avoided." Looking the other way to avoid knowing of the overpayment never protects the provider from having to repay an overpayment, but it could lead to False Claims Act liability, potentially triggering treble damages, civil monetary penalties, and, even worse, exclusion from federal health-care programs.

Here are some things you can do to protect yourself from being caught in a similar situation:

1. First, conducting regular self-audits and compliance checks will help you catch errors early, when they're small and easier to correct. If you discover you were erroneously reimbursed for incorrectly coded services, promptly repay the amounts. This not only avoids False Claims Act liability, but will demonstrate to the government that your compliance efforts are serious.

If you discover you were erroneously reimbursed for incorrectly coded services, promptly repay the amounts.

2. Next, if you're surprised by something - such as learning that a patient death occurred before the service date on a claim, or finding that services were provided on your behalf by someone who was excluded from health care programs but didn't tell you, or by a provider that may not have had the certifications they claimed to have - promptly investigate the matter. For example, if someone didn't have the proper certifications, were the services billed as though they did? If the services were billed as though someone did, which patients' claims were billed? Were the claims paid?

3. Next, watch for sudden spikes in reimbursement without any obvious explanation for the spike, such as bringing a new partner into the practice, which you would expect to increase reimbursements. When you investigate the situation, you may find another explanation that justifies the spike, or you may find overpayments that need to be repaid.

(continued next page)

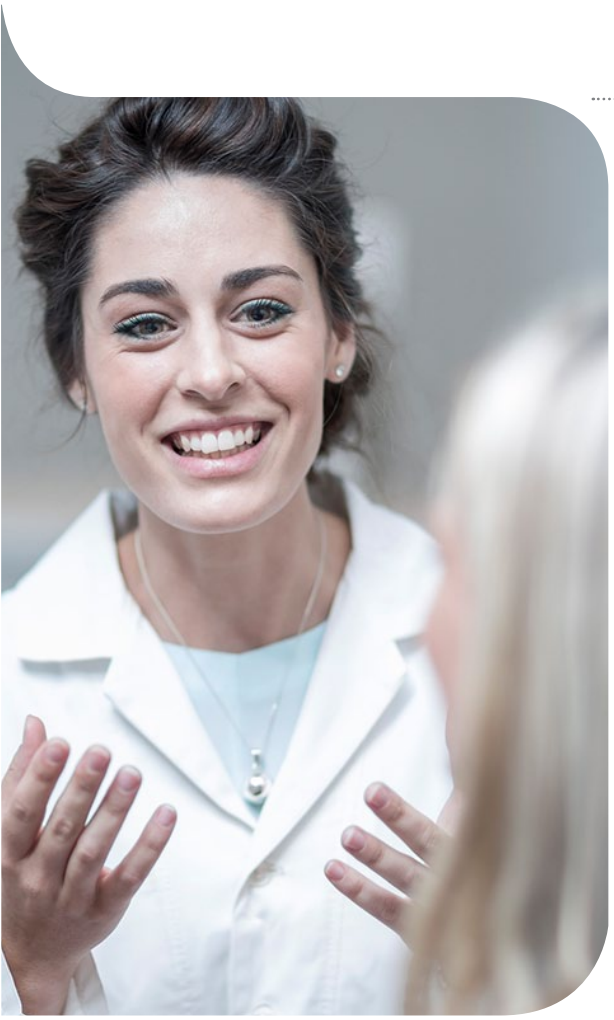
The standard imposed by the False Claims Act for reporting and returning overpayments is an exacting standard with dire consequences for missteps. The government is likely to continue its strong enforcement. Each year the federal government and states recover larger amounts of allegedly fraudulent payments, and as health care costs increase, so does the incentive to recover these fraudulent payments.

At the same time, health-care providers are often inundated with claim and billing information, some of which could be characterized as identified overpayments. Providers should take a critical and comprehensive look at their billing and compliance processes and create a streamlined process to review claim and billing information, investigate reports of possible noncompliance, and report and return overpayments within 60 days.

> **Report and return overpayments within 60 days.**

- An excerpt from Dentistry iQ Practice Management Article: Protect Your Dental Practice from Government Scrutiny—Watch for Medicare and Medicaid Overpayments.

Full article available at http://www.dentistryiq.com/articles/2016/02/protect-your-dental-practice-from-government-scrutiny-watch-for-medicare-and-medicaid-overpayments.html



Policy Statement

It is LIBERTY's policy that all decisions regarding the provision of dental care services are based solely on appropriateness of care and services and the existence of coverage.

LIBERTY affirms that it does not:

- **Provide direct, or indirect, reward to offer inappropriate information or telephone handling with regard to members' rights and responsibilities.**
- **Employ incentives to encourage barriers to care and services**
- **Specifically reward practitioners or other individuals conducting utilization review for issuing denials of coverage or service care**
- **Provide incentives for utilization review decision makers that result in underutilization**

Utilization Review
What to Expect

The utilization review process is designed to ensure that dental procedures reported on behalf of enrollees, by their dental office, are rendered consistent within the provisions of the benefit plan and the participating provider agreement.

As part of the contractual agreement dental benefit plans have with their employer groups, government programs and members, they are required to have a utilization review process. State regulators, CMS and Medicaid programs also have requirements for dental benefit plans to have antifraud policies and procedures in place for all programs.

The utilization review process may begin with pre-authorization requirements, review of services after treatment is rendered, and/or post-payment review. Concerns are generally related to patterns of over- or under-utilization of service identified through statistical analysis for peer groups, utilization data and/or dentist practice patterns. Identification of a concern can come from complaints and claims processing.

Based upon the result of the analysis, the dental plan may decide it is necessary to review a sample of patient records to evaluate and validate patterns. The plan may request that patient records be submitted for review or that the dental office participate in an on-site or desktop review. If you are a contracted provider, it is likely your agreement with the plan required you to comply with these types of requests.

Because many dental offices have contacted their state dental associations for assistance, it is important that dentists understand the purpose of the utilization process.

The utilization review is also designed to identify potential fraudulent billing patterns.

Here is a list of the type of issues that may be identified:

- **Billing for services not rendered**
- **Intentional misreporting of procedures, dates of service, name of the treating dentist**
- **Deliberate performance of unnecessary and/or costly services**
- **Alteration of patient record**
- **Reporting a more expensive procedure than what was rendered (upcoding)**

Provided by Dr. Richard Hague, LIBERTY Dental Plan Dental Director (CA)

Critical Incident Awareness Training

Did you know providers are required to report critical incidents to LIBERTY Dental Plan and the proper authorities? To help you comply with this requirement, LIBERTY has supplied a Critical Incident Awareness Training on our website, which providers must complete within 60 days of their contracts' effective date.

Members participating in Medicaid and Medicare programs may be vulnerable to abuse or neglect due to their health condition, age, social isolation and economic situation. CMS has identified a number of critical incidents to look out for.

These critical incidents include:

- Abuse
- Neglect
- Exploitation
- Disappearance
- Death
- Serious, life-threatening event requiring immediate emergency evaluation
- Seclusion and restraints
- Suicide attempt

did you know

LIBERTY provides complete Compliance Training Online

To find out more about this requirement, please visit www.cms.gov. There may be additional state-specific requirements in your state.

To comply with and complete this CMS-required training, please visit our website at https://www.libertydentalplan.com/Providers/Critical-Incident-Training.aspx or call our Professional Relations Team at **888.352.7924**.

Language Assistance Program (LAP)

Compliant with State Laws, plan members have a right to access free language assistance services, including interpretation and translation services for their healthcare needs.

The Language Assistance Program's (LAP) purpose is to establish and maintain an ongoing language assistance program that ensures Limited English Proficient (LEP) members and members with disabilities have appropriate access to language assistance services while accessing dental care.

did you know

LIBERTY provides complete Cultural & Linguistic Competency Training Online

Language Assistance Program *(continued)*

Regulated by the Department of Managed Health Care (DMHC), the LAP program requires providers to notify members of the availability of language assistance services that include oral interpretation services and written translation of certain vital documents, free of charge through LIBERTY Dental Plan.

The Language Assistance Program includes:

- **Surveying members to determine language preferences**
- **Making the information collected about member language preferences available to providers upon request**
- **Informing members and providers of the availability of free language services**
- **Providing information to members on the availability of bilingual providers in the online Provider Directory**
- **Providing free interpreter services in the member's language of choice to any member who requires language assistance**
- **Providing written interpretation of all relevant member documents**

LIBERTY discourages the use of family members, friends, and especially minors for translation and interpretation services. Language assistance services is available by contacting LIBERTY 24 hours a day, 7 days a week. If a dental emergency occurs and a qualified interpreter is unavailable, a minor may be used for translation or interpretation services. The provider must thoroughly document the use of a minor as an interpreter in the member charts.

LAP information and forms and notices of the availability of interpretation and translation services are also posted on the Plan's website, www.libertydentalplan.com.

LIBERTY offers Cultural and Linguistic Competency Training for you and your staff online on our website at https://www.libertydentalplan.com/Providers/Provider-Training-1.aspx.

Providers: LIBERTY offers complete Compliance Training online. Continuing Education (CE) credits are awarded upon completion. For more information regarding CE credits, this or any of our other offered trainings, please reach out to your Network Manager.

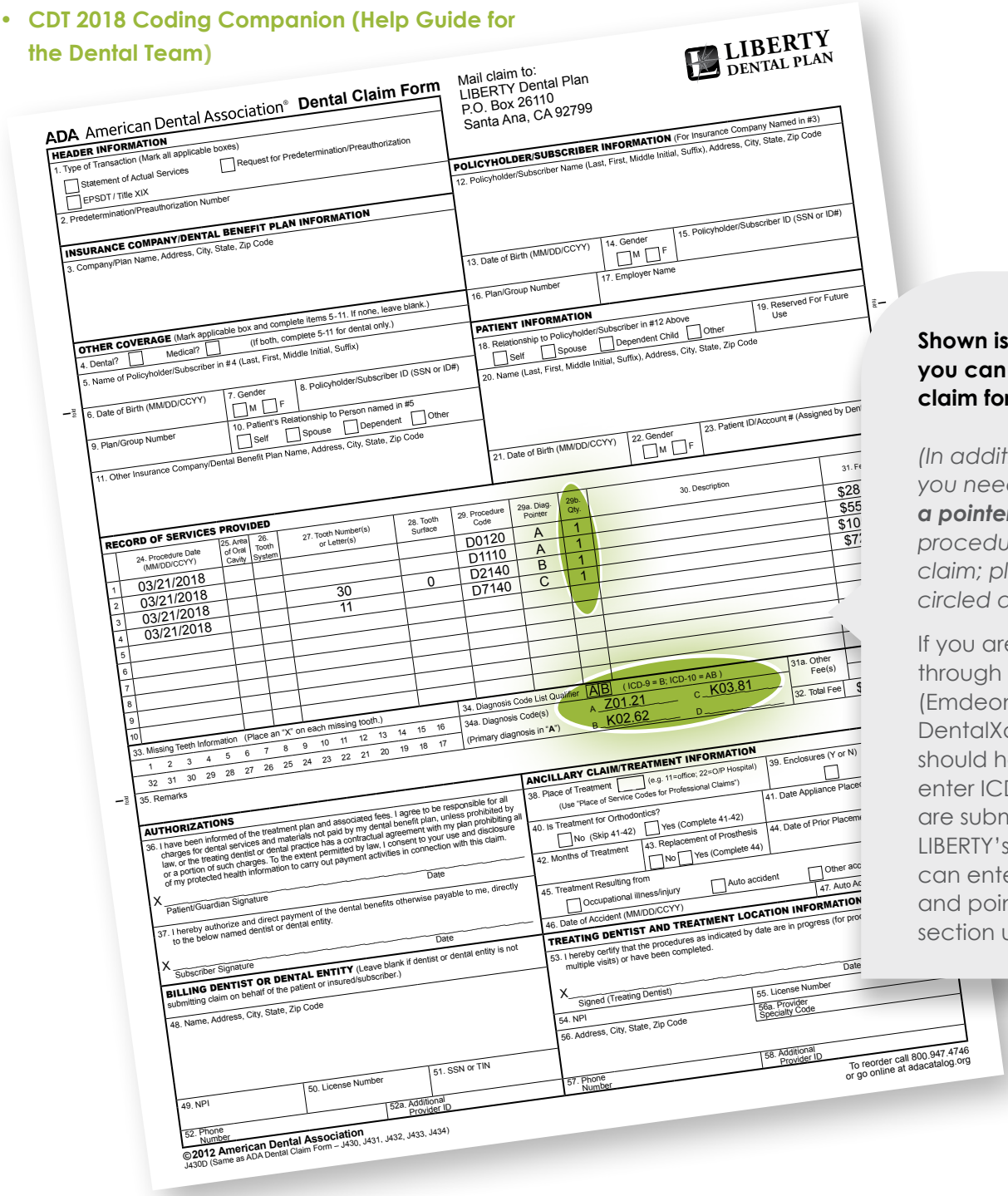
Provider's Responsibilities:

- **Display the Notice of Language Assistance Services, informing members of the availability of Language Assistance Services through LIBERTY Dental Plan**
- **Know how to contact the plan regarding language assistance services**
- **Document the acceptance or refusal of interpreter services in the member's treatment record**
- **Document the member's preferred language in their charts**

Nevada Medicaid
Submitting ICD-10 Codes

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

- **CDT 2018 Coding Companion (Help Guide for the Dental Team)**



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

(In addition to ICD-10 code, you need to also ***include a pointer*** *for each of the procedure codes on the claim; please reference the circled areas):*

If you are submitting claims through a clearinghouse (Emdeon, Tesia or DentalXchange), you should have access to enter ICD-10 codes. If you are submitting claims via LIBERTY's web portal, you can enter ICD-10 codes and pointers in the Remarks section until further notice.

Nevada Medicaid Member-Initiated Transfer Request

LIBERTY is proud to welcome 500,000+ new Nevada Medicaid Members! As a reminder, Members must be assigned to your office to receive treatment; otherwise your ***claims will be denied.***

LIBERTY has a self-service tool available now for members to request a transfer on our website at www.libertydentalplan.com/NVMedicaid.

Below are instructions for members to initiate their transfer request:

1. Go to Member Tools
2. Select Find & Select a Dentist
3. Select Request an Office Transfer
4. Select Benefit Plan and enter City or Zip Code
5. Search for a provider office
6. Check the Select box of the preferred office and provider
7. Member will need to fill in his/her information
8. Click on I'm not a robot and click Submit (only once)

Member-initiated transfer requests via the website will take effect on the submission date.