Medicaid

Child Health Plus (CHPlus)

Essential Plan

Provider Reference Guide

LIBERTY® DENTAL PLAN

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SECTION 1. LIBERTY DENTAL PLAN INFORMATION

INTRODUCTION

Welcome to LIBERTY Dental Plan's network of Participating Providers. We are proud to maintain a broad network of qualified dental providers who offer both general and specialized treatment, guaranteeing 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 Dental Plans. Please note that this Provider Reference Guide serves only as a summary of certain terms of the Provider Agreement between you (or the contracting dental office/facility) and LIBERTY Dental Plan and that additional terms and conditions of the Provider Agreement may apply. In the event of a conflict between a term of this Provider Reference Guide and a term of the Provider Agreement, the term of the Provider Agreement shall supersede this Provider Reference Guide. You received a copy of the fully executed Provider Agreement at the time of your activation on LIBERTY Dental Plan's network or when you were oriented to the Plan; however, you may also obtain a copy of the Provider Agreement at any time by submitting a request to prnational@libertydentalplan.com or by contacting **Professional Relations** at **866.674.1750** .

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

Customer Service 833.276.0853, Monday-Friday 8a.m- 8p.m. EST or visit www.libertydentalplan.com

<table>
<tr><th colspan="4">PROVIDER CONTACT & INFORMATION GUIDE</th></tr>
<tr><th>Important Phone Numbers & General Information</th><th>Eligibility & Benefits Verification</th><th>Claims Inquiries</th><th>Provider Web Portal (i-Transact)</th></tr>
<tr>
<td rowspan="2">LIBERTY Provider Service Line
833.276.0853
Eligibility & Benefits: option 1
Claims: option 2
Pre-estimates : option 3
Referrals option 4

Hours:
An adequate number of live representatives are available M-F, 8 am EST to 8 pm EST

Professional Relations Department
866.674.1750
800.268.0154 (fax)

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

email:
prnational@libertydentalplan.com</td>
<td>Provider Portal (i-Transact)
www.libertydentalplan.com
or
Telephone
833.276.0853 option 1</td>
<td>Provider Portal (i-Transact)
www.libertydentalplan.com
or
Telephone
833.276.0853option 2</td>
<td rowspan="2">www.libertydentalplan.com

LIBERTY Dental Plan offers 24/7 real-time access to important information and tools through our secure online system
• Electronic Claims Submission
• Claims Inquiries
• Real-time Eligibility Verification
• Member Benefit Information
• Referral Status

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

Your “Access Code” can be found on your LIBERTY Welcome Letter. If you cannot locate your access code, or need help with the login process, please call:
833.276.0853 for assistance, or email:
support@libertydentalplan.com</td>
</tr>
<tr>
<td>Referral Submission & Inquiries

Provider Portal (i-Transact)
www.libertydentalplan.com

Telephone
888.352.7924 option 4

Regular Referrals by Mail:

LIBERTY Dental Plan
ATTN: Referral Department
PO Box 15149
Tampa, FL 33684-5149

Emergency Referrals
All requests for emergency specialty care should be made by calling:
833.276.0853option 4</td>
<td>Claims Submissions

Provider Portal (i-Transact)
www.libertydentalplan.com

EDI
Payer ID #: CX083

Paper Claims by Mail:

LIBERTY Dental Plan
ATTN: Claims Department
PO Box 15149
Tampa, FL 33684-5149</td>
</tr>
</table>

SECTION 2. PROFESSIONAL RELATIONS

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

- Plan Contracting
- Escalated Claim Payment Issues
- Education on LIBERTY Members and Benefits
- Opening, Changing, Selling or Closing a 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:

	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 **866-674-1750**
	Email at prnational@libertydentalplan.com		

PROVIDER COMPLIANCE

LIBERTY Dental Plan supplies required compliance training online for providers supporting government business. Participating providers are required to complete training annually and/or attest to completion of compliant training.

Provider Training can be accessed at www.libertydentalplan.com/Providers/Provider-Training-1.aspx

Trainings include but are not limited to:

- CMS General Compliance
- CMS Fraud, Waste and Abuse
- Code of Conduct
- Critical Incidents
- Cultural and Linguistic Competency

Providers must maintain supporting documentation for a period of ten (10) years after training completion, and Code of Conduct dissemination, for all Provider employees supporting LIBERTY's government business, and can furnish the documentation upon request.

PROVIDER COMPLAINTS AND FORMAL GRIEVANCES

Providers may submit complaints or formal grievances for matters including billing or payment, or for issues such as disputes regarding the Plan's policies, procedures or services, lost or incomplete claim forms or electronic submissions; requests for additional explanation as to services or treatment rendered by a health care provider, inappropriate or unapproved referrals initiated by providers, or for any other reason. Complaints may be resolved informally via phone by calling LIBERTY Member Services at 833.276.0853. Formal provider grievances must be submitted in writing, and must be filed no later than thirty (30) days from the date that the issue occurred that initiated the grievance. Provider grievances will be acknowledged in writing within five (5) calendar days, and resolved within forty-five (45) calendar days.

PROVIDER APPEALS

Providers who are not satisfied with the LIBERTY's utilization or claim denial decision, or the Plan's resolution to a grievance may appeal in writing within ninety (90) days of the date of the grievance determination, or the date of the Explanation of Payment or Denial Letter. Cases appealed after that ninety (90) day period will be denied for untimely filing. If the Provider feels they have filed their case within the

appropriate timeframe, documentation may be submitted to affirm their assertion. LIBERTY has thirty (30) days to review the case for Medical Necessity and conformity to applicable guidelines. Cases submitted without the necessary documentation will be denied for lack of information, and the Provider must submit the requested documentation within sixty (60) calendar days of the denial to re-open the case. The case will remain closed if documents and records are received after the sixty (60) calendar day timeframe. Providers may not file a Grievance or an Appeal on behalf of a Member without written consent from the Member as the Member's representative.

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA)

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

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

Our commitment is demonstrated through our actions.

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, you and your staff must follow HIPAA guidelines regarding Protected Health Information (PHI).

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

ANTI-DISCRIMINATION

Discrimination is against the law. LIBERTY Dental Plan ("LIBERTY") complies with all applicable Federal civil rights laws and does not discriminate, exclude people or treat them differently on the basis of race, color, national origin, age, disability, or sex. LIBERTY provides free aids and services to people with disabilities, and free language services to people whose primary language is not English, such as:

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

If you need these services, please contact us at 1-888-844-3344. If you believe LIBERTY has failed to provide these services or has discriminated on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with LIBERTY's Civil Rights Coordinator:

Phone: 888-704-9833
TTY: 800-735-2929
Fax: 888-273-2718
Email: compliance@libertydentalplan.com
Online: https://www.libertydentalplan.com/About-LIBERTY-Dental/Compliance/Contact-Compliance.aspx

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

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)
Online at: https://ocrportal.hhs.gov/ocr/portal/lobby.jsf
Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html

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

CULTURALLY COMPETENT CARE

In accordance with state and federal regulations, LIBERTY provides culturally competent care and services in a nondiscriminatory manner that ensures all members including those with Limited English Proficiency (LEP) and members with disabilities, receive effective and respectful care in a timely manner compatible with their culture, health beliefs, practices and preferred language. LIBERTY collaborates and participates with applicable state and regulatory agencies to promote the delivery of care in a culturally competent manner.

Cultural considerations for appropriate care include but are not limited to ethnicity, race, gender, age, preferred language, English proficiency, sexual orientation, immigration status, acculturation factors, spiritual beliefs and practices, physical abilities and limitations, family roles, community networks, literacy, employment, and socioeconomic factors.

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):

- Interpretation services, including American Sign Language, are available at no cost to members, 24 hours a day, 7 days a week by contacting LIBERTY's Member Services Department at 833.276.0853. When and where required by law or client group requirement, LIBERTY Dental offers free telephonic interpretation through our language service vendor. When required, this service is available to the member at no cost.

- If member needs interpretation services at the time the member is ready to receive services, please call 833.276.0853. You will need the member's full name, date of birth and LIBERTY Dental ID number, to confirm eligibility and access interpretation services. It is not necessary to arrange for these services in advance. An eligible member shall be entitled to twenty-four (24)-hour access to interpreter services, where available, either through telephone language services or in-person interpreters. LIBERTY Dental discourages the use of family or friends as interpreters. Family members, especially children, should not be used as interpreters in assessments, therapy and other situations where impartiality is critical.

- Providers must also fully inform the member that he or she has the right not to use family, friends or minors as interpreters.

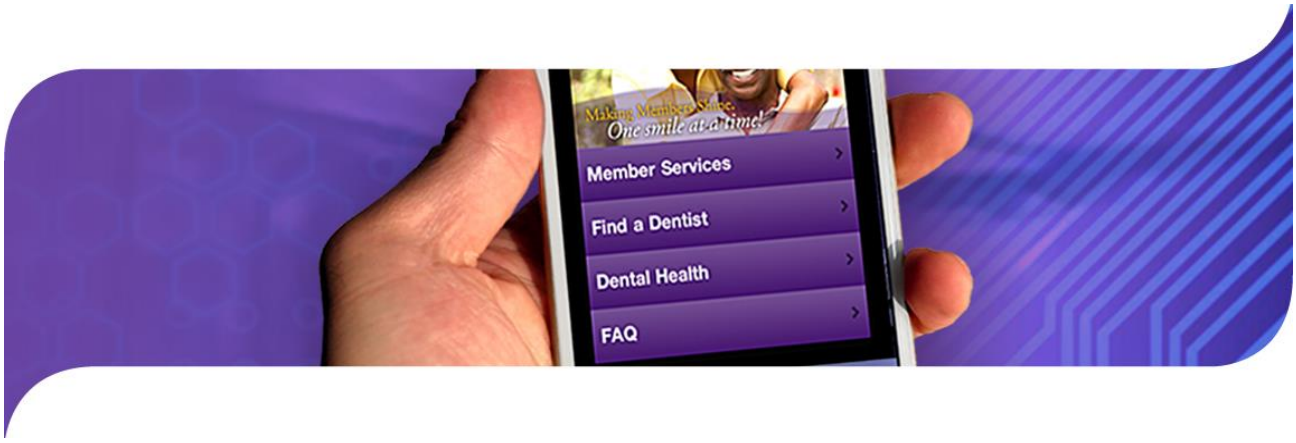
- If a member prefers not to use the interpretation services after s/he has been told that a trained interpreter is available free of charge, the member's refusal to use the trained interpreter shall be documented in the member's dental record, when in a provider setting, or the member's administrative file (call tracking record) in the Member Services setting.

- Language preferences of members will be available to directly contracted dentists upon request through telephone inquiries, and only for those members entitled to receive such services by virtue of state requirement or client group requirement.

- Written Member Informing Materials in threshold languages and alternative formats (including Braille and large font) are available to members at no cost and can be requested by contacting LIBERTY's Member Services Department at 833.276.0853.

  Assistance in working effectively with members using in-person, telephonic interpreters, other media such as TTY/TDD and remote interpreting services can be obtained by contacting LIBERTY's Member Services Department at 833.276.0853.

SECTION 3. ONLINE SERVICES



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

We offer 24/7 real-time access to important information and tools free of charge through our secure online Provider Portal. Registered users will be able to:

- Submit Electronic Claims
- Verify Member Eligibility and Benefits
- View Office and Contact Information
- Submit Referrals and Check Status
- Access Benefit Plans 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/staff. The Office Administrator will be responsible for adding, editing and terminating additional users within the office.

If you are unable to locate your Office Number and/or Access Code, please contact our **Professional Relations Department** at **866.674.1750** or email prnational@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

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 8 a.m. to 8 p.m. EST, Monday through Friday by contacting our **Provider Service Line** at **833.276.0853**, press option 1

Monthly Eligibility Rosters (Capitation Programs Only)

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

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

This listing 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 member does not appear on the monthly Roster please contact LIBERTY Dental Plan's **Member Services Department** at**833.276.0853**. Upon verification of eligibility LIBERTY Dental will fax confirmation of eligibility to your office.

MEMBER IDENTIFICATION CARDS

Members should present their Health Plan ID card at each appointment; They do not have a separate LIBERTY ID card. Providers are encouraged to validate the identity of the person presenting an ID card by requesting some form of photo identification. The presentation of an ID card does not guarantee eligibility and/or payment of benefits. In such cases, providers should check a photo ID and check against an eligibility list or contact Member Services or the online web portal for verification of eligibility. Please note that due to possible eligibility status changes, this information does not guarantee payment and is subject to change without notice.

SECTION 5. MEDICAID PROGRAM GUIDELINES

DEFINITION OF MEDICAL NECESSITY

We approve care that is "medically necessary" or "needed" This means:

- The treatment or supplies are needed to prevent, evaluate, diagnose, correct, prevent the worsening of, alleviate, ameliorate, or cure a physical or mental illness or condition and that meet accepted standards of dentistry;
- Will prevent the onset of an illness, condition, or disability;
- Will prevent the deterioration of a condition;
- Will prevent or treat a condition that endangers life or causes suffering, pain or results in illness or infirmity;
- Will follow accepted medical practices;
- Services are patient-centered and take into account the individuals' needs, clinical and environmental factors, and personal values. These Criteria do not replace clinical judgment, and every treatment decision must allow for the consideration of the unique situation of the individual;
- Services are provided in a safe, proper and cost-effective place, reflective of the services that can be safely provided consistent with the diagnosis;
- Services are not performed for convenience only; and
- Services are provided as needed when there is no better or less costly covered care, service or place available.

CHILD HEALTH PLUS (CHPLUS) PROGRAM

A child is defined as anyone under 21 years of age. The goal of the CHPlus program is to improve child heath by increasing access to primary and preventive healthcare through a subsidized insurance program. A child eligible for Medicaid is not eligible for CHPlus. For more information on the benefits, please refer to the agreed Schedule of Benefits.

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

Dental services for children are provided as a part of Medicaid's EPSDT program. Services may not be limited to emergency services. Dental screenings by the primary care physician in this context means, at a minimum, observation of tooth eruption, occlusion patterns, presence of caries, and/or oral infection. The Primary Care Physician is required to refer a child to the dentist by one year of age or soon after the eruption of the first primary tooth for a minimum of 2 dental visits a year. It is mandated that the PCP follow up during well child visits to ensure that all needed preventive and definitive dental services are provided thereafter through the age of twenty (20).

A referral to a dental specialist or dentist that provides dental treatment to patients with special needs shall be allowed when a primary care dentist requires a consultation for services by that specialty provider.

For more information, please see EPSDT/CTHP Provider Manual for CHPlus, by visiting www.emedny.org/ProviderManuals/EPSDTCTHP/index.aspx

CARE FOR MEMBERS WITH SPECIAL NEEDS

We offer care management services to children and adults with special health care needs, including referrals by the primary care dentist to a dental specialist when a consultation with a specialist is required. Our care management programs are offered to members who:

- Are developmentally disabled
- Are home-bound
- Are identified as needing assistance in accessing or using services; and
- Have long-term or complex health conditions, like asthma, diabetes, HIV/AIDS and high-risk pregnancy.

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

Our care management programs offer children and adults a care manager and other outreach workers. They'll work one-on-one to help coordinate oral health care needs. To do this, they:

- May ask questions to get more information about a member's health conditions;
- Will work with PCPs and PCDs to arrange services needed and to help members understand their illness; and
- Will provide information to help members understand how to care for themselves and how to access services, including local resources.

Offices are required to submit claims for all services rendered. It is recommended that claims be submitted each visit to ensure timely payment. For additional information regarding payment and eligibility, please contact the Member Services at 833.276.0853, Monday through Friday, 8a.m- 8p.m. EST, or visit the on-line Provider Portal.

ESSENTIAL SERVICES

The Medicaid dental benefit is limited and includes only essential services, rather than comprehensive care. The following general guidelines are used:

- Treatment will often not be approved when functional replacement with less costly restorative materials, including prosthetic replacement, is possible. Accordingly, there is often coverage for replacing but not treating a tooth.
- Treatment is not considered appropriate when the prognosis of the tooth is questionable or when reasonable alternative course of treatment would be extraction of the tooth and replacement.
- Treatment such as endodontics or crowns will not be approved in association with an existing or proposed prosthesis in the same arch, unless the tooth is a critical abutment for a prosthesis provided through the NYS Medicaid program, or unless replacement by addition to an existing prosthesis or new prosthesis is not feasible.
- If the total number of teeth which require, or are likely to require, treatment would be considered excessive or when maintenance of the tooth is not considered essential or appropriate in view of the overall dental status of the recipient, treatment will not be covered.
- Treatment of deciduous teeth when exfoliation is reasonably imminent will not be routinely reimbursable.
- Claims submitted for the treatment of deciduous cuspids and molars for children 10 years of age or older, or for deciduous incisors in children 5 years of age or older will be pended for professional review.

- As a condition for payment, it may be necessary to submit, upon request, radiographic images and other information to support the appropriateness and necessity of these restorations. Extraction of deciduous teeth will only be reimbursed if injection of a local anesthetic is required.

For more information regarding Essential Services, please see the Dental Policy and Procedure Code Manual, by visiting www.emedny.org/ProviderManuals/Dental/.

"8 POINTS OF CONTACT" RULE

When considering if services are essential, 8 posterior natural or prosthetic molars and/or bicuspids in occlusion will be considered adequate for functional purposes. This means that 4 maxillary and 4 mandibular teeth in functional contact with each other are considered adequate. If this is met, services may not be considered essential. Requests will be reviewed for necessity based upon the presence or absence of 8 points of natural or prosthetic occlusal contact in the mouth (bicuspid/molar contact). Be sure to provide as much documentation as possible to show that the procedure was medically necessary and that an insufficient number of teeth met the points of contact rule.

See Dental Policy and Procedure Code Manual, by visiting www.emedny.org/ProviderManuals/Dental/.

ORTHODONTIC CARE

When Prior Approval is obtained for orthodontic care for severe physically handicapping malocclusions, the care will be reimbursed for an eligible member for a maximum of three years of active orthodontic care plus one year of retention care. Cleft palate or approved orthognathic surgical cases may be approved for additional treatment time. Treatment not completed within the maximum allowed period must be continued to completion without additional compensation from the NYS Medicaid program, the member or family. Treatment must be approved, and active therapy begun (appliances placed and activated) prior to the member's 21st birthday. Treatment of cleft palate or approved orthognathic surgical cases may be approved after the age of 21 or for additional treatment time.

With the exception of D8210, D8220 and D8999, orthodontic care is reimbursable only when provided by an orthodontist or an Article 28 facility which have met the qualifications of the DOH and are enrolled with the appropriate specialty code.

See Dental Policy and Procedure Code Manual, by visiting www.emedny.org/ProviderManuals/Dental/.

CHPlus does not routinely cover orthodontics. It is only covered in the treatment of serious medical conditions such as cleft palate and cleft lip; maxillary/mandibular micrognathia (underdeveloped upper

or lower jaw); extreme mandibular prognathism; severe asymmetry (craniofacial anomalies); ankylosis of the temporomandibular joint; and other significant skeletal dysplasias.

If a CHPlus member meets the criteria above the case is medical, not dental. The medical plan is responsible for payment for the surgical and orthodontic components of the case. The medical plan must obtain preauthorization from the New York State Department of Health (NYS DOH) in order to receive compensation from NYS DOH for the case.

INTERRUPTED TREATMENT POLICY

When an individual changes insurer during a course of treatment, the insurer at the time of the decisive appointment is responsible for the payment for the entire treatment. Claims must be submitted when the product or service is completed and delivered as the date of service.

See Dental Policy and Procedure Code Manual, by visiting www.emedny.org/ProviderManuals/Dental/.

EXCLUDED SERVICES

The following dental services are excluded under the Medicaid and will not be reimbursed:

- Dental implants and related services;
- Fixed bridgework, except for cleft palate stabilization, or when a removable prosthesis would be contraindicated;
- Immediate full or partial dentures;
- Molar root canal therapy for beneficiaries 21 years of age and over, except when extraction would be medically contraindicated, or the tooth is a critical abutment for an existing serviceable prosthesis provided by the NYS Medicaid program;
- Crown lengthening;
- Replacement of partial or full dentures prior to required time periods unless appropriately documented and justified as stated in the Manual;
- Dental work for cosmetic reasons or because of the personal preference of the recipient or provider;
- Periodontal surgery, except for procedure D4210 – gingivectomy or gingivoplasty, for the sole correction of severe hyperplasia or hypertrophy associated with drug therapy, hormonal disturbances or congenital defects;

- Adult orthodontics, except in conjunction with, or as a result of, approved orthognathic surgery necessary in conjunction with an approved course of orthodontic treatment or the ongoing treatment of clefts;
- Placement of sealants for members under 5 or over 15 years of age;
- Improper usage of panoramic images (D0330) along with intraoral complete series of images (D0210);
- Experimental procedures.

If you believe that your claim has been improperly denied, you may request a plan appeal. For more information, please see Section 2.

OTHER NON-REIMBURSABLE SERVICES

- Treatment of deciduous teeth when exfoliation is reasonably imminent.
- Extraction of deciduous teeth without clinical necessity.
- Claims submitted for the treatment of deciduous cuspids and molars for children 10 years of age or older, or for the deciduous incisors in children 5 years of age or older will be pended for professional review. As a condition for payment, it may be necessary to submit, upon request, radiographic images and other information to support the appropriateness and necessity of these restorations.

HOSPITAL IN-PATIENT; AMBULATORY SURGERY; EMERGENCY ROOM

The "professional component" for dental services can be reimbursed pursuant to your contract. Payment for those services requiring prior approval/prior authorization is dependent upon obtaining approval from LIBERTY. For more information, please refer to the prior authorization section of this manual.

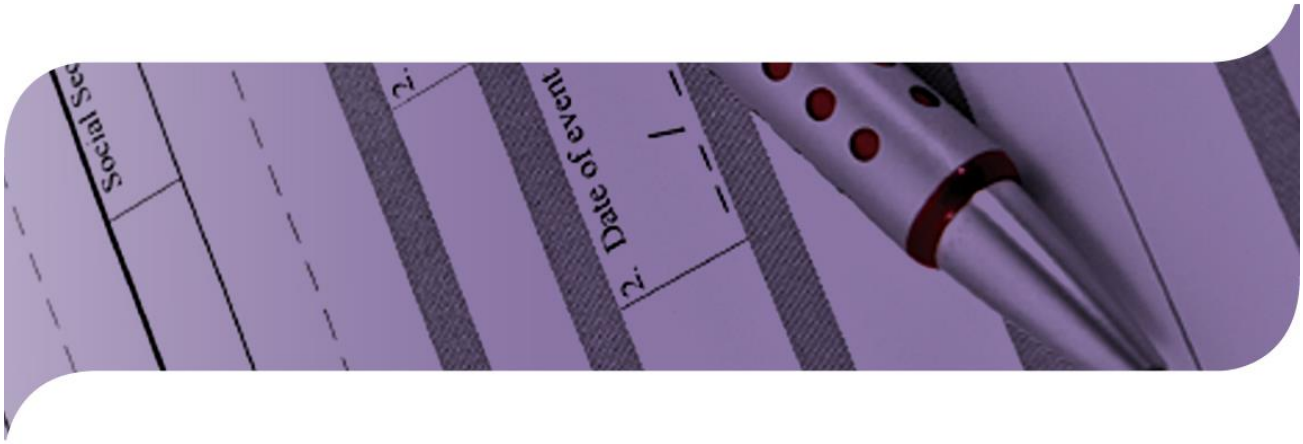
OWNERSHIP AND CONTROL DISCLOSURE

LIBERTY is required to obtain an ownership disclosure from all participating providers.

Contracted Dental Offices must provide LIBERTY with complete and accurate information regarding ownership and control of the Dental Office on the Disclosure Form specified by LIBERTY. In addition, on or before the anniversary of the Effective Date of the Provider Agreement, Dental Office must provide to LIBERTY an updated Disclosure Form or written confirmation that there has been no change in the ownership and/or control of the Dental Office as disclosed on the Disclosure Form. Failure to provide

ownership and control information annually may result in termination of the Provider Agreement pursuant to Section 4.2(c)(ii) of the Provider Agreement.

SECTION 6. CLAIMS AND BILLING



At LIBERTY, we are committed to accurate and efficient claims processing. It is imperative that all information be accurate and submitted in the correct format. Network dentists are encouraged to submit clean claims within 45 days once treatment is complete. Following are the ways to submit a claim:

ELECTRONIC SUBMISSION – CLAIMS, PRIOR AUTHORIZATIONS AND REFERRALS

LIBERTY strongly encourages the electronic submission of claims. This convenient feature assists in reducing costs, streamlining administrative tasks and expediting claim payment turnaround time for providers. There are two options to submit electronically - directly through the Provider Portal or by using a clearinghouse.

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

LIBERTY currently accepts electronic claims/encounters from providers through the clearinghouses listed below. If you do not have an existing relationship with a clearinghouse, please contact the clearinghouse of your choice to begin electronic claims submission. The EDI vendors accepted by LIBERTY are:

LIBERTY EDI VENDOR	PHONE NUMBER	WEBSITE	PAYER ID
DentalXchange	**800.576.6412**	www.dentalxchange.com	CX083
Emdeon	**877.469.3263**	www.emdeon.com	CX083
Tesia	**800.724.7240 x6**	https://www.tesia.com/	CX083

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

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

PAPER CLAIMS

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

ATTN: CLAIMS DEPARTMENT

LIBERTY Dental Plan
PO Box 15149
Tampa, FL 33684-5149

"CLEAN" CLAIMS

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

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

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

- A Diagnoses which is immediately identifiable as emergent or out-of-network urgent, and;
- The dental records required to determine medical/necessity/urgency.

CLAIMS SUBMISSION

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

1. All claims must be submitted to LIBERTY for payment for services no later than 180 days after the date of service.
2. Your National Provider Identifier (NPI) number and tax ID are required on all claims. Claims submitted without these numbers will be rejected. All health care providers, health plans and clearinghouses are required to use the National Provider Identifier number (NPI) as the ONLY identifier in electronic health care claims and other transactions.
3. All claims must include the name of the program under which the member is covered and all the information and documentation necessary to adjudicate the claim.

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

CLAIMS STATUS INQUIRY

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

	**833.276.0853**, press option 2		**Provider Portal:** www.libertydentalplan.com

Claims Status Explanations

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

CLAIMS RESUBMISSION

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

- Missing documentation
- Incorrect coding
- Processing errors

CLAIMS OVERPAYMENT

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

Notice of Overpayment of a Claim

If LIBERTY determines that it has overpaid a claim, LIBERTY will notify the provider in writing through a separate notice clearly identifying the claim; the name of the patient, the date of service and a clear explanation of the basis upon which LIBERTY believes the amount paid on the claim was in excess of the amount due, including interest and penalties on the claim. LIBERTY will not seek reimbursement for an overpayment later than 18 months after the date of the first payment on the claim was made.

Contested Notice

The provider may appeal LIBERTY's request for reimbursement of an overpayment within 45 days, following the internal claims appeal process. LIBERTY shall conduct the appeal at no cost to the provider.

No Contest

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

Offset to Payments – Uncontested Notice of Overpayment

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

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 percent of the cost of covered services. COB also ensures that no one collects more than the actual cost of the Member's dental expenses.

MULTIPLE CARRIERS

Medicaid and CHPlus are federal and state funded health insurance programs created to help qualified New York residents of any age access affordable health insurance. Medicaid and CHPlus is for people who do not have employer insurance.

Members may be enrolled in a Managed Care Organization (MCO) or have benefits through the state Fee for Service Medicaid Program.

Medicaid and CHPlus provide coverage to each eligible beneficiary of the state assistance program. If a Member has another coverage it would always be primary. Medicaid is always the carrier of last resort. Thus, Medicaid coverage is always secondary to any other coverage a Member might have.

Providers should always bill other coverage first, and provide an EOB from the primary carrier with their claim to LIBERTY for coverage. The Provider should submit Coordination of Benefits (COB) claims within 60 days from the date of primary insurer's Explanation of Benefits (EOB) or 180 days from the dates of service, whichever is later. LIBERTY will pay the difference up to the agreed upon or existing fee schedule.

SECTION 8. PROFESSIONAL GUIDELINES AND STANDARDS OF CARE

GENERAL DENTIST PROVIDER RESPONSIBILITIES

- Provide and/or coordinate all dental care for member;
- Perform an oral evaluation;
- Provide a written treatment plan to members upon request that identifies covered services, non-covered services, and clearly identifies any costs associated of each treatment plan that is understandable by a prudent layperson with general knowledge of oral health issues;
- Provide supporting materials for dental services and procedures which document their medical necessity;
- Treatment plans and informed consent documents must be signed by the member or responsible party showing understanding of the treatment plan;
- A financial agreement for any non-covered services shall be documented separate from any treatment plan or informed consent;
- 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 dental facility;
- Request the reassignment of an enrollee by contacting LIBERTY, and informing the enrollee that he/she must contact LIBERTY for assignment to a new office.
- Provide emergency dental treatment no later than forty-eight (48) hours, or earlier as the condition warrants and urgent care appointments within 3 days of referral;

- Maintain scheduled office hours;
- Maintain dental records in accordance with New York State Board of Dentistry regulations;
- Provide updated credentialing information upon renewal dates;
- Provide requested information upon receipt of patient grievance/complaint within the timeframe specified by LIBERTY on the written request;
- Notify LIBERTY of any changes regarding practice, including location name, telephone number, address, associate additions / terminations, change of ownership, plan terminations, etc. at least 30 days in advance.
- Provide dental services in accordance with peer reviewed clinical principles, criteria, guidelines and any evidence based parameters of care.
- Provider will not discriminate or retaliate against an enrollee or attempt to disenroll an enrollee for filing a grievance or appeal.

SPECIALTY CARE PROVIDERS RESPONSIBILITIES

LIBERTY's specialty providers are Board eligible. Providers who wish to advertise an area of dental specialty must meet the NY Board requirements for that dental specialty and have a current "specialty permit".

- All the Responsibilities & Rights of the General Dentist listed above;
- Provide specialty care to members;
- Work closely with primary care dentists to ensure continuity of care;
- Bill LIBERTY Dental Plan for all dental services that were provided;
- Dentists with certification in the following specialties: Endodontics, Oral Surgery/OMFS, Periodontics, and Prosthodontics must have, or have confirmation of application submission, of valid DEA and CDS certificates.
- Provide credentialing information upon renewal dates.

OFFSET TO PAYMENTS

LIBERTY may offset the payment of a future claim or claims against a provider's current claim submission(s) when the provider fails to reimburse LIBERTY or a Member within an appropriate timeframe, as determined by LIBERTY, for the provider's failure to comply with LIBERTY's applicable administrative policies, procedures and/or determinations relating to dental plan administration issues, including, but not limited to those involving balance billing, incorrect charges, and complaint or treatment resolution decisions. LIBERTY will provide the provider with a detailed written explanation identifying the payments that have been offset against the specific current claim or claims.

NATIONAL PROVIDER IDENTIFIER

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

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

How to Apply for an NPI

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

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

VOLUNTARY PROVIDER CONTRACT TERMINATION

Providers must give LIBERTY at least 90 days advance notice of intent to terminate a contract. Provider must continue to treat members when medically necessary until the last day of the fourth month following the date of termination. Provider must continue to treat members for postoperative care when medically necessary until the last day of the sixth month following the date of termination. Affected members are given advance written notification informing them of their transitional rights. Certain contractual rights survive termination, such as the agreement to furnish records during a grievance or claims review. Please consult your provider contract for your responsibilities beyond termination.

MOBILE DENTAL PRACTICES AND MOBILE DENTAL VANS

Mobile Dental Practice is a provider traveling to various locations who utilizes portable dental equipment to provide dental services to facilities, schools and residences. These providers are expected to provide on-site comprehensive dental care, necessary dental referrals to general dentists or specialists and emergency dental care in accordance with all State Board regulations and the NYS Contract. The sites served by the Mobile Dental Practice must allow Member access to treatment and allow for continuity of care. The corresponding Managed Care Plan is responsible for assisting the member and facility in locating a dentist when referrals are issued. Duplicate patient records must be maintained at the location when this is a LTCF or skilled nursing facility and are to be maintained in a central and secure area in accordance with State Board regulations. The corresponding Managed Care Plan must maintain documentation for all locations served to include schedule with time and days.

Mobile Dental Van is a designated vehicle specifically equipped to provide dental services on site. A mobile dental van is not to be considered a dental practice. Patient records are to be maintained in accordance with State Board regulations.

STANDARDS OF ACCESSIBILITY AND AVAILABILITY

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

Type of Appointment	National LIBERTY Appointment Waiting Time Standards
Routine Care	**Within 28 days**
Preventive Care	**Within 28 days**
Urgent Care	**Within 48-72 hours**
Emergency Care	**Within 24 hours of request**
Symptomatic Acute Care	Symptomatic acute care must be provided within 72 hours
After-Hours / Emergency Availability	**24 hours a day, 7 days a week**. All providers must have at least one of the following: After hours calls must be answered by a person, not voicemail. Answering service that is answered by a person, not voicemail, that will contact provider (or provider on call) on behalf of the member Calls involving life threatening conditions or imminent loss of limb or functions conditions may be referred to the 9-1-1, emergency medical services,

	emergency room or urgent care facilities in the community (must be answered by a person, not voicemail), as per regionally available resources.
Scheduled Appointment In-Office Wait Time	**Not to exceed 45 minutes.** Offices must maintain records indicating member appointment arrival time and the actual time the member was seen by provider
Office Hours	**Minimum of 3 days / 30 hours per week**
"Appointment Waiting Time" means the time from the initial request for health care services by a member or the member's treating provider to the earliest date offered for the appointment for services inclusive of time for obtaining authorization from the plan or completing any other condition or requirement of the plan or its contracting providers.	

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 dentist is not available to evaluate an emergency patient of record within 24 hours, it is his/her responsibility to make arrangements to ensure that emergency services are available.

A dental emergency is defined as an unforeseen dental condition recognizable by acute signs and symptoms, such as cellulitis, uncontrolled oral hemorrhage, infection, swelling or trauma of sufficient severity that a prudent layperson who possesses an average knowledge of dentistry could reasonably expect the absence of immediate dental attention to result in disability or harm to a member if not immediately diagnosed and treated.

A medical emergency is limited to procedures administered in a hospital, when the condition could cause:

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

A member must be scheduled to a time appropriate for the emergency or urgent condition, which could be within 24 hours, or the next business day in most cases. Only the emergency will be treated at an emergency or urgent care appointment. If the patient is unable to access emergency care within our guidelines and must seek services outside of your facility, LIBERTY will be financially responsible for the payment of the covered emergency services.

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.

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 seek corrective action for providers that are not meeting accessibility standards.

TREATMENT PLAN GUIDELINES

All members must be presented with an appropriate written treatment plan. If there is more than one treatment available, the treating dentist must also present those treatment plans, and any related costs for non-covered services.

Non-Covered Procedures and Treatment Plans: LIBERTY Dental members cannot be denied their plan benefits if they do not choose "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 and non-covered procedures.

Non-Covered Services: Non-covered services can be discussed with the member. **Important Notice:** Any non-covered services selected by a member must be clearly presented on a separate treatment plan clearly stating that the service is **not covered,** and that the member has been informed of covered services and elects the non-covered service and understands and accepts the financial responsibility. LIBERTY recommends that payment agreements with members be recorded in writing and agreed to by the member before any treatment is rendered. The recipient is responsible 100% of the entire fee.

SECOND OPINIONS

LIBERTY has a Second Opinion program that can be utilized at the enrollee's option for diagnosis and treatment of serious dental conditions, for elective surgical procedures, when a dentist recommends a treatment other than what the Member believes is necessary, or if the Member believes they have a condition that the dentist failed to diagnose. The program can also be utilized at the enrollee's option for diagnosis and treatment of dental conditions that are treated within a dental specialty. In addition, the Member may receive the second opinion within the LIBERTY's network or LIBERTY may arrange for the Member to obtain a second opinion outside the network at no cost to the Member. The Second Opinion program shall be incorporated into the LIBERTY's dental procedures and submitted to DMAHS for review and approval.

Network Dentist(s) should refer these members to the **Member Services Department** at **833-276-0847**, Monday through Friday, 8 a.m. to p.m. EST.

RECALL, FAILED OR CANCELLED APPOINTMENTS

Contracted dentists are expected to have an active recall system for established patients. Recall systems should incorporate follow up on missed appointments and referrals, including referrals to address problems identified through EPSDT exams. Contact Member Services or the LIBERTY website for more information. Missed or cancelled appointments should be noted in the patient's record. Please note that Medicaid beneficiaries cannot be charged for broken or missed appointments.

CONTINUITY AND COORDINATION OF CARE

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

A panel of network dentists shall be available in currently assigned counties from which members may select a provider to coordinate all their dental care.

Continuity of care between the Primary Care Dentist (PCD) and any specialty care dentist must be available and properly documented. Communication between the PCD and dental specialist shall

occur when members are referred for specialty dental care. LIBERTY expects PCDs to follow up with the Member and with the Specialist to ensure that referrals are occurring as per the best interest of the Member. Specialist providers are encouraged to send treatment reports back to the referring PCD to ensure that continuity of care occurs as per generally accepted clinical criteria.

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

MEMBER RIGHTS AND RESPONSIBILITIES

Members have specific rights and responsibilities when it comes to their care. The member rights and responsibilities are provided to members in the member's Member Handbook and Evidence of Coverage.

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

- To be treated with respect, giving due consideration to the Member's right to privacy and the need to maintain confidentiality of the Member's medical and dental information;
- To be provided with information about the plan and its services, including covered services;
- To request a printed copy of the Member Handbook at least once per year or more frequently as determined necessary;
- To be able to choose a Primary Care Dentist within the Contractor's network;
- Freedom to change their Primary Care Dentist upon request for any reason and as frequently as needed.
- Instructions on this procedure are provided and outlined in the Member Handbook;
- To participate in decision making regarding their own dental care including the member's preference about future treatment decisions, and the right to refuse treatment;
- To have access to the grievance and appeal system and file a grievance about the organization or the care received, excluding adverse benefit determinations; either verbally or in writing. To request an appeal;
- To receive interpretation services in their preferred language;
- To have access to all medically necessary dental service provided in Federally Qualified Health Centers, Rural

- Health Clinics or Indian Health Service Facilities, and access to emergency dental services outside the Contractor's network pursuant to federal law;
- To request a State fair hearing, including information on the circumstances under which an expedited fair hearing is possible;
- To have access to, and where legally appropriate, receive copies of, amend or correct their dental record;
- To be provided disenrollment requirements and limitations and to dis-enroll upon request;
- To receive written Member informing materials in alternative formats (including Braille, large size print, and audio format) upon request and in a timely fashion appropriate for the format being requested;
- To be provided information about the definitions of emergency care;
- To be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation;
- To receive information on available treatment options and alternatives, presented in a manner appropriate to the Member's condition and ability to understand;
- Freedom to exercise these rights without adversely affecting how they are treated by the Contractor, providers, or the State;
- Freedom from LIBERTY prohibiting a provider from advising on behalf of a Member;
- To have access to Contractor's health education programs and outreach services in order to improve dental health;
- To request a second opinion, including from a specialist at no cost;
- To formulate advance directives.

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

- Provide accurate and updated information to contracting dentists, dental office staff and LIBERTY administrative staff to provide care (to the extent possible);
- To not allow any other person to use their ID Card;
- To communicate changes in demographic of dependent information, or other changes that would affect eligibility;
- Notify LIBERTY of any other insurance coverage;

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

THE DENTAL PATIENT RECORD

Member dental records must be kept and maintained in compliance with applicable state and federal regulations (NYS Rules of the Board of Regents: Part 29 – section 29.2(a)(3)). Complete dental records of active or inactive patients must be accessible for at least 10 years State Board of Dentistry Regulations.

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/federal compliance. The dentist must make records available at no cost to the Plan or the patient. Non-compliance may result in disciplinary actions, up to and including transfer of enrollment or closure to new enrollment. Continued non-compliance may result in termination.

DENTAL RECORDS AVAILABILITY

Member dental records must be kept and maintained in compliance with applicable state and federal regulations. Complete dental records of active or inactive patients must be accessible for at least 10 years.

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/federal compliance. The dentist must make records available at no cost to the Plan or the patient. Non-compliance may result in disciplinary actions, up to and including transfer of enrollment or closure to new enrollment. Continued non-compliance may result in termination by the Plan.

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 onto LIBERTY Dental Plan members.

SECTION 9. REFERRAL AND PRIOR AUTHORIZATION GUIDELINES

SPECIALTY CARE REFERRAL

The following guidelines outline the specialty care referral process. Failure to follow any of these guidelines may result in financial penalties against your office through capitation adjustment if applicable.

*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 Benefit Schedule for plan-specific details regarding procedure codes.

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

NON-EMERGENCY 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:

Provider Portal: www.libertydentalplan.com

Fax: (888)700-1727

Mail: LIBERTY Dental Plan
Attn: Referral Department
PO Box 15149
Tampa, FL 33684-5149

If there is no contracted LIBERTY specialist available within a reasonable proximity to your office, our Member Services Representatives will assist in referring the member to a non-contracted Specialist.

If a referral is made by the members assigned General Dentist without prior approval, the referring office may be held financially responsible. Failure to use the proper forms and submit accurate information may cause delays in processing or payment of claims.

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 your office as needed.

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 digitalized images, are acceptable.

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 at 833.276.0853, Option 4.

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:

- Member'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;
- Procedure code(s), tooth number(s) and member copayments for the covered endodontic treatment, which requires referral.
- X-rays that clearly show all current conditions, and which allow for the proper evaluation and diagnosis of the entire dentition and any other pertinent information that will assist in determining the necessity and appropriateness of the referral.

Inform the member that:

- Only services approved by LIBERTY will be covered;
- The member will be financially responsible for non-covered and non-approved services provided by the Endodontist;
- 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, fax or via standard mail service. The Plan's Dental Consultant 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 of 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 833.276.0853, Option 4 for an emergency authorization number.

After completion of treatment, submit your claim for payment with pre-operative and 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.**

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-surgical access	No	Endodontist's claims for this procedure evaluated on a case-by-case		No
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		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**
D3346	Retreatment of previous root canal therapy - anterior	Yes	Case-By-Case	Swelling, bleeding and/or pain and the General Dentist has attempted palliative treatment.	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/calcific 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 root	Yes			
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:

- Member'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;
- Procedure code(s) and, tooth number(s)/quadrant(s), which require referral.

Inform the member that:

- Only services approved by LIBERTY will be covered
- The member will be financially responsible for non-covered and non-approved services provided by the Oral Surgeon.
- 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, fax or via standard mail service.

The Plan Dental Consultant 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.

Standard referrals will be reviewed and issued for approved services requested by the general dentist. Code D9310 (consultation, other than the requesting dentist) is payable on the same day as treatment. Any treatment plan modifications added to the referral by the oral surgeon are subject to pre-payment review and must meet benefit guidelines. Frequency limitations for code D0330 (panoramic radiographic image) will not apply if it is an initial film taken at the oral surgeon's office.

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 833.276.0853 , Option 4 for an emergency authorization number.

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.**

Emergency Situations - Providers should not turn away members who are in pain. If a member presents to the oral surgeon's office for an emergency without a referral, the provider should treat the condition and submit all appropriate documentation for payment. An emergency is described as the presence of pain, swelling, bleeding and/or infection. Providers should include a narrative to explain the emergency condition. All services provided will be subject to pre-payment review.

It is recommended that any additional, non-emergency treatment be preauthorized to ensure payment. If services are not preauthorized, they will be subject to pre-payment review.

Oral Surgery Referral Guidelines				
Oral Surgery Referrals (Subject to plan Benefits)		**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 forceps removal)	No	N/A	No
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

Oral Surgery Referral Guidelines				
Oral Surgery Referrals (Subject to plan Benefits)		**Procedures Usually Approved For Referral**	**Referral Criteria**	**Qualified for Emergency Referral**
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 surgical extractions	Yes
D7311	Alveoloplasty in conjunction with extractions - 1 to 3 teeth or tooth spaces, per quadrant	B/R		Yes
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

Oral Surgery Referral Guidelines				
Oral Surgery Referrals (Subject to plan Benefits)		**Procedures Usually Approved For Referral**	**Referral Criteria**	**Qualified for Emergency Referral**
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.

Members may self-refer or the general dentist can 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;
- Comments concerning the member's malocclusion.

Inform the member that:

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

Referral Guidelines for the Orthodontist - To be eligible for orthodontia services, the recipient must meet all the following general requirements:

1. Be under twenty-one (21) years of age.
2. Meet the financial standards for Medicaid eligibility.
3. Exhibit a **SEVERE PHYSICALLY HANDICAPPING MALOCCLUSION.**
4. HLD Index score of 26 or higher or one of the automatically qualifying conditions.

HLD Index: https://www.emedny.org/ProviderManuals/index.aspx

Orthodontic care for severely physically handicapping malocclusions will be reimbursed for an eligible recipient for a maximum of three years of active orthodontic care, plus one year of retention care. Treatment must be approved, and active therapy begun prior to the recipient's 21st birthday. Treatment of cleft palate or approved orthognathic surgical cases may be approved after the age of 21 or for additional treatment time. With the exception of D8210, D8220, and D8999, orthodontic care is reimbursable only when provided by an orthodontist or an Article 28 facility which has met the qualifications of the DOH and are enrolled with the appropriate specialty code.

Diagnostic services including D0330, D0340, D0350, and D0470 will be paid in addition to code D8660. Frequency limitations will not apply for code D0330 if it is the initial film taken at the orthodontist's office.

Orthodontists must include the treatment plan and the "Interceptive Treatment Request Form" when requesting for approval of D8050 and D8060.

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

Inform the member that:

- Only services approved by LIBERTY will be covered
- The member will be financially responsible for non-covered and non-approved services provided by the Periodontist;
- 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, fax or via standard mail service.

The Plan's Dental Consultant 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 or areas of recession. Submit x-rays that were enclosed with original authorization form (or copies);
- The member's LIBERTY Specialty Care Authorization.

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

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

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**
D4260	Osseous surgery (including flap entry & closure) - 4 or more contiguous teeth or bounded teeth spaces per quadrant	B/R	When approved, limited to no more than two quadrants on the same date of service	Full Mouth x-rays, Full mouth 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	Full Mouth x-rays, Full mouth periodontal probing's, dates of SRP's & follow-up evaluation
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	

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**
D4342	Periodontal scaling & root planing - 1 to 3 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
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 procedures	B/R

PERIODONTIC REFERRAL COVERAGE BASED ON DIAGNOSIS

Gingivitis associates with dental plaque

- Sulcus depths of 1 – 3 mm with the possibility of an occasional 4 mm pseudo pocket;
- Some bleeding upon probing; and
- 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 (0.5 mm - 1.0 mm) mobility;
- No furcation involvement or an isolated Grade 1 involvement (i.e., can probe into the concavity of a root trunk); and
- 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); and
- 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 is eligible for direct specialty referral.

Referral to a Periodontist covered, after scaling and root planing by the assigned 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); and
- 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.

SECTION 10. CLINICAL DENTISTRY PRACTICE PARAMETERS

The following clinical dentistry criteria, processing guidelines and practice parameters represent the view of the Peer Review Committee of LIBERTY Dental Plan and represent LIBERTY's processing guidelines, benefit determination guidelines and the generally acceptable clinical parameters as agreed upon by consensus of the Peer Review Committee to be professionally recognized best practices. In some cases, guidance is given about procedure codes services that may not be within the scope of benefits of all LIBERTY benefit plans.

Please consult New York State Medicaid Program Dental Policy and Procedure Code Manual for covered services under the Medicaid and CHPlus programs or other plan materials to determine plan-by-plan variations. https://www.emedny.org/ProviderManuals/Dental/index.aspx

NEW PATIENT INFORMATION

Registration information should include:

1. Name, sex, birth date, address and telephone number, cell phone number, e-mail address, name of employer, work address and telephone number, language of preference.
2. Name and telephone number of person(s) to contact in an emergency.
3. For minors, name of parent(s) or guardian(s) and telephone numbers, if different from above.
4. Pertinent information relative to the patient's chief complaint and dental history, including any problems or complications with previous dental treatment.
5. Medical History - There should be a detailed medical history form comprised of questions which require a "Yes" or "No" response, including:
    a. Patient's current health status

b. Name and telephone number of physician and date of last visit

c. History of hospitalizations and/or surgeries

d. Current medications, including dosages and indications

e. History of drug and medication use (including Fen-Phen/Redux and bisphosfonates)

f. Allergies and sensitivity to medications or materials (including latex)

g. Adverse reaction to local anesthetics

h. History of diseases or conditions:

i. Cardio-vascular disease, including history of abnormal (high or low) blood pressure, heart attack, stroke, history of rheumatic fever or heart murmur, existence of pacemakers, valve replacements and/or stents and bleeding problems, etc.

ii. Pulmonary disorders including COPD, tuberculosis, asthma and emphysema

iii. Nervous disorders, including psychiatric treatment

iv. Diabetes, endocrine disorders, and thyroid abnormalities

v. Liver or kidney disease, including hepatitis and kidney dialysis

vi. Sexually transmitted diseases

vii. Disorders of the immune system, including HIV status/AIDS

viii. Other viral diseases

ix. Musculoskeletal system, including prosthetic joints and when they were placed

x. History of cancer, including radiation or chemotherapy

6. Pregnancy

a. Document the name of the patient's obstetrician and estimated due date.

b. Follow current guidelines in the ADA publication, Women's Oral Health Issues.

7. The medical history form must be signed and dated by the patient or patient's parent or guardian.

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

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

10. The dentist must sign and date all baseline medical histories after review with the patient. If electronic dental records are used, indication in the progress notes that the medical history was reviewed is acceptable.

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

CLINICAL ORAL EVALUATIONS

A. Periodic oral evaluations (Code D0120) of an established patient may only be provided for a patient of record who has had a prior comprehensive examination. Periodontal evaluations and oral cancer screenings should be updated at appropriate intervals, dictated by the patient's history and risk factors, and should be done at least annually.

B. A problem-focused limited examination (Code D0140) must document the issue substantiating the medical necessity of the examination and treatment.

C. An oral evaluation of a patient less than seven years of age should include documentation of the oral and physical health history, evaluation of caries susceptibility and development of an oral health regimen.

D. A comprehensive oral evaluation for new or established patients (Code D0150) who have been absent from active treatment for at least three years or have had a significant change in health conditions should include the following:

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

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

3. Full mouth periodontal screening must be documented for all patients; for those patients with an indication of periodontal disease, probing and diagnosis must be documented, including an evaluation of bone levels, gingival recession, inflammation, etiologic factors (e.g., plaque and calculus), mobility, and furcation involvements.

4. A soft tissue/oral cancer examination of the lips, cheeks, tongue, gingiva, oral mucosal membranes, pharynx and floor of the mouth must be documented for all patients, regardless of age.

E. A post-operative office visit for re-evaluation should document the patient's response to the prior treatment.

F. A comprehensive periodontal evaluation (D0180) is for patients showing signs or symptoms of periodontal disease or significant risk factors such as diabetes or smoking. It includes evaluations of periodontal conditions, probing and charting, evaluation of the dental and medical history and general health assessment.

INFORMED CONSENT

A. The dentist should have the member sign appropriate informed consent documents and financial agreements.

B. Following an appropriate informed consent process, if a patient elects to proceed with a procedure that is not covered, the member is responsible for the dentist's usual fee.

PRE-DIAGNOSTIC SERVICES

A. Screening of a patient, which includes a state or federal mandate, is used to determine the patient's need to see a dentist for diagnosis.

B. Assessment of a patient is performed to identify signs of oral or systemic disease, malformation or injury and the potential need for diagnosis and treatment.

DIAGNOSTIC IMAGING

Based on the dentist's determination that there is generalized oral disease or a history of extensive dental treatment, an adequate number of images should be taken to make an appropriate diagnosis and treatment plan, per current FDA/ADA radiographic guidelines to minimize the patient's exposure. Photographic images may also be needed to evaluate and/or document the existence of pathology.

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

B. An adequate number of initial radiographic images should be taken to make an appropriate diagnosis and treatment plan, per current FDA/ADA radiographic guidelines. This includes the ALARA Principle (As Low As Reasonably Achievable) to minimize the patient's exposure. It is important to limit the number of radiographic images obtained to the minimum necessary to obtain essential diagnostic information.

C. The patient should be evaluated by the dentist to determine the radiographic images necessary for the examination prior to any radiographic survey.

D. Intraoral – complete series (including bitewings) (Code D0210)

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

1. Benefits for this procedure are determined within each plan design.

2. Any benefits for periapical and/or bitewing radiographs taken on the same date of service will be limited to a maximum reimbursement of the provider's fee for a complete series.

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

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

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

F. Radiographs should exhibit good contrast.

G. Diagnostic digital radiographs should be submitted electronically when possible or should be printed on photographic quality paper and exhibit good clarity and brightness.

H. All radiographs must be mounted, labeled left/right and dated.

I. Intra or extra-oral photographic images should only be taken to diagnose a condition or demonstrate a need for treatment that is not adequately visualized radiographically.

J. Any patient refusal of radiographs should be documented.

K. Radiograph duplication fees:

1. Radiographic image duplication fees may not be allowed. Refer to specific plan design.

2. When a patient is transferred from one contracted provider to another, diagnostic copies of all radiographic images less than two years old should be duplicated for the second provider.

3. If the transfer is initiated by the provider, the patient may not be charged any applicable radiographic image duplication fees.

L. Diagnostic casts (Code D0470) are only considered medically necessary as an aid for treatment planning specific oral conditions.

TESTS, EXAMINATIONS AND REPORTS

A. Tests, examinations and reports may be required when medically necessary to determine a diagnosis or treatment plan for an existing or suspected oral condition or pathology.

B. Oral pathology laboratory procedure/report may be required when there is evidence of a possible oral pathology problem.

PREVENTIVE TREATMENT

A. Dental prophylaxis (Code D1110 and D1120) may be medically necessary when documentation shows that there is evidence of plaque, calculus or stains on tooth structures.

B. Topical fluoride (Code D1206) treatment may be medically necessary when documentation shows that there is evidence of the need for this preventive procedure.

C. Nutritional Code D1310) or tobacco (Code D1320) counseling may be medically necessary when the patient is at risk for periodontal disease and/or caries or is a tobacco user.

D. A sealant (Code D1351) or preventive resin restoration (Code D1352) may be medically necessary to prevent decay in a pit or fissure or as a conservative restoration in a cavitated lesion that has not extended into dentin on a permanent tooth in a moderate to high caries risk patient.

E. A space maintainer (Code D1510) may be medically necessary to prevent tooth movement and/or facilitate the future eruption of a permanent tooth.

F. Recognizing medical conditions that may contribute to or precipitate the need for additional prophylaxis procedures, supported by the patient's physician. Verify plan benefits prior to performing additional prophylaxis procedures in excess of plan limitations.

G. Interim caries arresting medicament application (Code D1354) Silver Diamine Fluoride (SDF) is an interim caries arresting liquid medicament clinically applied to control and prevent the further progression of active dental caries, and reduce dental hypersensitivity. Treatment with Silver Diamine Fluoride will not eliminate the need for restorative dentistry to repair function or aesthetics, but this alternative treatment allows oral health care professionals to temporarily arrest caries with noninvasive methods, particularly with young children that have primary teeth. This should be submitted on a per tooth basis.

RESTORATIVE TREATMENT

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

Amalgam Restorations (Codes D2140-D2161)

1. Dental amalgam is a cavity-filling material made by combining mercury with other metals such as silver, copper and tin. Numerous scientific studies conducted over the past several decades, including two large clinical trials published in the April 2006 Journal of the American Medical Association, indicate dental amalgam is a safe, effective cavity-filling material for children and others. And, in its 2009 review of the scientific literature on amalgam safety, the ADA's Council on Scientific Affairs reaffirmed that the scientific evidence continues to support amalgam as a valuable, viable and safe choice for dental patients…"

2. On July 28, 2009, the American Dental Association (ADA) agreed with the U.S. Food and Drug Administration's (FDA) decision not to place any restriction on the use of dental amalgam, a commonly used cavity filling material:

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

    b. Facial or buccal restorations are generally considered to be "one surface" restorations, not three surfaces such as MFD or MBD.

c. The replacement of clinically acceptable amalgam fillings with an alternative material (composite, crown, etc.) is considered cosmetic and is not covered unless decay or fracture of the existing filling is present.

d. If a dentist chooses not to provide amalgam fillings, alternative posterior fillings must be made available for LIBERTY patients. Any listed amalgam copayments would still apply.

e. An amalgam restoration includes tooth preparation and all adhesives, liners and bases. (

f. An amalgam restoration may be medically necessary when a tooth has a fracture, defective filling or decay penetrating into the dentin.

g. An amalgam restoration should have sound margins, appropriate occlusion and contacts and must treat all decay that is evident.

B. Resin-based Composite Restorations (Codes D2330 – D2394)

1. 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 still be a candidate for a filling restoration if little to no other surfaces manifest caries or breakdown.

2. Facial or buccal restorations are generally considered to be "one surface" restorations, not three surfaces such as MFD or MBD.

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

4. A resin-based composite restoration includes tooth preparation, acid etching, adhesives, liners, bases and curing.

5. A resin-based composite restoration may be medically necessary when a tooth has a fracture, defective filling, recurrent decay or decay penetrating into the dentin.

6. A composite restoration should have sound margins, appropriate occlusion and contacts and must treat all decay that is evident.

7. If LIBERTY determines that there is a more appropriate procedure code to describe the restoration provided, either number of surfaces, or material used, an alternate procedure code may be approved.

C. Restorations for primary teeth are covered only if the tooth is expected to be present for at least six months.

D. For posterior primary teeth that have had extensive loss of tooth structure or when it is necessary for preventive reasons, the appropriate treatment is generally a prefabricated stainless steel crown or for anterior teeth, a stainless steel or prefabricated resin crown.

E. A resin infiltration of an incipient smooth surface lesion (decalcification) is appropriate for smooth surface lesions with some or minor enameloplasty.

F. An inlay or gold foil (Codes D2410 – D2430) filling is an intracoronal restoration and has similar indications as a filling. Inlays and gold foil restorations may not be practical due to the cost and limited use in current clinical dentistry practices.

G. An onlay (Codes may be considered when there is sufficient tooth structure, but additional cusp support is needed.

H. Crowns/Onlays - Single Restorations Only (Codes D2510 – D2794)

1. Administrative Issues

a. Providers may document the date of service for these procedures to be the date when final impressions are completed (subject to review).

b. Providers must complete any irreversible procedure started regardless of payment or coverage and only bill for indirect restorations when the service is completed (permanently cemented).

c. Crown services must be documented using valid procedure codes in the American Dental Association's Current Dental Terminology (CDT).

2. A crown or onlay may be medically necessary when the tooth is present and:

a. The tooth has evidence of decay undermining more than 50% of the tooth (making the tooth weak), when a significant fracture is identified, or when a significant portion of the tooth has broken or is missing and has good endodontic, periodontal and/or restorative prognoses and is not required due to wear from attrition, abrasion and/or erosion.

b. There is a significantly defective crown or onlay (defective margins or marginal decay) or there is recurrent decay.

c. The tooth is in functional occlusion.

d. 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 be a porcelain fused to base metal crown or a porcelain/ceramic substrate crown.

e. The tooth has a good endodontic, periodontic and restorative prognosis with a minimum crown/root ratio of 50% and a life expectancy of at least five years.

f. A provisional crown may be required only when there is evidence of medical necessity for this procedure

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

4. Final crowns for teeth with a good prognosis should be sequenced after performing necessary endodontic and/or periodontal procedures and such teeth should exhibit a minimum crown/root ratio of 50%.

5. Types of Crowns

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

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

c. Porcelain/ceramic substrate crowns and porcelain fused to metal crowns on molars may be susceptible to fracture during occlusal function. Depending on the properties of the material used, it may not be consistent with good clinical practice to routinely use all-porcelain/ceramic restorations on molar teeth.

d. Stainless steel crowns are primarily used on deciduous teeth and only used on adult teeth due to a patient's disability/inability to withstand typical crown preparation.

6. Crown and Bridge Unit Upgrades

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

   b. Typical upgrades include:

   i. Choice of metal – noble, high noble, titanium alloy or titanium

   ii. Porcelain on molar teeth

   iii. Based on the particular plan design, porcelain margins may be charged separately. A reasonable amount may be charged ($100 or less per unit). A patient signed informed consent accepting the optional nature and charge for this feature must be present.

   iv. 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, including risks, benefits and alternatives. Members must have an option to access to their covered benefit as well as any upgraded procedures.

7. Core Buildup, including any pins when required (Code D2950), must show evidence that the tooth requires additional structure to support and retain a crown.

   a. Core buildup refers to building up of coronal structure when there is insufficient retention for an extra-coronal restorative procedure.

   b. A core buildup is not a filler to eliminate any undercut, box form, or concave irregularity in a preparation.

8. Post and core (Code D2952 and D2954) procedures for endodontically treated teeth include buildups. By CDT definitions, each of these procedures includes a "core." Therefore, a core buildup, cannot be billed with either Codes D2952 or D2954 for the same tooth, during the same course of treatment.

   a. The tooth is functional, has had root canal treatment and the tooth requires additional structure to support and retain a crown.

b. Post and core in addition to crown (Code D2952), is an indirectly fabricated post and core custom fabricated as a single unit.

c. Prefabricated post and core in addition to crown (Code D2954) is built around a prefabricated post. This procedure includes the core material.

9. Pin retention (Code D2951) or restorative foundation may be medically necessary when a tooth requires a foundation for a restoration.

10. A coping (Code D2975) or crown under a partial denture (Code D2971) may be required when submitted documentation demonstrates the medical necessity of the procedure.

11. Repair of a restorative material failure may be medically necessary when submitted documentation establishes restorative material failure.

12. Resin infiltration may be medically necessary when a tooth shows evidence of early decalcification.

13. Outcomes: Guidelines for the Assessment of Clinical Quality and Professional Performance, published by The California Dental Association, and standards set by the specialty boards shall apply.

    a. Margins, contours, contacts and occlusion must be clinically acceptable.

    b. Tooth preparation should provide adequate retention and not infringe on the dental pulp.

    c. Crowns should be designed with a minimum life expectancy or service life of five years.

ENDODONTICS

A. Assessment

1. Diagnostic techniques used when considering possible endodontic procedures may include an evaluation of:

    a. Pain and the stimuli that produce or relieve it by the following tests:

        i. Thermal

        ii. Electric

        iii. Percussion

iv. Palpation

v. Mobility

b. Non-symptomatic radiographic lesions

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

1. Strategic importance of the tooth or teeth

2. Prognosis – endodontic procedures for teeth with a guarded or poor 5-year prognosis (endodontic, periodontal or restorative) are not covered

a. Excessively curved or calcified canals

b. Presence and severity of periodontal disease

c. Restorability and tooth fractures

3. Occlusion

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

C. Clinical Guidelines

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

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

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

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

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

6. For direct or indirect pulp caps, documentation is required that shows a direct or near exposure of the pulp. Direct or indirect pulp cap procedures are not considered bases and liners.

    a. 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.

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

7. For a pulpotomy (Code D3220) or pulpal therapy (Code D3221), documentation is required that shows pulpal pathology and a good prognosis that the tooth has a reasonable period of retention and function.

8. For endodontic treatment (Codes D3310 – D3330), documentation is required that shows the treatment is medically necessary (i.e., tooth is broken, decayed or previously restored, functional with an unhealthy nerve and more than 50% of the tooth structure is sound) and the tooth has a good endodontic, periodontal and/or restorative prognosis.

Note: LIBERTY may determine that a different, more appropriate procedure code better describes the endodontic treatment performed and may make our determination based on the alternate code.

9. For incomplete endodontic treatment (Code D3332), documentation is required that shows endodontic treatment has been started and that a subsequent determination has been made that it cannot be successfully completed.

10. Treatment of a root canal obstruction (Code D3331) may be needed when radiographic evidence shows a canal that is at least 50% closed or blocked.

11. For internal root repair (Code D3333), documentation is required that shows the need to repair a non-iatrogenic perforation.

12. For endodontic retreatment (Codes D3346 – D3348), documentation is required that shows a tooth with previous endodontic treatment that is symptomatic or shows evidence of periapical pathology.

13. For apexification/recalcification (Code D3351), documentation is required that shows the apex of the tooth root(s) is/are incompletely developed.

14. For treatment of root canal obstruction (Code D3331), documentation is required that shows a non-negotiable root canal blocked by foreign bodies, including but not limited to separated instruments, broken posts or calcification of 50% or more of the root.

    a. It is not generally known that a canal obstruction is present until the time of the root canal treatment. Therefore, LIBERTY will not approve a benefit for this procedure when submitted as part of a predetermination request, and/or prior to actual treatment.

    b. LIBERTY acknowledges that the treatment of a root canal obstruction (Code D3331) is a separate, accepted procedure code. This procedure should not be submitted in conjunction with endodontic retreatment procedures Codes D3346, D3347 or D3348, as treatment of a root canal obstruction is considered to be included in endodontic retreatment.

15. For apical surgery (Codes D3410 – D3426), documentation is required that shows apical or lateral pathosis that cannot be treated non-surgically and that the tooth has a good periodontal and restorative prognosis. Endodontic apical surgical treatment should be considered only in specific circumstances, including:

    a. The root canal system cannot be instrumented and treated non-surgically.

    b. There is active root resorption.

    c. Access to the canal is obstructed.

    d. There is gross over-extension of the root canal filling.

    e. Periapical or lateral pathosis persists and cannot be treated non-surgically.

    f. Root fracture is present or strongly suspected.

    g. Restorative considerations make conventional endodontic treatment difficult or impossible.

Note: LIBERTY may determine that the apical surgery requested could have a better/equivalent outcome with a different endodontic procedure code

16. For a periradicular bone graft (Code D3428), documentation is required that shows the disease process has resulted in a deformity and loss of bone.

17. For a retrograde filling (Code D3430), documentation is required that shows evidence of medical necessity for a retrograde filling during periradicular surgery.

18. For a surgical or endodontic implant procedure, documentation is required that shows evidence of medical necessity for the procedure.

19. Endodontic irrigation

    a. Providers are contractually obligated to not charge more than the listed copayment for covered root canal procedures whether the dentist uses BioPure, diluted bleach, saline, sterile water, local anesthetic and/or any other acceptable alternative to irrigate the canal.

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

REMOVABLE PROSTHETICS

Note: Providers may document the date of service for these procedures to be the date when prosthetic appliances are completed.

A. Complete Dentures (Codes D5110 and D5120)

1. Complete dentures are the appliances of last resort, particularly in the mandibular arch. Patients should be fully informed of their significant limitations. A complete denture may not be covered if some teeth are still present in the arch and extraction of the remaining teeth is not necessary.

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

3. An immediate complete or removable partial denture includes routine post-delivery care, adjustments and soft liners for six months. A conventional complete or removable partial denture includes routine post-delivery care and adjustments and soft liners for three months.

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

B. Immediate Complete Dentures (Code D5130 and D5140)

1. These covered dentures are inserted immediately after a patient's remaining teeth are removed. While immediate dentures offer the benefit of never having to be without teeth, they must be relined (refitted on the inside) during the healing period after the extractions have been performed.

2. An immediate complete denture includes routine post-delivery care, adjustments and soft liners for six months.

3. An immediate complete denture is not a benefit as a temporary denture. Subsequent complete dentures are not a benefit within a five-year period of an immediate denture.

4. If prior services are found to be clinically defective due to inadequate technical quality, the providers are expected to replace, or correct services rendered by them at no additional charge to the member.

C. Interim Complete Dentures (Codes D4810 and D5811)

1. These non-covered appliances are only intended to replace teeth during the healing period, prior to fabrication of a subsequent, covered, complete denture. Benefits may not exist for both an interim and definitive complete denture.

2. Discussion of coverage and benefits 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 a member signature on informed consent forms, treatment plan documents, chart progress notes and/or financial consent forms.

D. Partial Dentures (Codes D5211 – D5281)

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

2. Removable partial dentures are covered when posterior teeth require replacement on both sides of the same arch or multiple edentulous areas are present (excluding non-functional second or third molars). Remaining teeth must have a good endodontic prognosis and a good periodontal prognosis.

3. An interim partial denture may be needed when the remaining teeth have a good prognosis and the patient has an existing partial denture that is not serviceable or an initial partial denture is being performed and the patient has several missing teeth on both sides of the same arch.

4. For a treatment plan that includes both a fixed bridge and a removable partial denture in the same arch, the removable partial denture is considered the covered service.

5. A unilateral removable partial denture is rarely appropriate. Best practices include replacing unilateral missing teeth with a fixed bridge or implant.

6. Endodontic, periodontal and restorative treatment should be completed prior to fabrication of a removable partial denture.

7. Abutment teeth should be restored prior to the fabrication of a removable partial denture and would be covered if the teeth meet the same standalone benefit requirements of a single crown.

8. Removable partial dentures should be designed so that they do not harm the remaining teeth and/or periodontal tissues, and to facilitate oral hygiene.

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

10. Flexible partial dentures (Codes D5225, D5226) include the following brands: Valplast, Thermoflex, Flexite, etc. There is no differentiation between different brands of flexible material; only the specific CDT code applies. A flexible partial denture may be needed to replace an existing partial denture that is not serviceable, and the remaining teeth have a good prognosis.

11. Partial dentures with acrylic clasps (such as Valplast or others, also known as "Combo Partials") are considered under the coverage for Codes D5213 and D5214.

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

F. Replacement of an existing complete or partial denture:

1. Removable complete or partial dentures are not covered for replacement if an existing appliance can be made satisfactory by reline or repair.

2. Complete or partial dentures are not a covered if a clinical evaluation reveals the presence of a satisfactory appliance, even if a patient demands replacement due to their own perceived functional and/or cosmetic concerns.

G. Complete or partial denture adjustments (Codes D5410 – 5422):

1. An immediate complete or removable partial denture includes routine post-delivery care, adjustments and soft liners for six months.

2. A conventional complete or removable partial denture includes routine post-delivery care and adjustments for three months.

3. A prospective or retrospective request for a complete or partial denture adjustment must include documentation that the appliance is ill-fitting.

H. Repairs to complete and partial removable dentures (Codes D5510 – D5671) must include documentation that demonstrates the appliance is broken or in need of repair.

I. Rebases and relines for complete and partial removable dentures (Codes 5710 – D5761):

1. Supporting soft tissues and bone shrink over time, resulting in decreased retention and/or stability of the appliance.

2. A rebase or reline of a partial or complete denture would be covered (subject to plan limitations) if documentation demonstrates that the appliance is ill-fitting and may be corrected by rebasing or relining, resulting in a serviceable appliance.

J. Interim removable partial dentures (Codes D5820 and D5821)

1. These appliances are only intended to temporarily replace extracted teeth during the healing period, prior to fabrication of a subsequent, covered, fixed or removable partial denture. Benefits may not exist for both an interim and definitive partial denture.

2. The submitted documentation must show that the existing partial denture is unserviceable.

3. Removable partial dentures are covered when posterior teeth require replacement on both sides of the same arch or multiple edentulous areas are present (excluding non-functional second or third molars) and the remaining teeth have a good prognosis.

K. Tissue conditioning (Codes D5850 and D5851) may be required when documentation shows that the tissue under a removable appliance is unhealthy or must be treated prior to fabricating a new appliance or rebasing or relining an existing appliance.

L. A precision attachment (Code D5862) or the replacement of a part of a precision or semi-precision attachment requires documentation that it is medically necessary to stabilize a removable appliance.

M. An overdenture (Codes D5863 – D5866) may be required when documentation shows that additional retention and stability for a removable appliance is medically necessary.

N. Modification of a removable appliance (Code D5875) may be required when documentation shows that additional retention and stability for a removable appliance is medically necessary following implant surgery.

O. A maxillofacial prosthetics procedure (Code D5992) may be required when documentation shows medical necessity for functional and/or esthetic augmentation of the mouth or face.

P. A carrier may be required when documentation shows medical necessity for an appliance that carries and retains a substance necessary to treat a medical condition.

IMPLANTS

Please consult New York State Medicaid Program Dental Policy and Procedure Code Manual for covered services under the Medicaid and CHPlus programs or other plan materials to determine plan-by-plan variations. https://www.emedny.org/ProviderManuals/Dental/index.aspx

A. Pre-Surgical Services (Code D6190)

1. 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.

2. There should be adequate bone support and sufficient space for a replacement tooth.

3. 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 implants. This is not to assume that a removable partial denture would be the benefit in a case where there are multiple edentulous areas, but functional implants or bridge(s) is/are properly treating one or more of the pre-existing edentulous areas.

4. Bilateral implants in the same arch may be covered to support a full denture.

5. 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:

    a. Adverse systemic factors such as diabetes and history of recent smoking habit

    b. Poor oral hygiene and tissue management by the patient

c. Inadequate osseo-integration of the dental implant(s) (mobility)

d. Excessive para-function or occlusal loading

e. Poor positioning of the dental implant(s)

f. Excessive loss of bone around the implant prior to its restoration

g. Mobility of the implant(s) prior to placement of the prosthesis

h. Inadequate number of implants or poor bone quality for long span prostheses

i. Need to restore the appearance of gingival tissues in high esthetic areas

j. When the patient is under 16 years of age, unless unusual conditions prevail

6. Documentation must support the medical necessity of Pre-Surgical and Surgical Services.

B. For Surgical Services (Codes D6010 – D6104), documentation of medical necessity must be established prior to surgical treatment to place, remove or treat an implant.

C. Restoration

1. 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.

2. 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.

3. 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.

4. Jaw relationship and intra arch vertical distance should be considered in the initial treatment plan and selection of retentive and restorative appliances.

5. Documentation of medical necessity is required for an implant supporting structure.

D. Outcomes

1. The appearance of fixed prosthetic appliances for implants may vary considerably depending on the location, position and number of implants to be restored.

2. The appearance of the appliances must be appropriate to meet the functional and esthetic needs of the patient.

3. 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.

4. They must exhibit good design form to facilitate good oral hygiene, even in cases where the prosthesis may have a ridge lap form.

5. 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. Documentation of medical necessity is required for repair or maintenance of a dental implant.

6. Multiple unit fixed prostheses for implants must fit precisely and passively to avoid damage to the implants or their integration to the bone.

7. 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.

8. It is the responsibility of the restoring dentist to evaluate the initial acceptability of the implants prior to proceeding with a restoration.

9. 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.

10. Fixed partial prostheses, as well as a single unit crowns, are expected to have a minimum life expectancy or service life of 5-years.

11. Second stage implant surgery; placement of the healing collar after a sufficient period of osseo-integration is inclusive in the placement of the implant body (Code D6010).

12. Flap procedures (Codes D4240, D4241 or D4245) during placement of implant body (Code D6010) is inclusive.

FIXED PROSTHODONTICS

A. Efficacy of Fixed Bridges (Codes D6080 – D6077)

1. When a single posterior tooth is missing on one side of an arch and there are at least two endodontically and periodontally sound abutment teeth available, one on each side of the missing tooth, the general choices to replace the missing tooth would be a fixed bridge or an implant.

2. 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 the fixed bridge. This is not to assume that a removable partial denture would be the benefit in the case where there are multiple edentulous areas, but functional bridge(s) is/are properly treating one or more of the pre-existing edentulous areas.

3. It may be necessary to replace a fixed bridge that has defects in the bridge margins or has marginal decay. If a bridge is failing because of recurrent caries, an open margin or other structural defect and must be replaced, and there are other edentulous areas, the dental consultant may consider the replacement of both/all edentulous areas with a removable appliance.

4. This consideration may be altered in 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 a like bridge in the presence of other edentulous areas. Dental Consultants may deny the replacement bridge asking for additional information as to the treating dentist's plans for the other edentulous areas. However, upon resubmission with a valid narrative, replacement of the bridge may be considered.

5. 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 request for a benefit determination.

B. Contra-indications for a Fixed Bridge

1. Documentation does not establish that an existing fixed bridge is failing because of recurrent caries, open margin or other structural defect, and must be replaced.

2. There is a single missing tooth in the arch without an endodontically, periodontally and restoratively sound abutment (anchor) tooth on each side of the missing tooth.

3. Documentation does not show that there are two developmentally mature adjacent teeth to act as abutments for a fixed bridge.

4. The requested fixed bridge 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.

5. There is a single missing tooth in the arch without an endodontically sound abutment (anchor) tooth on each side of the missing tooth.

6. A fixed bridge is not a covered benefit in the presence of untreated moderate to severe periodontal disease, as evidenced in radiographs, or when a proposed abutment tooth or teeth have poor crown/root ratios.

7. A fixed bridge is not a covered benefit 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.

8. Double abutments to support a fixed bridge are generally considered to be unnecessary unless there is evidence or documentation of medical necessity.

9. The submitted documentation shows that there is more than one missing tooth in the arch and/or the replacement tooth (pontic) would not have an opposing tooth.

10. A cantilevered pontic is generally inappropriate for the replacement of a missing posterior tooth. However, a mesial cantilevered pontic may be acceptable for the replacement of a lateral incisor when an adjacent cuspid can be used for the abutment crown. A supporting narrative should be provided for any proposed cantilever bridge.

C. Other Fixed Prosthodontic Procedures (Codes D6080 – D6093)

1. The submitted documentation does not show that it is medically necessary to stabilize and anchor a removable overdenture prosthesis with a connector.

2. The submitted documentation does not show that it is medically necessary to re-cement or re-bond a fixed partial denture.

3. The submitted documentation does not show that it is medically necessary for a stress-breaker or precision attachment.

4. The submitted documentation does not show that it is medically necessary to repair a failure of restorative material.

5. The submitted documentation does not show that there are one or more missing teeth, that are medically necessary to replace.

D. Outcomes

1. Margins, contours and contacts and occlusion should be clinically acceptable.

2. Prognosis should be good for long term longevity; a fixed bridge should last a minimum of five years.

3. Guidelines for the Assessment of Clinical Quality and Professional Performance of the California Dental Association shall apply.

ORAL SURGERY

A. Extractions (Codes D7111 – D7251)

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

2. For extraction of a deciduous tooth (Codes D7111 and D7140) there must be evidence of medical necessity showing that the tooth has pathology and will not exfoliate soon or a patient complaint of acute pain.

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

   a. Extractions of erupted teeth

      i. An uncomplicated extraction (Code D7140) of an erupted or exposed root includes removal of all tooth structure, minor smoothing of socket bone and closure, as necessary. Extraction of an erupted tooth may be needed when the tooth has significant decay, is causing irreversible pain and/or infection, or is impeding the eruption of another tooth.

      ii. A surgical extraction of an erupted tooth (Code D7210) requires removal of bone and/or sectioning the tooth, including elevation of a mucoperiosteal flap if indicated.

   b. An impacted tooth is "An unerupted or partially erupted tooth that is positioned against another tooth, bone, or soft tissue so that complete eruption is unlikely." (CDT)

i. Extraction of a soft tissue impaction (Code D7220) is a tooth with the occlusal surface covered by soft tissue, and extraction requires elevation of a mucoperiosteal flap.

ii. Extraction of a partial bony impaction (Code D7230) is a tooth with part of the crown covered by bone and requires elevation of a mucoperiosteal flap and bone removal.

iii. Extraction of a completely bony impaction (Code D7240) is a tooth with most or all of the crown covered with bone and requires elevation of a mucoperiosteal flap and bone removal.

iv. Extraction of a complicated completely bony extraction (Code D7241) requires documentation of unusual surgical complications.

c. Removal of residual tooth roots (Code D7250) requires cutting of soft tissue and bone and includes closure.

d. Coronectomy (Code D7251) is an intentional partial removal of an impacted tooth when a neurovascular complication is likely if the entire impacted tooth is removed.

e. The prophylactic removal of an impacted or unerupted tooth or teeth that appear(s) to exhibit an unimpeded path of eruption and/or exhibit no active pathology is not covered. During our clinical review of requests for extraction of impacted and/or erupted teeth, LIBERTY may determine that treatment better fits the description of a different, more appropriate procedure code. In that situation, LIBERTY may approve the extraction under a different code.

i. The removal of asymptomatic, unerupted, third molars in the absence of active pathology may not be covered.

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

iii. Narratives describing the presence of pericoronitis on a fully erupted tooth are ambiguous. In such cases, the radiographic or photographic presentation will be the determining factor in the determination of coverage.

B. Other Surgical Procedures

1. Removal of residual tooth roots (Code D7250) may be needed when the residual tooth root is pathological or is interfering with another procedure.

2. Sinus perforation or oroantral fistula closure (Code D7260) requires documentation that there is a pathological opening into the sinus.

3. Tooth re-implantation and/or stabilization of an accidentally evulsed or displaced tooth (Code D7270) requires documentation that a tooth or teeth have been accidentally evulsed or displaced.

4. A tooth transplantation (Code D7272) requires documentation that it is medically necessary to remove a developing tooth and transplant it to an accessible place.

5. A biopsy of oral tissue (Codes D7285 and D7286) requires documentation that there is a suspicious lesion in the mouth that needs evaluation and the harvesting of oral tissue.

6. A surgical procedure to facilitate tooth movement (Codes D7292 – D7295) requires documentation that demonstrates the medical necessity of a surgical procedure to facilitate appropriate tooth positioning.

C. Alveoloplasty-Preparation of Ridge (Codes D7310 – D7321) requires documentation that demonstrates the medical necessity for the surgical recontouring of the alveolus.

D. Vestibuloplasty (Codes D7340 and D7350) (a surgical procedure to increase relative alveolar ridge height) requires documentation that demonstrates the medical necessity of enhancing the alveolar ridge to facilitate successful prosthetic restoration.

E. Excision of soft tissue or intra-osseous lesions (Codes D7410 – D7461) requires documentation of the presence of an intra-oral lesion and the medical necessity to remove it.

F. Excision of bone tissue (Codes D7471 – D7473) (an exostosis) requires documentation that a bony growth interferes with the ability to function or wear a prosthesis.

G. Reduction of an osseous tuberosity (Code D7485) requires documentation that shows a large tuberosity that interferes with the ability to wear a prosthesis.

H. Incision and drainage of an abscess (Codes D7510 - D7521) requires documentation that shows an oral infection that requires drainage.

I. Removal of a foreign body (Code D7530), non-vital bone or a tooth fragment requires documentation that it is medically necessary to remove it.

J. Open/closed reduction of a fracture (Codes D7610 – D7640) requires documentation that demonstrates evidence of a broken jaw.

K. Reduction of dislocation (Codes D7810 and D7820) and management of other temporomandibular joint dysfunctions require documentation showing a dislocation or other pathological condition of the temporomandibular joint.

L. Repair of traumatic wounds (Code D7910) and other repair procedures requires documentation showing that it is medically necessary to suture a traumatic wound and/or other repair procedures.

M. A bone replacement graft (Code D7950) requires documentation that demonstrates the need for ridge preservation for planned implants or prosthetic reconstruction.

N. A frenulectomy (Code D7960) requires documentation that demonstrates evidence that a muscle attachment is interfering with proper oral development or treatment.

O. Excision of hyperplastic tissue (Code D7970) or reduction of a fibrous tuberosity (Code D7972) requires documentation that demonstrates the medical necessity of removing redundant soft tissue to facilitate a removable prosthesis.

P. Excision of pericoronal gingiva (Code D7971) requires documentation that demonstrates the medical necessity of removing inflammatory or hypertrophied tissues surrounding partially erupted or impacted teeth.

ADJUNCTIVE SERVICES

A. Unclassified Treatment

1. Palliative Treatment (Code D9110)

    a. Typically reported on a "per visit" basis for emergency treatment of dental pain.

    b. The submitted documentation must show the presenting issue and/or the emergency treatment provided that was medically necessary for the procedure.

2. Fixed Partial Denture Sectioning (Code D9120)

    a. This procedure involves separation of one or more connections between abutments and/or pontics when some portion of a fixed prosthesis is to remain intact and serviceable following sectioning and extraction or other treatment and includes all recontouring and polishing of retained portions.

    b. The submitted documentation must show that it is medically necessary to section and remove part of a fixed partial denture and that the remaining tooth or teeth have a good prognosis.

B. Anesthesia

1. Local or regional block anesthesia in or not in conjunction with operative or surgical procedures (Code D9210):

   a. Local or regional block anesthesia is considered to be part of and included in conjunction with operative or surgical procedures.

   b. Submitted documentation must show that it is necessary to anesthetize part of the mouth when it is not in conjunction with operative or surgical procedures.

2. Deep Sedation/General Anesthesia or Intravenous moderate sedation/analgesia (Codes D9223 and D9243)

   a. Anesthesia time begins when the doctor administering the anesthetic agent initiates the appropriate anesthesia and non-invasive monitoring protocol and remains in continuous attendance of the patient. Anesthesia services are considered completed when the patient may be safely left under observation of trained personnel and the doctor may leave the room to attend to other patients or duties.

   b. The level of anesthesia is determined by the anesthesia provider's documentation of the anesthetics effect upon the central nervous system and not dependent on the route of administration. It is expected that dentists performing anesthesia on patients be properly licensed by their state's regulatory body and comply with all monitoring requirements dictated by the licensing body.

   c. LIBERTY provides benefits for covered General Anesthesia ("GA") or Intravenous ("IV") Sedation in a Dental Office Setting ONLY when medical necessity is demonstrated by the following requirements, conditions and guidelines:

      i. A medical condition that requires monitoring (e.g., cardiac, severe hypertension);

      ii. An underlying medical condition exists which would render the patient non-compliant without the GA or IV Sedation (e.g., cerebral palsy, epilepsy, developmental/intellectual disability, Down's syndrome);

      iii. Documentation of failed conscious sedation (if available);

      iv. A condition where severe infection would render local anesthesia ineffective.

3. Requirements for Documentation:

a. The medical necessity for treatment with GA or IV Sedation in a dental office setting must be clearly documented in the patient's dental record and submitted by the treating dentist;

b. Pre-authorization and submission requirements:

i. Prior to providing GA or IV Sedation in a dental office setting, all necessary medical and dental documentation, including the dental treatment plan, must be reviewed and approved by LIBERTY.

ii. Submit the patient's dental record, health history, charting of the teeth and existing oral conditions, diagnostic radiographs (except where not available due to conditions listed above) and intra-oral photographs.

iii. Submit a written narrative documenting the medical necessity for general anesthesia or IV Sedation;

iv. Treatment rendered as an emergency, when pre-authorization was not possible, requires submission of a complete dental treatment plan and a written narrative documenting the medical necessity for the GA or IV Sedation.

c. The dental office has established, implemented and provided LIBERTY with approved sedation and general anesthesia policies and procedures that comply with the American Dental Association Guidelines for the Use of Sedation and General Anesthesia by Dentists.

4. The following oral surgical procedures may qualify for GA or IV Sedation:

a. Removal of impacted teeth;

b. Surgical root recovery from maxillary antrum (sinus);

c. Surgical exposure of impacted or unerupted cuspids (for orthodontic cases, the orthodontic treatment must have been approved in advance);

d. Radical excision of lesions in excess of 1.25 cm.

e. Children under the age determined by applicable state regulations with an extensive treatment plan may qualify for a GA or IV Sedation benefit.

5. Use of Nitrous Oxide (Code D9230) requires documentation of medical necessity to alleviate discomfort or anxiety associated with dental treatment (once per visit).

6. Non-intravenous Conscious Sedation (Code D9248) (Includes non-IV minimal and moderate sedation)

    a. This is a medically controlled state of depressed consciousness while maintaining the patient's airway, protective reflexes and the ability to respond to stimulation or verbal commands. It includes non-intravenous administration of sedative and/or analgesic agent(s) and appropriate monitoring.

        i. The submitted documentation must demonstrate the medical necessity of non-IV conscious sedation.

        ii. The level of anesthesia is determined by the anesthesia provider's documentation of the anesthetics effect upon the central nervous system and not dependent on the route of administration.

C. Professional Consultation (Code D9310)

2. This is a patient encounter with a practitioner whose opinion or advice regarding evaluation and/or management of a specific problem; it may be requested by another practitioner or appropriate source and it includes an oral evaluation.

3. The consulted practitioner may initiate diagnostic and/or therapeutic services.

4. The submitted documentation must demonstrate the medical necessity of assistance in determining the treatment required for a specific condition.

D. Professional Visits (Codes D9410 – D9450)

1. Hospital, house, extended care or ambulatory surgical center call

    a. Includes nursing homes, long term care facilities, hospice sites, institutions, hospitals or ambulatory surgical centers.

    b. Services delivered to the patient on the date of service are documented separately using the applicable procedure codes.

    c. The submitted documentation must demonstrate the medical necessity of treatment outside of the dental office.

2. Office visit for observation or case presentation during or after regularly scheduled hours

a. This is for an established patient and is not performed on the same day as evaluation.

b. The submitted documentation must demonstrate the medical necessity of an office visit or case presentation during or after regularly scheduled office hours.

E. Drugs (Codes D9610 – D9630)

1. Administration of one or more parenteral drugs or dispensing of drugs or medicaments for home use require submitted documentation demonstrating the medical necessity of the drugs or medicaments for treating a specific condition.

F. Miscellaneous Services

1. Application of a desensitizing medicament or resin (Codes D9910, D9911)

a. This is reported on a per visit treatment for application of topical fluoride or a per tooth basis for adhesive resins.

b. This is not to be used for bases, liners or adhesives under restorations.

c. This requires documentation demonstrating the medical necessity of a desensitizing medicament or resin.

2. Behavior Management (Code D9920)

a. This should be reported in addition to treatment provided and should be reported in 15-minute increments.

b. Documentation submitted must demonstrate the medical necessity of managing the patient's behavior, emotional and/or developmental status to allow the dentist to provide treatment.

3. Treatment of post-surgical complications or unusual circumstances (by report) (Code D9930) must provide documentation demonstrating the medical necessity of the procedure.

4. Cleaning and inspecting removable prostheses (Codes D9932 – D9935) does not include adjustments and must be supported by documentation demonstrating the medical necessity of the procedure.

5. Occlusal Guard (Code D9940)

a. This is a removable dental appliance designed to minimize the effects of bruxism and other occlusal factors.

b. This must be supported by documentation demonstrating the medical necessity fabricating, adjusting or repairing/relining an occlusal guard to minimize the effects of bruxism or TMJ symptoms/pathology.

6. Fabrication of an athletic mouthguard (Code D9941) requires documentation demonstrating medical necessity of the appliance.

7. Occlusal analysis or adjustment (Codes D9950 – D9952) requires documentation demonstrating the medical necessity of the process to reshape occlusal surfaces.

8. Enamel microabrasion or odontoplasty (Codes D9970 – D9971) requires documentation demonstrating the medical necessity of the process for other than exclusively cosmetic concerns.

9. Internal or external bleaching per tooth (Codes D9973 and D9974) or external bleaching per arch (Codes D9972 and D9975) requires documentation demonstrating the medical necessity of the process for other than exclusively cosmetic concerns.

RETROSPECTIVE REVIEW

Prospective and retrospective review will require documentation that demonstrates medical necessity. This documentation can include diagnostic radiographic or photographic images, the results of tests or examinations, descriptions of conditions in progress notes and/or a written narrative providing additional information. In cases where objective information (such as diagnostic images) conflicts with subjective information (such as written descriptions), objective information will be given preference in making a determination.

Retrospective review of services that had been previously pre-authorized will require documentation confirming that the procedure(s) was (were) completed as authorized and within the standard of care as defined by LIBERTY Dental Plan's Criteria Guidelines and Practice Parameters.

Please consult New York State Medicaid Program Dental Policy and Procedure Code Manual for covered services under the Medicaid and CHPlus programs or other plan materials to determine plan-by-plan variations. https://www.emedny.org/ProviderManuals/Dental/index.aspx

SECTION 11. QUALITY MANAGEMENT

LIBERTY Dental Plan's Quality Management Program is compliant with all New York state, and Federal laws and regulations, and applicable contract requirements.

QUALITY MANAGMENT AND IMPROVEMENT PROGRAM DESCRIPTION

LIBERTY Dental Plan's Quality Management and Improvement (QMI) Program approaches all clinical and non-clinical aspects of quality with a comprehensive array of well-defined, and tested quality assessment functions and activities. The Program is designed to provide a structured and comprehensive review of the quality and appropriateness of care delivered by the entire network of dental providers with the ultimate goal of maintaining and improving the dental health of our diverse members.

LIBERTY's Dental Director, has been given the authority and responsibility by the Board of Directors for the management and oversight of the QMI Program, policies and procedures and related activities that ensure the day-to-day quality assurance functions are carried out in compliance with state, federal requirements and dental program contracts.

The QMI Program policies and procedures assure the delivery of medically necessary services, and quality patient care through the consistent provision and management of dental care services. Our approach to total quality management is one that is coordinated, comprehensive, fair, consistent, culturally competent care and nondiscriminatory.

LIBERTY carries out ongoing quality improvement responsibilities and activities as described in our formal Annual QMI Work Plan, overseen by our Dental Director. The Work Plan is designed to provide a comprehensive review of the entire scope of member dental care evaluating performance using objective quality indicators. Data driven decision making allows LIBERTY to support programmatic improvements of clinical and non-clinical processes based on findings from ongoing measurements. Planned initiatives and ongoing activities described in our Work Plan strive toward our goals to identify

and fulfill the dental health care needs of members, improve member accessibility to services, improve member satisfaction with their participating dentists and improve member and provider satisfaction with LIBERTY's administrative services.

LIBERTY QMI Program, Work Plan, policies and procedures, all incorporate best practice standards as defined by the National Committee for Quality Assurance modified for dental services. The QMI Program has established Committees, chaired by our Dental Director, or his/her designee that address the accessibility, appropriateness, continuity, effectiveness, efficacy and timeliness of patient care, and issues related to patient dissatisfaction and safety of the environment dental care is being provided.

Contact LIBERTY Quality Management Department at QM@libertydentalplan.com with any questions or to request a full copy of the Quality Management and Improvement Program.

SECTION 12. FRAUD WASTE AND ABUSE

LIBERTY Dental Plan's Fraud, Waste and Abuse Program is compliant with all New York state, and Federal laws and regulations, and applicable contract requirements.

FRAUD, WASTE, AND ABUSE PROGRAM DESCRIPTION

LIBERTY Dental Plan is committed to conducting its business in an honest and ethical manner and to operate in strict compliance with all regulatory requirements that relate to and regulate our business and dealings with our employees, members, providers, business associates, suppliers, competitors and government agencies. LIBERTY takes provider fraud, waste and abuse seriously. We engage in considerable efforts and dedicate substantial resources to prevent these activities and to identify those committing violations. LIBERTY has made a commitment to actively pursue all suspected cases of fraud, waste and abuse and will work with law enforcement for full prosecution under the law.

LIBERTY promotes provider practices that are compliant with all federal and state laws on fraud, waste, abuse and overpayment. Our expectation is that providers will submit accurate claims, not abuse processes or allowable benefits, and exercise their best independent judgment when deciding which services to order for their patients.

Our policies in this area reflect that both LIBERTY and providers are subject to federal and state laws designed to prevent fraud and abuse in government programs, federally funded contracts and private insurance. LIBERTY complies with all applicable laws, including Federal False Claims Act, state false claims laws and makes a person liable to pay damages to the Government if he or she knowingly:

- Conspires to violate the FCA
- Carries out other acts to obtain property from the Government by misrepresentation

- Knowingly conceals or knowingly and improperly avoids or decreases an obligation to pay the Government
- Makes or uses a false record or statement supporting a false claim
- Presents a false claim for payment or approval.

As a provider, you are responsible to:

- Comply with all federal and state laws and LIBERTY requirements regarding fraud waste and abuse and overpayment;
- Ensure that the claims that you (or your staff or agent) submit and the services you provide do not amount to fraud, waste or abuse, and do not violate any federal or state law relating to fraud, waste or abuse.
- Ensure that you provide and bill only for services to members that are medically necessary for services that were rendered, and consistent with all applicable requirements, regulations, policies and procedures.
- Ensure that all claims submissions are accurate;
- Notify LIBERTY immediately of any suspension, revocation, condition, limitation, qualification or other restriction on your license, or upon initiation of any investigation or action that could reasonably lead to a restriction on your license, or the loss of any certification or permit by any federal authority, or by any state in which you are authorized to provide healthcare services;

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

"Fraud" includes, but is not limited to, "knowingly making or causing to be made any false or fraudulent claim for payment of a health care benefit." Fraud also includes fraud or misrepresentation by a subscriber or enrollee with respect to coverage of individuals and fraud or deception in the use of the services or facilities of LIBERTY or knowingly permitting such fraud or deception by another.

"Waste" means the thoughtless or careless expenditure, consumption, mismanagement, use, or squandering of resources. Waste also includes incurring unnecessary costs because of inefficient or ineffective practices, systems, or controls. Waste does not normally lead to an allegation of "fraud", but it could.

"Abuse" means the excessive, or improper use of something, or the use of something in a manner contrary to the natural or legal rules for its use; the intentional destruction, diversion, manipulation, misapplication, maltreatment, or misuse of resources; or extravagant or excessive use so to abuse one's position or authority. "Abuse" does not necessarily lead to an allegation of "fraud" but it could.

"Overpayment" means any funds that a person receives or retains under Medicaid and Medicare and other government funded healthcare programs to which the person, after applicable reconciliation, is not entitled under such healthcare program. Overpayment includes any amount that is not authorized to be paid by the healthcare program whether paid as a result of inaccurate or improper cost reporting, improper claiming practices, fraud, abuse or mistake.

REPORTING SUSPECTED FRAUD, WASTE, AND ABUSE OR OVERPAYMENT

LIBERTY expects providers and their staff and agents to report any suspected cases of fraud, waste, abuse or overpayments. LIBERTY will not retaliate against you if you inform us, the federal government, state government or any other regulatory agency with oversight authority of any suspected cases of fraud, waste or abuse.

To ensure ongoing compliance with federal law, if you determine that you have received an overpayment from LIBERTY, you are contractually obligated to report the overpayment and to return the overpayment to LIBERTY within thirty (30) calendar days after the date on which the overpayment was identified. You must also notify LIBERTY in writing of the reason for and claims associated with the overpayment.

All suspected cases of fraud, waste or abuse related to LIBERTY, including Medicare and Medicaid, should be reported to LIBERTY's Special Investigation Unit. The caller will have the option of remaining anonymous. **Reports may be made to LIBERTY via one of the following methods:**

- **Corporate Compliance Hotline**: (888) 704-9833
- **Compliance Unit email**: compliance@libertydentalplan.com
- **Special Investigations Unit Hotline**: (888) 704-9833
- **Special Investigations Unit email**: SIU@libertydentalplan.com

Reports to the Corporate Compliance Hotline may be made 24 hours a day/seven days a week. Callers may choose to remain anonymous. All calls will be investigated and remain confidential.

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

NON-RETALIATION POLICY

LIBERTY will not retaliate against you or any of our employees, agents and contractors for reporting suspected cases of fraud, waste, overpayments or abuse to us, the federal government, state government, or any other regulatory agency with oversight authority. Federal and state law also prohibits LIBERTY from discriminating against an employee in the terms or conditions of his or her employment because the employee initiated or otherwise assisted in a false claims action. LIBERTY also is prohibited from discriminating against agents and contractors because the agent or contractor initiated or otherwise assisted in a false claims action.

FRAUD, WASTE, AND ABUSE TRAINING AND EDUCATION

LIBERTY encourages providers in our Medicare and Medicaid provider network to actively pursue information on their role in treating Medicare and Medicaid enrollees. CMS, Medicaid and Medicare information can be accessed directly at www.cms.gov.

As a provider in our Medicaid and/or Medicare network, and in order to treat Medicare and/or Medicaid enrollees, you agree to:

- Comply with any CMS, LIBERTY or Medicaid/Medicare Advantage health plan training requirements including, but not limited to, annual completion of Medicaid/Medicare Fraud, Waste and Abuse training, review and distribution of LIBERTY's Code of Conduct;
- It is the owning providers responsibility to ensure that all staff and providers complete Medicaid/Medicare Fraud, Waste and Abuse training, and review LIBERTY's Code of Conduct within ninety (90) days of hire;

LIBERTY provides, free of charge, Fraud, Waste and Abuse Prevention Training for all contracted providers and any other downstream entity that you contract with to provide health, and/or administrative services on behalf of LIBERTY.

This training is available on-line at https://www.libertydentalplan.com/Providers/Provider-Training-1.aspx. Upon completion, you will be able to print out a certificate/attestation.

Organizations must retain a copy of all documentation related to this training for a period of no less than 10 years – including methods of training, dates, materials, sign-in sheets, etc.

SECTION 13. FORMS

The following forms are available to download from LIBERTY Dental Plan's Resource Library by visiting https://www.libertydentalplan.com/Providers/Provider-Resource-Library.aspx

- ADA Attestation Form
- ADA Claim Form
- ADA Caries Risk Assessment Form (Age 0-6)
- ADA Caries Risk Assessment Form (Age > 6)
- AAP Oral Health Risk Assessment Tool
- Clinical Guidelines for Prescribing Fluoride Supplements for Caries Prevention
- Compliance Attestation Form
- Electronic Fund Transfer (EFT) Form
- Informed Consent Form for Alternative Treatment Form – ENG, CHI, SPA
- New York Interceptive Request Form
- New York Specialty Care Referral Form
- NYS Orthodontic HLD Form
  https://www.emedny.org/ProviderManuals/Dental/PDFS/HLD_Index_NY.pdf
- Online Provider Portal User Guide

LIBERTY Dental Plan's Provider Training modules are available online by visiting https://www.libertydentalplan.com/Providers/Provider-Training-1.aspx

- Critical Incident Training
- Code of Business Ethics and Conduct
- Cultural Competency Provider Training
- Fraud, Waste and Abuse Training
- General Compliance Training