PROVIDER REFERENCE GUIDE

CALIFORNIA

health net™

LIBERTY DENTAL PLAN®

Making members shine, one smile at a time™

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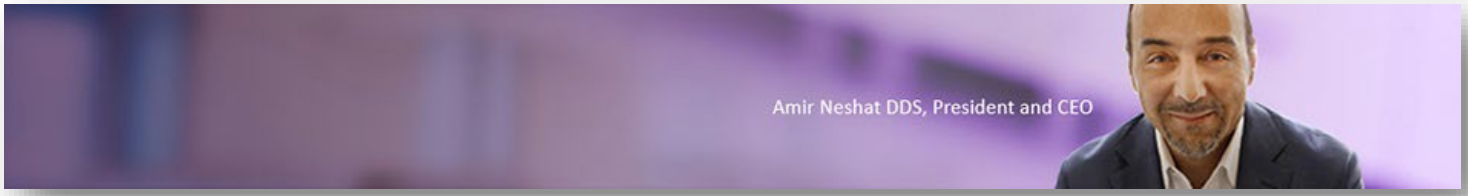
SECTION 1. LIBERTY DENTAL PLAN INFORMATION



INTRODUCTION

Welcome to LIBERTY Dental Plan's (LIBERTY's) 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. 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 and that additional terms and conditions of the Provider Agreement apply. In the event of a conflict between a term of this Provider Reference Guide and a term of the Provider Agreement, the term of the Provider Agreement shall control. You will receive a copy of the fully executed Provider Agreement at time of your activation on LIBERTY's network; however, you may also obtain a copy of the Provider Agreement at any time by submitting a request to prinquiries@libertydentalplan.com or by contacting Professional Relations at 800-268-9012.

LIBERTY will not refuse to contract with, or pay, an otherwise eligible dental office for the provision of covered services solely because such dental office has in good faith communicated with, or advocated on behalf of, one or more of his or her prospective, current, or former patients regarding the provisions, terms, or requirements of the member's LIBERTY benefit plan.

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

CALIFORNIA PROVIDER CONTACT AND INFORMATION GUIDE

LIBERTY Dental Plan (LIBERTY) provides 24/7 real-time access to important information and tools through our secure online Provider Portal (i-Transact) at www.libertydentalplan.com.

Please visit www.libertydentalplan.com to create your i-Transact account. To register as a new user and/or login, use the "Access Code" found in your LIBERTY Welcome Letter. If you cannot find your "Access Code", or need help with the log-in process, please call use for assistance.

<table>
<tr><th>IMPORTANT PHONE NUMBERS</th><th>GENERAL INFORMATION</th></tr>
<tr><td>CALL: 800-268-9012
Eligibility & Benefits: Option 1
Claims: Option 2
Pre-estimates: Option 3
Referrals: Option 4
Request Materials: Option 5
General Info.: Options 6</td><td>HOURS: Monday-Friday 8:00 a.m.- 5:00 p.m. (PST)
ONLINE: www.libertydentalplan.com
MAILING ADDRESS:
LIBERTY Dental Plan
PO Box 26110
Santa Ana, CA 92799-6110</td></tr>
<tr><th>PROVIDER PORTAL (I-Transact)</th><th>ELIBILITY & BENEFITS</th></tr>
<tr><td>Go to www.libertydentalplan.com to create an account.
i-transact allows you:
Electronic Claims Submission
Claim Status & Inquiries
Real-time Eligibility Verification
Member Benefits
Referral Submission & Status</td><td>Use i-transact to for real time status at www.libertydentalplan.com
Phone: 800-268-9012 Option 1
PROFESSIONAL RELATIONS
Email: prinquiries@libertydentalplan.com
Phone: 800-268-9012
Fax: 800-268-0154</td></tr>
<tr><th>REFERRAL SUBMISSIONS & INQUIRIES</th><th>CLAIM SUBMISSIONS AND INQUIRIES</th></tr>
<tr><td>Use i-transact for submissions & to check status at www.libertydentalplan.com

EMERGENCY REFERRALS: 800-268-9012 Option 4

Standard referrals by mail use mailing address ATTENTION: REFERRALS DEPARTMENT</td><td>Use i-transact for submissions & to check status at www.libertydentalplan.com

EDI PAYOR ID#: CX083

Phone: 800-268-9012 Option 2
Paper claims by mail use mailing address
ATTENTION: CLAIMS DEPARTMENT</td></tr>
</table>

PROVIDER DISPUTE RESOLUTION (PDR)	MEMBER GRIEVANCES & APPEALS (G&A)
Use i-transact for PDR submissions at www.libertydentalplan.com PDR Forms available online through Provider Resource Library at www.libertydentalplan.com Mail PDR forms to mailing address **Attention: Grievances & Appeals Department**	**LIBERTY Dental Plan** Member G&A form and online submission are available at www.libertydentalplan.com **Fax:** 833-250-1814 **Phone**: 800-268-9012 Option 6 Mail member G&A forms to the mailing address **Attention: Grievances & Appeals Department** **Health Net Dental** Members G&A form and online submission are available at www.hndental.com. **Phone**: 800-977-7307/TTY: 711 **Fax:** 877-831-6019 **Mailing address:** Health Net Dental Appeals & Grievances PO Box 10348 Van Nuys, CA 91409

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

LIBERTY maintains two separate and distinct files for each provider. The first is the provider's quality improvement file, which is maintained with restricted access by the Quality Management Department. This file includes confidential credentialing information. The second file is the provider's facility file that is maintained by the Professional Relations Department, which also includes audit results. The latter contains copies of signed agreements, addenda, and related business correspondence.

SECTION 2. PROFESSIONAL RELATIONS AND PROVIDER TRAINING

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

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

To ensure that your information is displayed accurately, please submit all changes within 30 calendar days to Prinquiries@libertydentalplan.com or in writing. Professional Relations will address your inquiry within 3 business days of receipt. Please mail all updated information to the following:

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

Our Professional Relations team is available to assist you Monday – Friday, from 8:00 a.m. – 5:00 p.m. by calling 800-268-9012, press option 4. You can also contact us by email at PRinquiries@libertydentalplan.com.

PROVIDER TRAINING

LIBERTY provides initial orientation and training to all new providers and offices. All California Medicaid providers will receive initial orientation prior to or within 10 calendar days of activation, for more information on the Medicaid programs, please reference **Section 5 California Medicaid**. Providers contracting with all other lines of business will receive initial orientation within 30 calendar days of activation. Additional training is provided for new staff, when changes in the program occur, or when there is a change in provider utilization and/or other activity. Further, LIBERTY provides training through webinars, as well as telephonic and in-person meetings.

Providers and supporting dental office staff are required to complete annual compliance training modules. All trainings regarding the requirements, including any contract amendments and special needs of members are available to providers and their staff. Providers are also trained on identifying adverse incidents and requirements to report adverse incidents to LIBERTY within 48 hours of the incident.

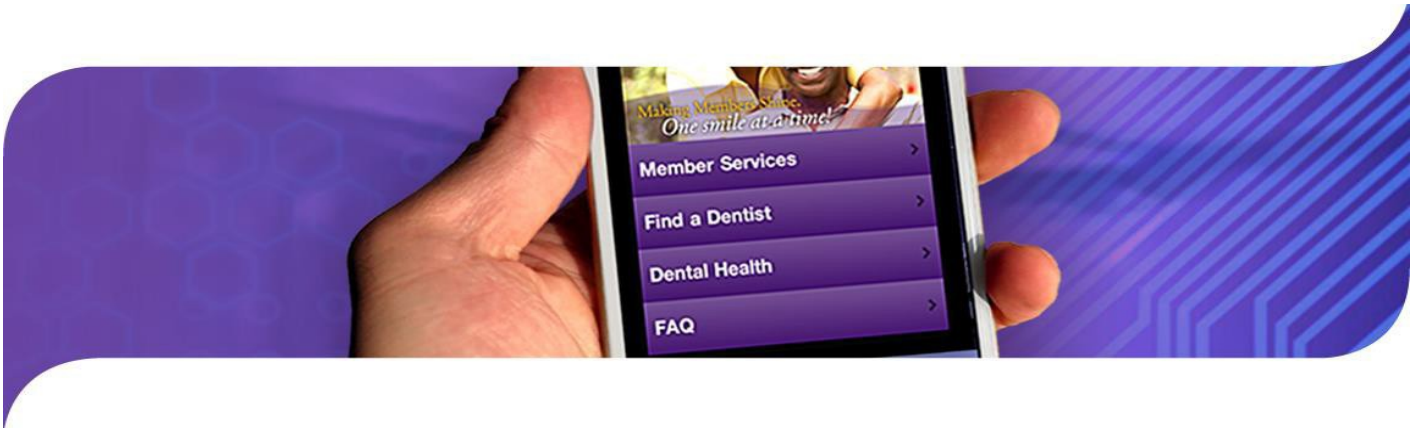
LIBERTY provides the following free training modules. It is mandatory for all your office staff, dentists, and associates to complete and attest to have completed the compliance training. Training modules are available online through our Provider Portal at www.libertydentalplan.com/Providers/Provider-Training-1.aspx

Mandatory annual compliance training modules include, but are not limited to:

- Affordable Care Action Section 1557
- Code of Conduct
- Compliance Plan
- Critical Incident
- Cultural and Linguistic Competency
- Cultural Competency Training
- Fraud, Waste, and Abuse (CMS)
- Fraud, Waste, and Abuse (LIBERTY)
- General Compliance (CMS)
- HIPAA (Privacy and Security)

Providers must maintain supporting documentation of all completed training for a period of 10 years for all office personnel supporting LIBERTY's government business and can furnish the documentation upon request.

SECTION 3. ONLINE SELF-SERVICE TOOLS



LIBERTY is dedicated to meeting the needs of our providers by utilizing leading technology to increase your offices 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 and prior authorizations
- Verify member eligibility and benefits
- View office and contract information
- Submit referrals and check status
- Access benefit plans
- Print monthly eligibility rosters
- Perform a provider search

ON-LINE ACCOUNT ACCESS

To register and obtain immediate access to your office's online account through the Provider Portal (i-transact), visit: https://www.libertydentalplan.com/Providers/Provider-Self-Service-Tools/ITransact.aspx

All contracted network dental offices are issued a unique **Office Number** and **Access Code**. These numbers canbe found on your LIBERTY Welcome Letter and are required to register your office on LIBERTY's OnlineProvider Portal.

The 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 Member Services Department at **800-268-9012** for assistance. For technical assistance, email portalsupport@libertydentalplan.com.

For more detailed instructions on how to utilize the Provider Portal, please reference the Online Provider Portal User Guide by visiting https://www.libertydentalplan.com/Providers/Provider-Self-Service-Tools/ITransact.aspx.

DIRECTORY INFORMATION VERIFICATION (DIV) ONLINE

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

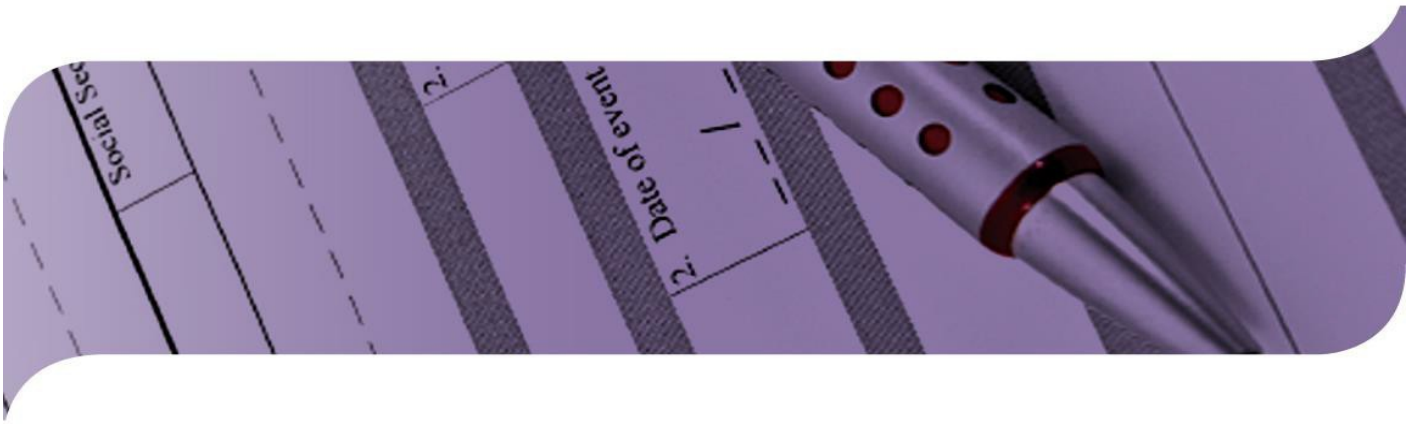
There is an easier way to update your information through our Provider Directory Information Verification (DIV)website at: www.libertydentalplan.com/ProviderDIV.

Anytime you have changes, including, but not limited to appointment times, office hours, address, phone number, fax number, associate dentist, etc., your office must notify LIBERTY and update your information through the Provider DIV website. This will reduce calls your office and ensure accurate office information.

You'll also be able to confirm and **attest** that no changes were made no less than **every 90 days** by going online. We also **highly recommend that** you set a calendar reminder in your system to go to the website every 85 days and validate the information.

You will need to have your office **Access Code** to use the online feature. This number can be found in your LIBERTY Welcome Letter. If you are unable to locate your **Access Code**, please contact us for assistance at **800-268-9012 (TTY 877-855-8039).**

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 5 p.m. PST, Monday through Friday by contacting our Provider Service Line at **800-268-9012**, Option 1 **(TTY 877-855-8039).**
- **Monthly Eligibility Rosters**

  California Medi-Cal Dental and Capitation Plans, will receive an updated eligibility roster (eligibility list), at the beginning of each month. The eligibility list will include a record of LIBERTY members who have selected your office for their dental care. This eligibility 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

The eligibility list will be alphabetical order with dependents listed individually. Dependents include spouses and eligible children. In most cases, eligible children are those who are unmarried, and dependent upon the member, including natural, adopted, step, 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 or dependent does not appear on the monthly eligibility list, please contact LIBERTY's Member Services Department at 800-268-9012. Upon verification of eligibility, LIBERTY will fax confirmation of eligibility to your office.

Member Identification Cards

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

SECTION 5. CALIFORNIA MEDI-CAL DENTAL PROGRAM

LIBERTY is a dental benefits administrator for the Sacramento Geographic Managed Care (GMC) and Los Angeles Pre-Paid Health Plan (PHP) Medi-Cal Dental Programs. LIBERTY is also the dental benefits administrator for the Health Net Dental GMC and PHP Medi-Cal Dental plans. Your office can obtain immediate access to the Department of Health Care Services (DHCS) Quick Reference Guide for more information on the Medi-Cal Dental Program:
https://www.dental.dhcs.ca.gov/MCD_documents/providers/quick_reference_for_denti-cal_dentists.pdf

PROVIDER TRAINING

LIBERTY California Medi-Cal dental providers will receive initial orientation and training to all new offices, dentists, and associates prior to or within 10 days of activation. Please reference **Section 2. Professional Relations and Provider Training** for more details and additional training that is available through LIBERTY.

MONTHLY ELIGIBILITY ROSTERS

Your office will receive an updated eligibility roster (eligibility list), at the beginning of each month. The eligibility list will include a record of LIBERTY members who have selected and are assigned to your office for their general dental care. Please reference **Section 3. Online Self-Service Tools** for more information.

MEDICAID DENTAL BENEFITS

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

An adequate informed consent for must state that the services are not covered, include the procedure code and description, the cost of the services, and the member's signature, indicating they understand that the services are not covered and agree to be financial responsible for the costs.

Your office may use your own informed consent forms, that meet the criteria above, or you can use the LIBERTY form that is available on our website: https://www.libertydentalplan.com/Resources/Documents/ma_Consent_Non-Covered_Treatment_ENG.pdf

MEDI-CAL DENTAL MANUAL OF CRITERIA AND SCHEDULE OF MAXIMUM ALLOWANCES

The state of California has specific clinical criteria and policies associated with the plan benefits allowed through the Medi-Cal Dental Program. LIBERTY, our contracted providers, and dental office staff must adhere to the Medi-Cal Dental Manual of Criteria (MOC) when applying dental plan benefit for Medi-Cal dental members. The clinical criteria and policies outlined in the MOC will be applied to all Medi-Cal Dental benefits, followed by LIBERTY's Clinical Criteria and Guidelines, if applicable.

Your office can obtain immediate access to the MOC through the DHCS Quick Reference Guide. Please reference **Section 5. Manual of Criteria and Schedule of Maximum Allowance** https://www.dental.dhcs.ca.gov/MCD_documents/providers/quick_reference_for_dentical_dentists.pdf.

Please reference **Section 10. Clinical Dentistry Guidelines** for more information on how to access LIBERTY's Clinical Criteria and Guidelines.

Please review the following example of specific clinical criteria and policies outlined in the MOC:

Orthodontics

1. A benefit only for medically necessary handicapping malocclusion, cleft palate, and facial growth management cases, for patients age 13 to under age 21 with primary dentition.

2. Cleft palate and craniofacial anomaly cases are a benefit for primary, mixed, and permanent dentitions. Craniofacial anomalies are treated using facial growth management.
3. All necessary procedures that may affect orthodontic treatment must be completed before orthodontic treatment will be considered.
4. Orthodontic benefits are a benefit only when the diagnostic cases verify a minimum score of 26 points on the Medicaid Orthodontic Initial Assessment Form (scorecard). The Orthodontist must complete an evaluation by using the Medicaid Orthodontic scorecard. The scorecard form must be submitted along with records and a pre-estimate for prior approval. Medicaid Ortho Initial Assessment Form (IAF).pdf (libertydentalplan.com)

Please reference the Orthodontic General Policies (D8000-D8999) in Section 5. Manual of Criteria and Schedule of Maximum Allowance for more information on the orthodontic treatment criteria

CALIFORNIA ADVANCE AND INNOVATING MEDI-CAL (CALAIM) ORAL HEALTH INITIATIVES

There are three oral health initiatives for Medi-Cal providers.

1. Pay-for-Performance (P4P): To improve oral health through increasing the utilization of preventive dental care services. Under this initiative Medi-Cal providers will continue to quality for bonuses as a P4P initiative and be able to offer additional covered services. Under this initiative Medi-Cal providers will continue to quality for bonuses as a P4P initiative and be able to offer additional covered services to your patients. Select eligible preventive procedure codes for P4P payments at an enhanced rate can be found on the DHCS bulletin. DHCS Bulletin – Volume 37, Number 24: Special Provider Bulletin November 2021 (ca.gov)
2. Additional Benefits: Initiative adds two statewide oral health benefits.
   The Caries Risk Assessment (CRA) bundle (D0601/D0602/D0603/D1310) and Silver Diamine Fluoride (SDF) (D1354) are two new benefits added to promote a risk-based utilization of preventive services.
   - **Treating Young Kids Everyday (TYKE) training:**
     - All rending dental providers must complete the training to be eligible for reimbursement for the CRA Bundle. To complete training register via the link: https://www.cda.org/Home/Education/Learning/TYKE-Program
     - Upon completion of the training please submit the certificate to the email address: professionalservices@libertydentalplan.com

- All rending dental providers who have previously taken the TYKE training need to submit certificates issued to the following email address: professionalservices@libertydentalplan.com

3. CalAIM initiative is to establish a dental home for all members by scheduling and providing follow up on recall exams to increase patient's return to your office year after year for continuity of care and improved dental outcomes.

COORDINATION OF BENEFITS

In cases where a member may have dual coverage with a group plan or a Medicare plan (Duals), Medicaid is always the payer of last resort. Please see **Section 7. Coordination of Benefits** for more information.

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

As required by federal law, LIBERTY provides comprehensive, diagnostic, and preventive dental services to eligible recipients under the age of 21 years, if such services are medically necessary to correct or ameliorate a defect, condition, or a physical or mental illness that exceeds the state's Medicaid benefit. This includes emergency, preventive, diagnostic, and therapeutic services for dental disease that, if left untreated, may become acute dental problems, or cause irreversible damage to the teeth or supporting structures.

Members have the right to EPSDT benefits that ensure children and adolescents receive appropriate preventive dental and specialty dental care. For more information, please refer to your applicable state Medicaid Periodicity Schedule.

PRE-ESTIMATE OF EPSDT Dental Services

For all EPSDT service(s), a pre-estimate is required for any dental service that is not listed on the state Medicaid benefit schedule, and any service(s) that are listed on the Medicaid benefit schedule that is subject to frequency limitations, or periodicity schedule guidelines. Any EPSDT service(s) that were not submitted for a pre-estimate described above will be denied and the members cannot be held financially responsible for the denied services. For all pre-estimate requests, medical necessity will be determined based on radiographic and/or other documented rationale.

You can learn more about EPSDT benefits through the Medi-Cal Provider Manual here: https://files.medi-cal.ca.gov/pubsdoco/publications/masters-mtp/part2/epsdt.pdf

CASE/CARE MANAGEMENT

LIBERTY provides Case/Care Management for Medi-Cal dental members, including those under Health Net Dental. LIBERTY's Case Management team will coordinate dental services when a Medi-Cal dental member, child, or adult, is identified with a complex dental condition and/or special health care needs.

LIBERTY's Case/Care Program offers Medi-Cal dental children and adults a Case/Care Manager and other outreach workers that will work one-on-one to help coordinate oral health care needs. LIBERTY Case/Care Managers are trained to help providers, children, and adults to arrange services, including referrals for special case facilities, that are needed to manage treatment. On occasions, when determined necessary, the Case/Care Managers may contact your office to obtain additional information on the member's health conditions or to help arrange services/specialty care.

Providers who have identified patients with complex dental needs and/or special health care needs are encouraged to contact and notify LIBERTY. Our Case/Care Managers will work with your office to facilitate treatment and to help members understand their dental needs and how to maintain good oral health.

MEMBER TRANSITION OF CARE NOTIFICATION TO LIBERTY PROVIDERS

LIBERTY's Medi-Cal Dental members who are transferring from a Medi-Cal Dental fee-for-service plan to LIBERTY may request benefits for transition of care. Members may request that a current treatment plan be completed by an out of network provider with whom LIBERTY can establish that the member has been a patient of record in the past **12 months**.

Members, at any time, have the option to elect the continuation of care with a LIBERTY network provider. To make a formal request for Transition of Care benefits, a member or provider may contact LIBERTY's Member Services Department. Upon receipt of the request LIBERTY will:

- Begin the process within 5 business days following the receipt of the request Verify member's patient of record status at an out of network dental office (if necessary).
- Develop a treatment plan with the treating provider and negotiate fees (if LIBERTY and an out of network provider cannot agree on fees, LIBERTY may recommend an in-network provider option).
- Complete non-urgent requests within 30 calendar days, 15 calendar days for more serious dental conditions and 3 calendar days for members with imminent risk of harm.

- Upon completion, notify member and provider of determination, and for approvals, provide the timeframe (no longer than 12 months from date of LIBERTY enrollment) for the transition of care.
- Notify the member 30 calendar days prior to the end of the Transition of Care period.
- Retroactive requests for Transition of Care benefits may also be made through Member Services so long as treatment occurred after February 1, 2017, and the request is made within 30 days from first date of service.

If you have any questions regarding LIBERTY's Medi-Cal Dental Members Transition of Care policy, please contact LIBERTY's Member Services Department.

COVERED CALIFORNIA TO MEDI-CAL TRANSITION

LIBERTY will honor any active pre-estimate for up to 60 days or until a new treatment plan is completed by a provider in the LIBERTY network. The new treatment plan must address services specified in the pre-transition authorized treatment. LIBERTY will honor all pre-transition treatment authorizations without requests from the provider or member.

LIBERTY will offer up to 12 months of continuity of care with an out of network provider, so long as the continuation of services requirements noted above are met. LIBERTY will allow continuity of care benefits for covered services in accordance with the requirement for the following conditions: acute, serious chronic, pregnancy, terminal illness, the care of a newborn child between birth and age 36 months, and surgeries or other procedures that were previously authorized as part of a documented course of treatment that has been recommended and documented by the provider to occur within 180 days of the contract's transition date or within 180 days of the effective date of coverage for a newly covered member.

MEDICAID AND MEDICARE (DUALS) PRIOR-ESTIMATE OUTREACH

LIBERTY complies with applicable law and contractual obligations, including Center for Medicare and Medicaid Services (CMS) guidelines, state and federal regulations, and accreditation standards.

LIBERTY processes all written or verbal requests for Expedited/Urgent ("Expedited") Utilization Management (UM) pre-estimate decisions within the required timeframes.

When LIBERTY receives a Medicaid or Duals member pre-estimate request, which lacks the information necessary to make a medical necessity determination, LIBERTY will make reasonable provider outreach attempts to obtainthe information needed to decide as early in the decision-making process as possible. Examples of reasonable provider outreach attempts include attempts to contact a provider via telephone, fax, email, and mail as appropriate, and within acceptable timelines determined by whether the initial pre-estimate request relates to a standard, or expedited determination.

Each provider outreach attempt will clearly identify the information and/or documents LIBERTY needs to make a medical necessity pre-estimate decision and will include LIBERTY's contact information for the provider to respond to the outreach request.

If LIBERTY does not receive a response to the request for additional information, LIBERTY will decide based on the available information. Pre-estimate denials may be appealed through the member appeal process. Please reference **Section 12. Quality Management** for more information on the member grievance and appeals process.

REQUESTS FOR PRE-ESTIMATE

To determine benefits for Medi-Cal Dental members, some services require the submission of a pre-estimate. Additionally, Medi-Cal Dental members have the right to request the submission a pre-estimate for large, complex treatment plans, and for non-covered services.

Your office cannot refuse to submit a pre-estimate for a Medi-Cal Dental member on the basis that the service is not covered. Please see **Section 10. Clinical Dentistry Guidelines** for more information.

CLAIMS

Medicaid members cannot be charged for missed or cancelled appointments**.** Missed or cancelled appointments should be noted in the member's record and reported to LIBERTY through the claims submission process any missed (D9986) and cancelled (D9987) patient appointments. Continue outreach to these members to educate them on the important of keeping their appointmentand reschedule the appointment to avoid interruption in dental care. Please see **Section 7. Claims and Billing** for more information.

MEMBER RIGHTS AND RESPONSIBILITIES

Federal law provides all Medicaid members with specific rights that must be adhered to by LIBERTY, our contracted dental providers, and dental office staff. Please reference **Section 9. Professional Guidelines and Standard of Care** for more information on member rights and responsibilities.

APPOINTMENT ACCESSIBILITY STANDARDS

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 set by the state of California for the Medicaid programs.

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

California Medi-Cal Dental Appointment Accessibility Standards	
Type of Appointment	**Appointment Scheduling/Wait Time**
Initial (exams and x-rays)	**Within 28 days**
Routine Care, Non-Emergency (restorative care)	**Within 28 days**
Preventive Care (prophylaxis or periodontal care)	**Within 28 days**
Emergency (acute pain/swelling/bleeding)	**As quickly as the member's condition requires but no later than 24 hours**
Urgent Care (Lost crown, broken filling)	**As quickly as the member's condition requires but no later than 72 hours**
After-Hours/Emergency Availability **All providers must have at least one of the following:** • **Answering service that will contact provider on behalf of the member** • **Call forwarding system that automatically directs members call to the Provider** • **Answering system with explicit instructions on how to reach the provider and emergency instructions**	**Must be available 24 hours a day, 7 days a week.**

California Medi-Cal Dental Appointment Accessibility Standards	
Type of Appointment	**Appointment Scheduling/Wait Time**
Specialists	**Within 30 days from approved authorization**
In-Office Wait Time (scheduled appointments)	**Not to exceed 30 minutes.** Offices must maintain records indicating member appointment arrival time and theactual time the member was seen by provider
Telephone Wait Time to Answer	**Within 30 seconds**
Return Telephone Call	**Within 30 minutes**
Office Hours	**Minimum of 3 days/30 hours per week**

MEMBER GRIEVANCES AND APPEALS PROCESS

Health Net Medi-Cal Dental

LIBERTY is not delegated grievances and appeals for Health Net Medi-Cal Dental. Health Net Medi-Cal Dental members may file a grievance and/or appeal by calling Health Net's Member Service Department, by creating an account and filing a grievance online, or printing a grievance and appeals form and mailing or faxing it to the following:

Phone: 800-977-7307/TTY: 711
Online: www.hndental.com
Writing: Health Net Dental, Appeals & Grievances, PO Box 10348, Van Nuys, CA 91410-0348
Fax: 1-877-713-6182

LIBERTY Medi-Cal Dental

LIBERTY Medi-Cal Dental members who wish to file a grievance and/or appeal, can call LIBERTY's Member Services Department, file a grievance online, or printing out a grievance and appeals form and mail or fax it to the following:

Phone: Los Angeles County members 888-703-6999, Sacramento County members 877-550-3875, TTY: 877-855-8039
Electronically: https://www.libertydentalplan.com/Legal/Grievances.aspx

Writing: LIBERTY Dental Plan, Grievances & Appeals, PO Box 26110, Santa Ana, CA 92799-6110
Fax: 1-833-250-1814

IMPORTANT INFORMATION

Federal laws state that all Medicaid members have the following grievances and appeals rights:

- **Grievances:** Members can file a grievance at **any time** following any incident or action that is the subject of their dissatisfaction.
- **Appeals**: Members have the right to request an appeal of decision made by LIBERTY to deny, modify, or pend a request for payment or treatment, within **sixty (60) calendar days** from the date of the Notice of Action (NOA) issued by the Plan.
    - Providers submitting an appeal on behalf of a member, must obtain and supply LIBERTY with a copy of a signed document from the member indicating consent for the appeal to be filed on his/her behalf. If LIBERTY does not receive such a document, the appeal cannot be processed.
- **Continuation of Benefits:** Members who are currently receiving treatment that they want to continue, must submit a request to the Plan within **ten (10) calendar days** from the date the letter was postmarked or delivered to them, or prior to the date the health plan states that services will stop. The member's appeal must state that they want to continue receiving treatment during the appeal process.
- **Independent Medical Review (IMR):** Members who receive a Notice of Appeal Resolution (NAR) from LIBERTY that was denied due to medical necessity, or experimental/investigational may request IMR within **one-hundred-eighty (180)** calendar days from the date of the NAR letter.
- **State Fair Hearings:** Medicaid members who receive a NAR from LIBERTY, that is not fully in their favor, may request a State Fair Hearing no later than **one-hundred-twenty (120) calendar days** from the date on NAR letter.
    - Members may represent themselves at the State Fair Hearing, or be represented by a friend, lawyer, or any other person. If they want someone else to represent them, they are responsible for making the arrangements. Members are informed that to get free legal assistance, they may call the Public Inquiry and Response Unit of the Department of Social Services at their toll-free number, 1-800-952-5253.

- Requesting a State Fair Hearing will not affect a member's eligibility for coverage, and members will not be penalized for seeking a hearing. Members may request benefit continuation during an appeal, IMR or State Fair Hearing by contacting LIBERTY's Member Services Department toll-free for GMC at 877-550-3875 and for PHP at (888) 703-6999 (TTY/TDD 877-855-8039).

- **Expedited/Fast Track Review**: In cases in which a member's health or dental function is in immediate danger a request for an expedited grievance, appeal, State Fair Hearing, or IMR may be requested. All requests for expedited review, that meet the criteria, will be resolved within **(72) hours** from time of receipt.
    - Please reference **Section 12. Quality Management** for more information on the member grievance and appeals process.

ANTI-DISCRIMINTATION

Medi-Cal dental members have the right to file a grievance at any time if they feel that they have been discriminated against in any way. Members may file a grievance with LIBERTY, Department of Managed Health Care, and/or the U.S. Department of Health and Human Services, Office for Civil Rights. Please reference **Section 9. Professional Guidelines and Standards of Care** for more information on Anti-Discrimination.

Office of Civil Rights
Department of Health Care Services
PO Box 997413, MS 0009
Sacramento, CA 95899-7413
(916) 440-7370, 711 (California State Relay)
Email: CivilRights@dhcs.ca.gov

SECTION 6. SUMMARY OF PLAN OFFERINGS

DHMO – Select

Dental Health Maintenance Organization Network (DHMO) – Dentist compensation consists of fixed monthly payments (capitation), member charges (copayments) and procedural guarantee payments for specific plans. Monthly capitation payments are issued on the 20th day of each month and will reflect the members listed on the monthly roster. Members can select any contracted participating provider in the DHMO network as their primary care dentist. A referral from the member's primary care dentist will be required to see a specialist, unless specifically noted otherwise.

DHMO (Copayment only)

Dental Health Maintenance Organization Network (DHMO) – Dentist compensation consists of member charges (copayments). Dependent on member's plan benefits, additional reimbursement from LIBERTY maybe available for specific services.

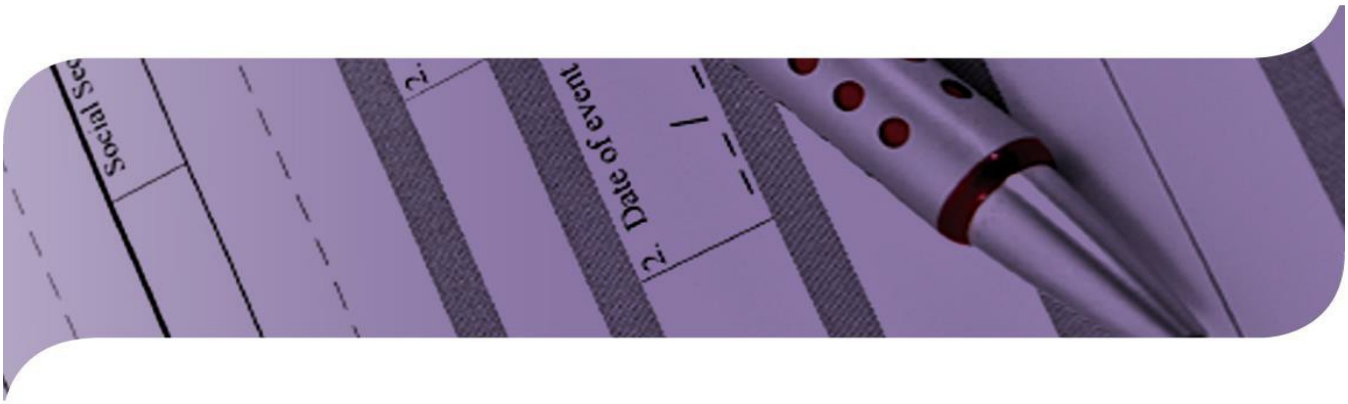
DHMO – Choice

DHMO – Choice Network dentists are compensated on a contracted fee schedule, less applicable member's copayment. Offices are encouraged to submit claims each month to ensure timely payment.

DHMO Benefit Copayment Schedules

Benefit Copayment Schedules are available by logging into the Provider Portal or by contacting the Provider Service Line at **800-268-9012 (TTY 877-855-8039).**

SECTION 7. 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

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 choose one of the following to contact 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 ext. 6	www.tesia.com	CX083

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

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

PAPER CLAIMS

Paper claims must be submitted on ADA approved claim forms. You can find the ADA claim forms on LIBERTY's website at ADA Claim Form.pdf (libertydentalplan.com). Please mail all paper claim/encounter forms to:

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

CLAIMS SUBMISSION REQUIREMENTS

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 **6 months or (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 detail explanation of the emergency circumstances.

CLAIMS STATUS INQUIRY

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

1. Provider Portal: www.libertydentalplan.com
2. Telephone: 800-268-9012, Press Option 3

Claims Status Explanations

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

CLAIMS RESUBMISSION

Providers have **365 calendar days** from the date of service to request a resubmission, reconsideration, or dispute 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. Claims submitted by any contracted provider who is not licensed when the services were rendered will beconsidered overpayments.

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.

CONTESTING A NOTICE OF OVERPAYMENT OF A CLAIM

If the provider contests LIBERTY's notice of overpayment of a claim, a written notice must be sent to LIBERTY within **30 business days** from the receipt of the notice of overpayment of a claim. The written notice to LIBERTY must include the basis upon which the provider believes that the claim was not overpaid.

LIBERTY will process the contested notice in accordance with LIBERTY's contracted Provider Dispute Resolution Process (PDR) described in the **Section 12 – Quality Management**.

NO CONTEST OF OVERPAYMENT OF A CLAIM

If the provider does not contest LIBERTY's notice of overpayment of a claim, the provider must reimburse LIBERTY within **30 business days** of the provider's receipt ofthe notice of overpayment of a claim. If the provider fails to reimburse LIBERTY within 30 business 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.

OFFEST TO PAYMENTS

LIBERTY may only offset an uncontested notice of overpayment of a claim against a provider's current claim submission when:

1. The provider fails to reimburse LIBERTY within the timeframe set forth above, and
2. LIBERTY's contract with the provider specifically authorizes LIBERTY to offset an uncontested notice of overpayment of a claim from the provider's current claims submissions.

If 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 8. 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.

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

IDENTIFY THE PRIMARY CARRIER

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

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

PATIENT IS THE MEMBER	PRIMARY
Member has dental coverage through employer	Member coverage is always primary
Member has dental coverage as an active employee and through the spouse	Member coverage is primary
Member has two active insurance carriers; bothprovide dental coverage	The carrier with the earliest effective date is primary
Member has dental coverage through a group planand COBRA coverage	Group plan is primary

PATIENT IS THE MEMBER	PRIMARY
Member has dental coverage through a group plan and individual or supplemental coverage through another carrier **Note**: Supplemental/Individual plans are purchased by the member for added coverage **Examples**: Student Accident Plans Supplemental Plans, Prepaid Trust Plans	Group plan is primary
Member has dental coverage as an active employee of one plan and as retired employee of another plan	The active coverage is primary
Member has two retiree plans	The plan that covered the member longer is primary
Member has a retiree plan and spouse holds a group plan	Spouse's group plan is primary
Member has a government funded plan and individual or supplemental coverage through another carrier	Individual/Supplemental coverage is primary
Member has two government funded plans. One is Federal (Medicare) and the other is State (Medicaid, Medi-Cal or Value Add)	Federal coverage is primary
Member has dental coverage through a group plan and a government funded plan	Group plan is primary
Member has dental coverage through a retiree plan and a government funded plan	Government funded plan is primary

PATIENT IS THE MEMBER	PRIMARY
Member has two Medicare plans	The Plan with the earliest effective date is considered primary
Dependent Child and the Birthday Rule	The plan of the parent whose birthday falls earlier in the calendar year (month and day only) holds the primary coverage for dependent children. If both parents have the same birthday, the plan that has covered either of the parents the longest is the primary plan. However, if the other plan follows the "gender rule" with male coverage always primary, LIBERTY will follow the rules of that plan. These rules may be superseded by a court order that establishes the responsible party for the child's coverage. When determining the primary carrier for dependents with dual coverage, verify that both parents are the biological parents before applying the birthday rule. Coverage through the biological parent is primary.
If coverage is through a biological parent and a stepparent residing in the same household	The biological parent's plan is primary

PATIENT IS THE DEPENDENT	PRIMARY
If parents are divorced or separated and there are two dental plans	The parent with custody to be the primary
If coverage is through both biological parents and stepparent, in absence of a court order, if the biological parents are legally separated or divorced	1. The plan covering the parent with custody or with whom the child resides is primary. 2. The plan covering the stepparent residing in the same household is secondary. 3. The plan covering the other biological parent's coverage is third (tertiary). 4. The plan covering the other stepparent's coverage is fourth.
If child has a government funded plan and group plan through child's parent. Examples of Government Funded Plans: Healthy Families Denti-Cal Medicaid Medi-Cal Medicare Healthy Kids Viva Scan Coventry TRICARE (see note below) **Note**: TRICARE is a self-funded government plan and does not follow the Active vs. Retiree guidelines. TRICARE follows the effective date regardless of the plan's active or retiree status. The plan with the earliest effective date is considered prime. If a member has a group plan and TRICARE; the group plan will be primary.	Group plan through parent is primary

SCENARIOS FOR COB:

When Member has two Managed Care Plans (DHMO-CAP program)

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

Examples:

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

WHEN LIBERTY IS PRIMARY CARRIER

When LIBERTY is the primary carrier, payment is made for covered services without regard to what the other plan might pay. The secondary carrier, then, depending upon its provisions and limitations, may pay the amounts not covered by LIBERTY. Because LIBERTY's participating dentists have agreed to accept LIBERTY's allowance as payment in full for covered services, they should bill the secondary carrier for the member's coinsurance, any amounts exceeding the annualor lifetime maximums and/or any amounts applied towards the patient's deductible or non-covered services.

WHEN LIBERTY IS SECONDARY CARRIER

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

When LIBERTY is secondary, payment is based on the lesser of either the amount that it would have paid in the absence of any other dental benefit coverage, or the member's total out-of-pocket cost payable under the primary carrier for benefits covered under the secondary carrier (according to AB895).

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

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

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

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

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

Example #1:

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

After applying COB:

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

Example #2:

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

After applying COB:

- Member's portion is reduced to $0.00 (member's primary liability is less than LIBERTY's portion - $67.40 < $95.00)
- LIBERTY pays office = $67.40 (LIBERTY pays the lesser of either the amount that it would have paid in the absence of any other dental benefit coverage or the member's total out-of-pocket liability under the primary carrier)

SECTION 9. PROFESSIONAL GUIDELINES AND STANDARDS OF CARE

Network providers have the right to contact a LIBERTY dental director for a peer-to-peer discussion. LIBERTY dental directors can be reached by calling 888-442-3514 or email umpeertopeer@libertydentalplan.com. LIBERTY encourages our network of dental providers to, when necessary; refer members with signs of behavioral health issues and/or substance abuse issues, to their medical plans for appropriate treatment.

PROVIDER RESPONSIBILITIES AND RIGHTS

- Provide and/or coordinate all dental care for member.
- Perform an initial dental assessment.
- 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.
- Ensure that emergency dental services are available and accessible 24 hours a day, 7 days a weekthrough primary care dentist.
- Maintain scheduled office hours.
- Maintain dental records for a period of 10 years.
- Document member's preferred language and request/refusal of interpreting services in dental chart.
- Post the availability of language assistance services signage in provider office.
- Provide language assistance services to member when requested.
- Provide updated credentialing information upon renewal dates.
- Provide requested information upon receipt of member grievance/complaint within 3 business days of receiving a notice letter.

- Provide encounter data on standard ADA claim form in a timely manner (for capitation plans).
- Notify LIBERTY immediately of any changes regarding practice, including location name, telephone number, address, associate additions / terminations, change of ownership, plan terminations, etc.
- Providers may not close, or otherwise limit, their acceptance of members as patients unless the same limitations apply to all commercially insured members.
- Provider understands and agrees that assignment or delegation by Provider of services under its agreement with LIBERTY is null and void unless prior written approval is obtained from LIBERTY and, to the extent required, by LIBERTY from relevant Health Plan clients.

SPECIALTY CARE PROVIDERS RESPONSIBILITIES & RIGHTS

In addition to the above provider rights and responsibilities, specialty care providers must:

- Provide specialty care to members.
- Work closely with primary care dentists to ensure continuity of care.
- Bill LIBERTY for all dental services that were authorized.

ANTI-DISCRIMINTATION

As a LIBERTY contracted provider, you agree to comply with all non-discrimination laws and contractual requirements. Federal laws, under Section 1557 of the Patient Protection and Affordable Care Action prohibits discrimination against individuals participating in certain health programs or activities based on race, color, national origin, sex, age, or disability. This anti-discrimination clause extends to:

- Any health program or activity any part of which receives funding from HHS
- Any health program or activity that HHS administers
- Health Insurance Marketplace and all plans offered by issuers that participate in those Marketplaces.

ANTI-DISCRIMINATION AGAINST GENDER IDENTITY AND SEXUAL ORIENTATION

Provider will ensure their practices are non-discriminatory in regard to race, color, national origin, sex, sexual orientation, gender identity, or disability. Any policy or practice that has the effect of discriminating based race, color, national origin, sex, sexual orientation, gender identity, or disability is federally prohibited.

Providers and dental office staff will not discriminate against individuals eligible to enroll on the basis of race, color, national origin, sex, sexual orientation, gender identity, or disability and shall not use any policy or practice that has the effect of discriminating on the basis of race, color, or national origin, sex, sexual orientation, gender identity, or disability pursuant to 42 CFR § 438.3(d).

NATIONAL PROVIDER IDENTIFIER ("NPI")

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

The NPI is a HIPAA Administrative Simplification Standard. The NPI is a unique identification number for covered health care providers. Covered health care providers and all health plans and health care clearinghouses must use the NPIs in the administrative and financial transactions adopted under HIPAA. The NPI is a 10-position, intelligence-free numeric identifier (10-digit number). This means that the numbers do not carry other information about healthcare providers, such as the state in which they live or their medical specialty. The NPI must be used in lieu of legacy provider identifiers in the HIPAA standards transactions.

As outlined in Federal Regulations, HIPAA, covered providers must also share their NPIs with other providers, health plans, clearinghouses, and any entity that may need it for billing purposes.

HOW TO APPLY FOR AN NPI

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

- Web based application: http://nppes.cms.hhs.gov
- Dental providers can agree to have an Electronic File Interchange (EFI) Organization submit the 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 until the last day of the month following the date of termination.

Affected members are given advance written notification informing them of their transitional rights. Providers are also responsible for assisting LIBERTY with transfer of care.

STANDARDS OF ACCESSIBILITY

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 regulation or by client performance standards.

COMPLIANCE WITH THE STANDARDS OF ACCESSIBILITY AND AVAILABILITY

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

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

California Dental Appointment Accessibility Standards (Non Medi-Cal Dental)	
Type of Appointment	**Appointment Scheduling/Wait Time**
Initial (exams, and x-rays)	36 business days
Routine Care, Non-Emergency (restorative care)	36 business days
Preventive Care (prophylaxis or periodontal care)	40 business days
Emergency (acute pain/swelling/bleeding)	**As soon as the member's condition requires, not later than 24 hours**
Urgent Care (Lost crown, broken filling)	**As soon as the member's condition requires, no later than 72 hours**

California Dental Appointment Accessibility Standards (Non Medi-Cal Dental)	
Type of Appointment	**Appointment Scheduling/Wait Time**
After-Hours/Emergency Availability **All providers must have at least one of the following:** • **Answering service that will contact provider on behalf of the member** • **Call forwarding system that automatically directs members call to the Provider** • **Answering system with explicit instructions on how to reach the provider and emergency instructions**	**24 hours a day, 7 days a week**.
Specialists	**Within 30 days from authorized request**
In-Office Wait Time (Scheduled appointments)	For scheduled appointments. **Not to exceed 30 minutes.** Offices must maintain records indicating member appointment arrival time and the actual time the member was seen by provider.
Telephone Wait Time to Answer	**Within 30 seconds**
Return Telephone Call	**Within 30 minutes**
Office Hours	**Minimum of 3 days/30 hours per week**

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, 7 days a week. In the event the primary care provider is not available to see an emergency patient within **24 hours**, it is his/her responsibility to make arrangements to ensure that emergency services are available. Members requiring after-hours emergency dental services must receive an assessment by telephone from the provider within **1 hour** of the time the member contacts the provider's "after hours" telephone service.

Member must be scheduled within **24 hours** and should be informed that only the emergency will be treated at that time. If the member is unable to access emergency care within our guidelines and must seek services outside of your facility, you may be held financially responsible for the total costs of such services. Additionally, if your office is unable to meet LIBERTY guidelines, LIBERTY has the right to transfer some or all capitation programs enrollment or close your office to new enrollment.

FACILITY PHYSICAL ACCESS FOR THE DIASBLED – 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 ADA 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.

RECALL, FAILED OR CANCELLED APPOINTMENTS

Contracted dentists are expected to have an active recall system for established patients who fail to keep or cancel appointments. Failed appointment charges may apply; copayments will vary based on the members' plan benefits.

INTERPRETER SERVICES

Interpreter services shall be coordinated with scheduled appointments for dental services in a manner that ensures the provision of interpreter services at the time of the appointment.

TREATMENT PLAN GUIDELINES

All members must be presented with an appropriate written treatment plan containing an explanation of benefits and related costs. If there are alternate treatments available, the treating dentist must also present those treatment plans and the related costs for covered and non-covered services.

ALTERNATE, ELECTIVE/NON-COVERED PROCEDURES AND TREATMENT PLANS

LIBERTY members cannot be denied their dental plan benefits if they do not choose "alternative or elective/non-covered" procedures. All accepted or declined treatment plans must be signed and dated by the member or his/her guardian and the treating dentist. Refer to the Members' benefit plans to determine covered, alternate, and elective procedures.

Note: Most plans allow for an upgrade to noble and high noble metal and for porcelain on molar teeth with an informed consent by the Member. Please reference the MOC for benefit information for Medi-Cal Dental members: https://www.dental.dhcs.ca.gov/MCD_documents/providers/quick_reference_for_dentical_dentists.pdf

SECOND OPINIONS

Members and providers may request a consultation with another network dentist for a second opinion to confirm the diagnosis and/or treatment plan, at no cost. Please call LIBERTY's Member Services Department at 800-268-9012 (TTY/TDD 877-855-8039) Monday through Friday, 8:00 a.m. to 5:00 p.m. PST. Second opinions may be requested on non-covered services.

CONTINUITY AND COORDINATION OF CARE

LIBERTY 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. All care rendered to LIBERTY members must be properly documented in the patient's dental charts according to established documentation standards.

Communication between the Primary Care Dentist (PCD) and dental specialist occurs when members are referred for specialty dental care. LIBERTY enforces Quality Management Improvement Program policies and procedures that will ensure:

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

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 SERVICES

Language Assistance services are available to ensure LEP members have appropriate access to language assistance including special format for hearing and visually impaired members, while accessing dental care.

Interpretation services for LEP members (when and where required by state law or group/client arrangement are available at no cost):

- 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 800-268-9012 (TTY/TDD 877-855-8039).
- To engage an interpreter once the member is ready to receive services, please call 800-268-9012 (TTY/TDD 877-855-8039).
- You will need the member's LIBERTY Dental ID number, date of birth, and the member's full name to confirm eligibility and access interpretation services. It is not necessary to arrange for these services in advance.
- LIBERTY discourages the use of family or friends as interpreters. 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.
- Providers and dental office staff are required to coordinate language assistance services, upon request by the member.
- 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.
- Assistance in working effectively with members using in-person, telephonic interpreters, other media suchas TTY/TDD and remote interpreting services can be obtained by contacting LIBERTY's Member Services Department.

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA)

LIBERTY takes pride in the fact that we administer our dental plan in an effective and innovative manner while safeguarding our members' protected health information. We are committed to complying with the requirements and standards of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).
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 and Quality Management Programrequirements. Member protected Personal Health Information (PHI) may be shared with LIBERTY as per the requirement in the HIPAA laws that enables the sharing of such information for Treatment, Payment and Health Care Operations (TPO), as well as for peer review and qualitymanagement and improvement requirements of health plans. There is no need for special member authorizationswhen submitting member PHI for these purposes.

OUT COMMITMENT IS DEMONSTRATED THROUGH OUR ACTIONS

LIBERTY has appointed a Privacy Officer to develop, implement, maintain, and provide oversight of our HIPAA Compliance Program, as well as assist with the education and training of our employees on the requirements andimplications of HIPAA. As a health care provider and covered entity, you and your staff must follow HIPAA guidelines regarding PHI.

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

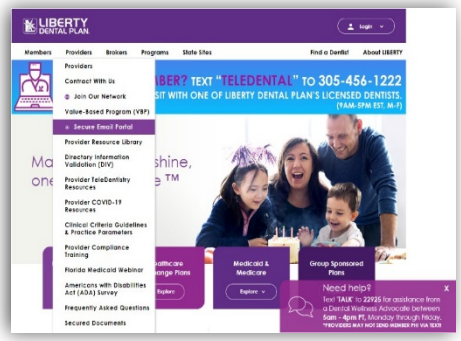
PROTECTED HEALTH INFORMATION (PHI)

All dental providers and their offices should be fully aware that HIPAA requires the protection and confidential handling of member PHI. HIPAA requires health care providers to develop and implement safeguards that ensure the confidentiality and security of all forms of PHI (whether electronic, verbal, or tangible) when transmitted or stored. Failure to properly safeguard PHI can result in breaches, enforcement actions and significant monetary penalties and, is a violation of LIBERTY's provider agreement.

Please take this opportunity to review your office's privacy and security practices to ensure they comply with HIPAA requirements and take note of the below reminders regarding safeguarding LIBERTY member PHI. If we discover you have transmitted LIBERTY member PHI via a potentially non-secure method, or if we are otherwise notified that you may not be properly safeguarding such PHI, we will contact you to investigate the matter. Non-compliance will result in a Corrective Action Plan (CAP) and continued, or egregious non-compliance will result in contract termination.

ELECTRONIC PHI

Ensure referrals, pre-estimate requests, medical records and other e-PHI are transmitted in a HIPAA compliant manner using secure fax, secure FTP, encrypted email (which requires member authentication to access email content), or LIBERTY's secure web portal.



Note the following:

- Use of PHI (including member name, ID, or other identifying information) inthe subject lines of emails or to name-files is **not** permitted.
- Use of free email service providers, such as, but not limited to Gmail, Hotmail, Yahoo, is **not** permitted method for transmitting LIBERTY Member PHI.
- Transmission of PHI via text is **not** permitted.

LIBERTY providers may transmit e-phi using LIBERTY's HIPAA compliant, secure web portal by following these simple steps:

- Go to www.libertydentalplan.com
- Go to Provider menu at top of the page
- Select Secure Email Portal

Use physical and technical safeguards to ensure that monitors cannot be viewed by unauthorized individuals, and that screens automatically lock on devices, after a reasonable period of inactivity.
Maintain protocols to ensure faxes containing PHI are issued to the correct member, and that increased precautions are applied when faxing especially sensitive information (such as sensitive diagnoses).

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

VERBAL PHI

Do not discuss members in public areas (including waiting rooms, hallways, and other common areas), even if you believe you are masking the member's identity. Ensure conversations within examination rooms or operatories cannot be overheard by those outside of the room. Use heightened discretion when discussing sensitive diagnoses or other sensitive matters, including when such discussions occur with the member in an exam room or operatory.

BEST PRACTICES INCLUDE:

- Implementing appropriate physical safeguards such as closed doors and insulated walls for exam rooms and operatories.
- Implementing ambient music or white noise to cover conversations in common areas.
- Arranging waiting areas to minimize one-member overhearing conversations with another.
- Posting a sign requesting that members who are waiting to sign-in or be seen, do not congregate in reception area.
- Ensuring unauthorized persons cannot overhear phone calls and limiting what is communicated by phone and voicemail to the minimum necessary information to accomplish the required purpose. Avoid use of speaker phones.

TANGIBLE PHI

Do not display or store paper or other tangible PHI in common areas. Do not leave such PHI unattended on desks or in exam rooms or operatories. Never dispose of paper or other tangible PHI in the trash.

Use secure methods to destroy and dispose of such PHI (for example, cross-cut shredder).

- All PHI must be locked away during close of business (for example, in a locked cabinet).
- Window blinds must be closed to prevent outside disclosure
- Mailing envelopes must not be overstuffed and mailing addresses must be printed accurately and clearly to minimize the possibility that mail is lost in transit.
- When transporting tangible PHI take precautions to ensure it is not lost in transit, and do not leave tangible PHI in vehicles unattended.

MEMBER RIGHTS AND RESPONSIBILITIES

Everyone is entitled to the following **rights** under Federal law:

- A member has the right to be treated with courtesy and respect, with appreciation of his or her individual dignity and with protection of his or her need for privacy.
- A member has the right to a prompt and reasonable response to questions and requests.
- A member has the right to know who is providing medical services and who is responsible for his or hercare.
- A member has the right to know what member support services are available, including whether an interpreter is available if he or she does not speak English.
- A member has the right to know what rules and regulations apply to his or her conduct.
- A member has the right to be given by the health care provider information concerning diagnosis, planned course of treatment, alternatives, risks, and prognosis.
- A member has the right to refuse any treatment, except as otherwise provided by law.
- A member has the right to be given, upon request, full information, and necessary counseling on the availability of known financial resources for his or her care.
- A member who is eligible for Medicare has the right to know, upon request and in advance of treatment, whether the health care provider or health care facility accepts the Medicare assignment rate.

- A member has the right to receive, upon request, prior to treatment, a reasonable estimate of charges for dental care.
- A member has the right to receive a copy of a reasonably clear and understandable, itemized bill and, upon request, to have the charges explained.
- A member has the right to impartial access to medical treatment or accommodations, regardless of race, national origin, religion, handicap, or source of payment.
- A member has the right to treatment for any emergency medical condition that will deteriorate from failure to provide treatment.
- A member has the right to know if medical treatment is for purposes of experimental research and to give his or her consent or refusal to participate in such experimental research.
- A member has the right to express grievances regarding any violation of his or her rights, as stated in the applicable state law, through the grievance procedure of the health care provider or health care facility which served him or her and to the appropriate state licensing agency.

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

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

SECTION 10. CLINICAL DENTISTRY GUIDELINES

CLINICAL CRITERIA GUIDELINES (CCG)

For additional information please reference the CCG online at: https://www.libertydentalplan.com/Resources/Documents/ma_Clinical_Criteria_Guidelines_and_Practice_Parameters.pdf. If you would like a copy of the CCG please contact Member Services at 800-268-9012 (TTY/TDD 877-855-8039).

NEW PATIENT INFORMATION

A. Registration information should minimally include:
    1. Name, sex, birth date, address and telephone number, cell phone number, e-mail address, name of employer, work address and telephone number
    2. Name and telephone number of person(s) to contact in an emergency
    3. For minors, name of parent(s) or guardian(s) and telephone numbers, if different from above.
B. Pertinent information relative to the patient's chief complaint and dental history, including any problems or complications with previous dental treatment should always be documented.
C. Medical History – There should be a detailed medical history form comprised of questions which require a "yes" or "no" responses, minimally including:
    1. Patient's current health status
    2. Name and telephone number of physician and date of last visit
    3. History of hospitalizations and/or surgeries
    4. History of abnormal (high or low) blood pressure
    5. Current medications, including dosages and indications
    6. History of drug and medication use (including Fen-Phen/Redux and bisphosphonates)
    7. Allergies and sensitivity to medications or materials (including latex)
    8. Adverse reaction to local anesthetics

9. History of diseases:
    i. Cardio-vascular disease, including heart attack, stroke, history of rheumatic fever, existence of pacemakers, valve replacements and/or stents and bleeding problems, etc.
    ii. Pulmonary disorders including tuberculosis, asthma, and emphysema
    iii. Nervous disorders
    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
10. Pregnancy
    i. Document the name of the member's obstetrician and estimated due date.
    ii. Follow guidelines in the ADA publication, Women's Oral Health Issues, November 2006.
11. History of cancer, including radiation or chemotherapy
12. The medical history form must be signed and dated by the member, member's parent or guardian.
13. Dentist's notes following up on member comment's, significant medical issues and/or the need for a consultation with a physician should be documented on the medical history form or in the member's progress notes.
14. Medical alerts reflecting current significant medical conditions must be uniform and conspicuously visible on a portion of the chart used during treatment.
15. The dentist must sign and date all baseline medical histories after review with the member.
16. The medical history should be updated and signed by the member and the dentist at least annually or as dictated by the member's history and risk factors.

INFECTION CONTROL

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

DENTAL RECORDS

Member dental records must be kept and maintained in compliance with applicable state and federal regulations. The Centers for Medicare & Medicaid Services (CMS) requires providers to retain records for 10 years. Complete dental records of active or inactive patients must be accessible for a minimum of 10 years, even if the facility is no longer under contract or is under new ownership.

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 member records to the Plan within 3 business days 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 member. 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.

BASELINE CLINICAL EVALUATION DOCUMENTATION

A. Observations of the initial evaluation are to be recorded in writing and charted graphically where appropriate, including missing or impacted teeth, existing restorations, prior endodontic treatment(s), fixed bridges, and removable appliances (dentures).
B. Assessment of TMJ status (necessary for adults) and/or classification of occlusion (necessary for minors) should be documented.
C. Documentation of periodontal type, full mouth periodontal probing and diagnosis must be documented, including an evaluation of bone levels, gingival recession, inflammation, etiologic factors (e.g., plaque and calculus), mobility, and furcation involvements.
D. A soft tissue/oral cancer examination of the lips, cheeks, tongue, gingiva, oral mucosal membranes, pharynx, and floor of the mouth must be documented.

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

RADIOGRAPHS (X-RAYS)

A. Please reference the MOC for x-ray criteria, processes, and for Medi-Cal Dental members: https://www.dental.dhcs.ca.gov/MCD_documents/providers/quick_reference_for_denti-cal_dentists.pdf
B. An attempt should be made to obtain any recent x-ray(s), completed within 7 to 14 days prior, from the previous dentist.
C. An adequate number of initial x-ray(s) should be taken by the treating provider to make an appropriate diagnosis and treatment plan. Refer to the current, published ADA/FDA radiographic guidelines: **The Selection of Patients for Dental Radiographic Examination.**
D. **D0210 Intraoral – complete series (including bitewings) (Full mouth x-ray(s))**
   - "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." *CDT 2011/2012, page 7*.
   - Benefits for this procedure are determined within each plan design.
   - Any combination of covered x-ray(s) that meets or exceeds a provider's fee for a complete series may be adjudicated as a complete series, *for benefit purposes only*.
   - In addition, any panoramic film taken in conjunction with periapical and/or bitewing x-ray(s) may be considered as a complete series, *for benefit purposes only*.
E. Decisions about the types of recall films should also be made by the dentist and based on current *ADA/FDA* x-ray(s) guidelines, including the complexity of previous and proposed care, caries, periodontal susceptibility, types of procedures and time since the member's last x-ray examination.
F. A panoramic x-ray is a screening film and is not a substitute for periapical and/or bitewing x-ray(s) when a dentist is performing a comprehensive evaluation.
G. Diagnostic x-ray(s) should reveal contact areas without cone cuts or overlapping and periapical films should reveal periapical areas and alveolar bone.
H. X-ray(s) should exhibit good contrast.
I. Diagnostic digital x-ray(s) should be printed on photographic quality paper and exhibit good clarity and brightness.
J. Recent x-ray(s) must be mounted, labeled left/right, and dated.
K. Any member refusal of x-ray(s) should be documented.
L. X-ray duplication fee

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

- If the transfer is initiated by the provider, the member may not be charged any x-ray duplication fees.
- If the transfer is initiated by the member, many plans allow the provider to charge for the actual cost of copying the x-rays up to a maximum fee of $25. This does not apply to Medi-Cal Dental members, and they cannot be charged for x-ray duplicate fees.

NOTE: Under some benefit plans, x-ray duplication fees may not be allowed. Refer to the specific benefit plan to determine if a duplication fee is allowable.

PREVENTION

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

A. Please reference the MOC for preventive services criteria, process, and benefits for Medi-Cal Dental members: https://www.dental.dhcs.ca.gov/MCD_documents/providers/quick_reference_for_denti-cal_dentists.pdf
B. Caries prevention may include the following procedures where appropriate:
    1. Patient education in oral hygiene and dietary instruction
    2. Periodic evaluations and prophylaxis (cleaning) procedures
    3. Topical or systemic fluoride treatment
    4. Sealants and/or preventive resin restorations
    5. Use of caries preventing medication
C. Periodontal disease prevention may include a comprehensive program of plaque removal and control in addition to the following procedures:
    1. Oral and systemic health information
    2. Oral hygiene and dietary instructions
    3. Prophylaxis procedures on a regular basis
    4. Occlusal evaluation
    5. Correction of malocclusion and malposed teeth
    6. Restoration and/or replacement of broken down, missing or deformed teeth
D. Other areas of prevention may include:
    1. Smoking cessation programs
    2. Discontinuing the use of smokeless tobacco
    3. Good dietary and nutritional habits for general health

4. Elimination of mechanical and/or chemical factors that cause irritation
5. Space maintenance in children were indicated for prematurely lost posterior teeth
6. Motivational Interviewing

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

TREATMENT PLANNING

A. Treatment plans should be comprehensive and documented in ink.
B. Treatment plans should be consistent with the clinical evaluation findings and diagnosis.
C. Procedures should be sequenced in an order of need consistent with diagnostic and evaluation findings and in compliance with accepted professional standards. Normal sequencing would include relief of pain, discomfort and/or infection, treatment of extensive caries and pulpal inflammation including endodontic procedures, periodontal procedures, restorative procedures, replacement of missing teeth, prophylaxis and preventive care and establishing an appropriate recall schedule.
D. Informed Consent Process
    1. Dentists must document that all recommended treatment options have been reviewed with the member and that the member understood the risks and benefits.
    2. Appropriate informed consent documentation must be signed and dated by the member and dentist for the specific treatment plan that was accepted.
    3. If a member refuse recommended procedures, the member must sign a specific "refusal of care" document.
E. Poor Prognosis
    1. Procedures recommended for teeth with a guarded or poor prognosis (endodontic, periodontal or restorative) are not covered.
    2. When providers recommend endodontic, periodontal, or restorative procedures (including crown lengthening), they should take into account and document the anticipated prognosis, restorability and/or maintainability of the tooth or teeth involved.
    3. LIBERTY licensed Staff Dentists adjudicate prognosis determinations for the above procedures on a case-by-case basis. LIBERTY will reconsider poor prognosis determinations for the above procedures upon receipt of a new claim with appropriate documentation and new diagnostic x-ray(s) taken a minimum of 6 months after the original date of service.

F. Some upgraded procedures (i.e., metals and porcelain on molars) may not be covered.

G. **Alternate Treatment Plans**

1. If more than one procedure would be considered appropriate in treating a dental condition, the Alternate Treatment Plan Formula should be utilized and presented:
2. This formula credits the member's benefited procedure against the cost of the alternative procedure and the member's responsibility is calculated as follows:
    i. The usual total cost of the alternate treatment minus (–) the usual cost of the covered procedure plus (+) any listed copayment for the covered procedure.

H. If the dentist recommends or the member chooses between two covered procedures, the chosen procedure would be covered. **Example:** if an extraction is agreed to instead of an endodontic procedure, the extraction would be covered.

I. Alternative treatment plans and options should be documented with a clear and concise indication of the treatment the member has chosen. In such cases, the Alternate Treatment Plan Formula should be presented and documented. The form can be found on the LIBERTY website at https://libertydentalplan-ga.azurewebsites.net/Providers/Provider-Resource-Library.aspx.

J. Should a dentist not agree with a procedure requested by a member, the dentist may decline to provide the procedure and request that the member be transferred. In such cases, the dentist is responsible for completion of treatment-in-progress and emergencies until the transfer request is effective in accordance with prescribed Dental Board of California guidelines.

K. Consultations, referrals, and their results should be documented.

REQUEST FOR PRE-ESTIMATE

To confirm benefits and member copayments for LIBERTY programs, it is highly recommended that a pre-estimate be submitted for large or complex treatment plans. Following are some treatment examples where a pre-estimate would be highly recommended:

- Three or more crowns in the treatment plan
- Bridges (fixed partial dentures)
- Extensive treatment plans involving seven or more teeth
- Treatment plans that include elective or non-covered services
- Multiple arches receiving prosthetic replacement

PROGRESS NOTES

A. Progress notes constitute a legal record and must be detailed, legible and in ink.
B. All entries must be signed or initialed and dated by the person providing treatment. Entries may be corrected, modified, or lined out, but require the name of the person making any such changes and the date.
C. The type and amounts of all local anesthetics must be documented, including the amount of any vasoconstrictor present. If no local anesthetic is used for a procedure that normally requires it (i.e., scaling and root planing), the related rationale should be documented.
D. All prescriptions must be documented in the progress notes and copies kept in the chart, including the medication, strength, amount, directions, and number of refills.
E. Copies of all laboratory prescriptions should be kept in the chart.
F. For paperless dental records, computer entries cannot be modified without identification of the person making the modification and the date of the change.

ENDODONTICS

A. Please reference the MOC for endodontic services criteria, process, and benefits for Medi-Cal Dental members: https://www.dental.dhcs.ca.gov/MCD_documents/providers/quick_reference_for_denti-cal_dentists.pdf
B. **Palliative Treatment**
    1. Responsibility for palliative treatment, even for procedures that may meet specialty care referral guidelines, is that of the contracted dentist. Palliative services are applicable per visit, not per tooth, and include all the treatment provided during the visit other than necessary x-rays. A description of emergency and palliative treatment should be documented.
C. **Endodontic Pulpal Debridement and Palliative Treatment**
    1. For benefit purposes providers should document endodontic dates of service as the dates when procedures have been entirely completed, submit to review. Diagnostic techniques used when considering possible endodontic procedures may include an evaluation of:
        i. Pain and the stimuli that induce or relieve it by the following tests:
        ii. Thermal
        iii. Electric
        iv. Percussion
        v. Palpation

vi. Mobility

2. Non-symptomatic radiographic lesions

D. **Treatment planning for endodontic procedures & prognosis 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
3. Presence and severity of periodontal disease
4. Restorability and tooth fractures
5. Excessively curved or calcified canals
6. Occlusion
    i. Following an appropriate informed consent process, if a member elects to proceed with a procedure that is not covered, the member is responsible for the dentist's usual fee. The dentist should have the member sign appropriate informed consent documents and financial agreements.
    ii. **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.**

E. **Clinical Guidelines**

1. Diagnostic pre-operative x-ray(s) of teeth to be endodontically treated must reveal all periapical areas and alveolar bone.
2. A rubber dam should be used and documented (radiographically or in the progress notes) for all endodontic procedures. Documentation is required for any inability to use a rubber dam.
3. **All canals should be obturated and densely packed and sealed when viewed on a post-operative radiograph.**
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 x-ray(s) should be taken at appropriate periodic intervals.

F. **Endodontic referral necessity**

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

G. **Pulpotomy**

1. A pulpotomy may be indicated in a primary or permanent tooth when pulpal pathology is limited to the coronal pulp and the tooth has a reasonable period of retention and function.
2. Apexification may be indicated in a permanent tooth when there is evidence of a diseased pulp with an incompletely developed root or roots to allow maturation and completion of the root apex. Endodontic treatment should be completed when the root is fully formed.

H. **Pulp Cap**

1. This procedure is not to be used for bases and liners
2. 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
3. Indirect pulp capping (re-mineralization) is indicated to attempt to minimize the possibility of pulp exposure in very deep caries in vital teeth

I. **Endodontic surgical treatment should be considered only in special circumstances, including:**

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

J. **Endodontic procedures will not be covered when a tooth or teeth have a poor prognosis due to:**

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

ORAL SURGERY

A. Please reference the MOC oral surgery services criteria, process, and benefits for Medi-Cal Dental members: https://www.dental.dhcs.ca.gov/MCD_documents/providers/quick_reference_for_denti-cal_dentists.pdf

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

C. **Primary Care Dentists are expected to provide routine oral surgery, including:**
   1. Uncomplicated extractions & emergency palliative care
   2. Surgical extractions of erupted teeth
   3. Incision and drainage of intra-oral abscesses
   4. Minor surgical procedures and postoperative services

D. **Extractions may be indicated in the presence of:**
   1. Non-restorable caries
   2. Untreatable periodontal disease
   3. Pulpal and periapical disease not amendable to endodontic therapy
   4. To facilitate surgical removal of a cyst or neoplasm
   5. When an overriding medical condition exists providing compelling justification to eliminate existing or potential sources of oral infection.

B. When teeth are extracted, all portions of the teeth should be removed. If any portion of a tooth (or teeth) is not removed, member notification must be documented and initiate referral to specialist.

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

E. **Documentation of a surgical procedure should include:**
   1. Notation of the tooth number
   2. Tissue removed, and a description of the surgical method used, including the wound closure
   3. A record of unanticipated complications such as, failure to remove planned tissue/root tips
   4. Displacement of tissue to abnormal sites
   5. Unusual blood loss
   6. Presence of lacerations and other surgical or non- surgical defects
   7. All suspicious lesions should be biopsied and examined microscopically.

F. **Third molar extractions**
   1. LIBERTY's licensed Staff Dentist adjudicate benefits on a case-by-case basis.
   2. It is appropriate to report procedure D7220, D7230, D7240 or D7241 for the removal of an impacted tooth, with active pathology.
   3. "Impacted tooth is defined as an unerupted or partially erupted tooth that is positioned against another tooth, bone, or soft tissue so that complete eruption is unlikely." (CDT 2011-2012, pg. 216)

4. The prophylactic removal of an unerupted tooth or teeth that appear to exhibit an unimpeded path oferuption and/or exhibit no active pathology will not be covered.
5. The removal of asymptomatic, unerupted, third molars in the absence of active pathologywill not be covered.
6. The removal of third molars, or any other tooth, where pathology such as infection, non-restorable carious lesions, cysts, tumors, and damage to adjacent teeth is evident may be covered.
7. Completely covered and unerupted third molars cannot exhibit pericoronitis.

PERIODONTICS

A. Please reference the MOC for periodontal services criteria, process, and benefits for Medi-Cal Dental members: https://www.dental.dhcs.ca.gov/MCD_documents/providers/quick_reference_for_denti-cal_dentists.pdf
B. All children, adolescents, and adults should be evaluated for evidence of periodontal disease. If pocket depths do not exceed 3 millimeter and there is no bleeding on probing or evidence of radiographic bone loss, it is appropriate to document the member's periodontal status as being Within Normal Limits (WNL).
C. Comprehensive oral evaluations should include the quality and quantity of gingival tissues. Following the completion of a comprehensive evaluation, a diagnosis, and treatment plan should be completed.
D. **Additional components of the comprehensive oral evaluation would include documenting:**
    1. Six-point periodontal probing for each tooth
    2. The location of bleeding, exudate, plaque, and calculus
    3. Significant areas of recession
    4. Mucogingival problems
    5. Mobility, open or improper contacts
    6. Furaction involvement
    7. Occlusal contacts or interferences
E. **Periodontal surgical procedures**
    1. The patient must exhibit a willingness to accept periodontal treatment and practice an appropriate oral hygiene regimen prior to consideration for periodontal surgical procedures.

2. Case history, including patient motivation to comply with treatment and oral hygiene status, must be documented.
3. Patient motivation may be documented in a narrative by the attending dentist and/or by a copy of patient's progress notes documenting patient follow through on recommended regimens.
4. In most cases, there must be evidence of scrupulous oral hygiene for at least three months prior to the pre-estimate for periodontal surgery.
5. Consideration for a direct referral to a Periodontist would be considered on a by report basis.
6. Periodontal surgical procedures are covered only in cases that exhibit a favorable long-term prognosis. Surgical procedures for the retention of teeth that are being used as prosthetic abutments is covered only when the teeth would exhibit adequate bonesupport for the forces to which they are, or will be, subjected.
7. Periodontal pocket reduction surgical procedures may be covered in cases where the pocket depths are 5 millimeter or deeper, following soft tissue responses to scaling and root planning.

F. **Osseous surgery procedures may not be covered if:**
1. Pocket depths are 4 mm or less and appear to be maintainable by non-surgical means (i.e. periodontal maintenance and root planing).
2. Patients are smokers or diabetics whose disease is not being adequately managed.
3. Periodontal pocket reduction surgical procedures should result in the removal of residual calculus and granulation tissue with improved physiologic form of the gingival tissues.
4. Osseous surgery and regenerative procedures should also correct and reshape deformities in the alveolar bone where indicated.
5. Soft tissue gingival grafting should be done to correct gingival deficiencies where appropriate.
6. Periodontal maintenance and supportive therapy intervals should be individualized, although three-month recalls are common for many patients.

RESTORATIVE

A. Please reference the MOC for restorative services criteria, process, and benefits for Medi-Cal Dental members: https://www.dental.dhcs.ca.gov/MCD_documents/providers/quick_reference_for_denti-cal_dentists.pdf

B. **Diagnosis and Treatment Planning**

1. It is appropriate to restore teeth with radio radiographic evidence of caries, lost tooth structure, defective or lost restorations, and/or for post-endodontic purposes. Sequencing of treatment must be appropriate to the needs of the member.
2. Restorative procedures must be reported using valid/current *CDT* procedure codes as published by *The American Dental Association*. This source includes nomenclature and descriptors for each procedure code.
3. Treatment results, including margins, contours, and contacts, should be clinically acceptable. The long-term prognosis should be good (estimated at 5 years or more).
4. Restorative dentistry includes the restoration of hard tooth structure lost because of caries, fracture, erosion, attrition, or trauma.
5. Restorative procedures in operative dentistry include amalgam, composites, inlays, on lays, crowns as well as the use of various temporary materials.
6. The choice of restorative materials depends on the nature and extent of the defect to be restored, location in the mouth, stress distribution expected during mastication and esthetic requirements.
7. 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 a direct restoration.
8. 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.
9. The replacement of clinically acceptable amalgam fillings with alternative materials (composite, crown, etc.) is considered cosmetic and is not covered.
10. 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.
11. Pulpotomies and pre-formed crowns for primary teeth are covered only if the tooth is expected to be present for at least six months.
12. Posterior primary teeth that have had extensive loss of tooth structure, the appropriate treatment is generally a prefabricated stainless-steel crown or for anterior teeth, a stainless steel or prefabricated resin crown.

13. When incisal edges of anterior teeth are undermined because of caries or replacement of a restoration undermining the incisal edges or a fracture, the procedures of choice may be veneers or crowns, either porcelain fused to metal or porcelain/ceramic substrate.

C. An onlay should be considered when there is sufficient tooth structure, but cusp support is needed.

D. An inlay is usually not a restoration of choice.

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

F. If a dentist elects to provide an upgraded high noble crown, the allowable benefit of a D2751 is applied.

G. Restorations for chipped teeth may be covered.

H. **Amalgam free dental offices**

1. If a dentist chooses not to provide amalgam fillings, alternative posterior fillings must be made available for LIBERTY members at the listed amalgam copayment amount.

I. **D1351 sealant – per tooth**

1. Mechanically and/or chemically prepared enamel surface sealed to prevent decay. If the resin restoration does not penetrate dentin, D1351 is appropriate.

J. **D2330, D2391 or D2392 - Resin-based composites**

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

K. **D9910/D9911 - Desensitizing**

1. Appropriate reporting of these procedures is clearly detailed below.
2. All acid etching, adhesives (including resin bonding agents), liners, bases and/or curing techniques are a part of and included in amalgam and composite restoration procedures.
3. Is included with overarching procedures and cannot be unbundled and charged as a separate service.
4. **D9910 – application of desensitizing medicament**
    i. Includes in-office treatment for root sensitivity. Typically reported on a "per visit" basis for application of topical fluoride. This code is not to be used for bases, liners or adhesives under restorations.

5. **D9911 – application of desensitizing resin for cervical and/or root surface, per tooth**
    i. Typically reported on a "per tooth" basis for application of adhesive resins. This code is not to be used for bases, liners, or adhesives used under restorations." *CDT2022, page 79*

CROWNS AND FIXED BRIDGES

A. Please reference the MOC for crowns and fixed bridge services criteria, process, and benefits for Medi-Cal Dental members: https://www.dental.dhcs.ca.gov/MCD_documents/providers/quick_reference_for_denti-cal_dentists.pdf
B. Providers should report the dates of service for these procedures to be the dates when the crowns and/or fixed bridges are cemented and delivered, subject to review.
C. **Crown Upgrades**
    1. Individual plan designs may limit the total maximum amount chargeable to a member for any combination of upgrades to a specified dollar amount.
    2. **Typical upgrades may include:**
        i. Choice of metal – noble, high noble, titanium alloy or titanium
        ii. Porcelain on molar teeth
        iii. Porcelain margins, by report (porcelain margin upgrades may be reported as D2999 for single crowns or as D6999 for abutment crowns)
D. **Single Crowns**
    1. When bicuspid and anterior crowns are covered, the benefit is usually a porcelain fused to a base metal crown or a porcelain/ceramic substrate crown.
    2. When molar crowns are indicated due to caries, an undermined or fractured off cusp or the necessary replacement of a restoration due to pathology, the benefit is usually a porcelain fused to base metal crown.
    3. Porcelain/ceramic substrate crowns and porcelain fused to metal crowns on molars may be more susceptible to fracture than full metal crowns.
    4. When anterior teeth have incisal edges/corners that are undermined or missing because of caries, a defective restoration or are fractured off, a labial veneer may not be sufficient. The treatment of choice may then become a porcelain fused to a base metal crown or porcelain/ceramic substrate crown.

5. Final crowns for teeth with a good prognosis should be sequenced after performing necessary endodontic and/or periodontic procedures and such teeth should exhibit a minimum crown/root ratio of 50%.
6. Crown procedures should always be reported and documented using valid procedure codes as found in the *American Dental Association's Current Dental Terminology (CDT)*.

E. **Brand name dental materials/alternatives**

1. The America Dental Association publishes the Current Dental Terminology (CDT) booklet once every year. The CDT booklet includes the Code on Dental Procedures and Nomenclature.
    i. "The Code is designated by the Federal Government under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) as the national terminology for reporting dental services and is recognized by third-party payers nationwide." CDT 2011-2012 Introduction, page i.
    ii. Contracts, plan designs and benefit determinations are based upon the CDT procedure codes, not Brand Names
2. **Benefit determination protocols utilized by LIBERYT's licensed Staff Dentists:**
    i. Verify what procedure(s) a provider is recommending, regardless of any submitted Brand Name
    ii. Apply the most accurate CDT code(s) to describe the verified procedure(s)
    iii. Refer to the specific, applicable plan design to determine if the verified procedure:
        a. Is listed as covered
        b. Considered a type of upgrade comparted to the based covered procedure
        c. Is not covered at all
3. **It is the responsibility of the provider to complete an adequate/accurate informed consent/financial disclosure process including:**
    i. Benefits - the procedure code(s) for the member's basic benefit(s)
    ii. Alternatives – the procedure code(s) for any recommended alternate/upgraded service and the member's responsibility based on the application of the alternative treatment formula
    iii. Risks – the risks of treatment as well as the risks of doing nothing

F. **Post and core procedures include buildups**
   1. "D2952 post and core in addition to crown, indirectly fabricated post and core are custom fabricated as a single unit."
   2. "D2954 prefabricated post and core in addition to crown core is built around a prefabricated post. This procedure includes the core material." CDT 2022, page 20.
   3. By CDT definitions, each of these procedures includes a "core." Providers may not unbundle procedure D2950 core buildup, including any pins and report it separately from either of these procedures for the same tooth during the same course of treatment.

G. **Outcomes**
   1. Margins, contours, and contacts must be clinically acceptable
   2. Prognosis should be good for a minimum of 5 years

Fixed Bridges

A. When a single posterior tooth is missing on one side of an arch and there are clinically acceptable abutment teeth on each side of the missing tooth, the general choice to replace the missing tooth would be a fixed bridge or implant.

B. If it is also necessary to replace teeth on the opposite side of the same arch, the benefit would generally be a removable partial denture instead of the fixed bridge.

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

D. 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 may will be evaluated on a case-by-case basis.
   1. Evaluation and diagnosis of any patient's periodontal status or active disease should be documented with recent full mouth periodontal probing and then submitted for any benefit determination request.

E. Bridge abutments would generally be full coverage crowns.

F. A distal cantilevered pontic is not inappropriate for the replacement of a missing posterior tooth. However, a mesial cantilevered pontic but may be acceptable for the replacement of a maxillary lateral incisor when an adequate adjacent cuspid can be used for the abutment crown.

G. Third molars should generally not be replaced, particularly if the replacement would not be functional.

H. **Outcomes**

1. Margins, contours and contacts should be clinically acceptable
2. Prognosis should be good for long term longevity

REMOVABLE PROSTHODONTICS

A. Please reference the MOC for removable prosthodontics criteria, process, and benefits for Medi-Cal Dental members: https://www.dental.dhcs.ca.gov/MCD_documents/providers/quick_reference_for_denti-cal_dentists.pdf

1. **Note: Providers may report the dates of service for these procedures to be the dates when these removable appliances are actually delivered, subject to review**.

B. **Partial Dentures**

1. A removable partial denture is normally not indicated for a single tooth replacement of non-functional second or third molars.
2. Partial dentures may be covered when posterior teeth require replacement on both sides of the same arch.
3. Full or partial dentures may not be covered for replacement if an existing appliance can be made satisfactory by relining or repair.
4. Full or partial dentures may not be covered if a clinical evaluation reveals the presence of a satisfactory appliance, even if a patient demands replacement due to their own perceived functional and/or cosmetic problems.
5. Unilateral removable partial dentures are rarely appropriate, as they may be readily swallowed or inhaled into a patient's lungs.
6. Abutment teeth should be restored prior to the fabrication of a removable appliance and may be covered if such teeth meet the same standalone benefit requirements of a single crown.
7. Partials should be designed to minimize any harm to the remaining natural teeth.
8. Materials used for removable partial dentures should be strong enough to resist breakage during normal function, non-porous, color stable, esthetically pleasing, non-toxic and non-abrading to the opposing or supporting dentition.
9. Appliances should be designed to minimize any harm to abutment teeth and/or periodontal tissues, and to facilitate oral hygiene.
10. Flexible partial dentures (D5225/D5226) include the following brands: Valplast, Thermoflex, Flexite, etc.

11. **Combo Partial Dentures** – because these appliances may include cast metals, they would beappropriately reported as D5213/D5214.

C. **Complete Dentures**

1. Complete dentures are the appliances of last resort, particularly in the mandibular arch. Patients should be fully informed of their significant limitations.
2. Establishing vertical dimension is considered to be a part of and included in the fee/process for fabricating a complete denture (standard, interim or immediate). Benefits for a complete denture are not limited or excluded in any way simply because of the necessity to establish vertical dimension.

D. **Interim Complete Dentures**

1. These appliances are only intended to replace teeth during the healing period, prior to fabrication of a subsequent, covered complete denture.

E. **Immediate Complete Dentures**

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. The reason for such relining is that the shape of the supporting soft tissues and bone changes significantly during healing, causing the denture to become loose.
2. In many cases, immediate dentures may need to be discarded and replaced with non-covered (limitation) complete dentures within the first six months.

F. **Repairs and Relines**

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

IMPLANTS

A. Please reference the MOC for implant and implant related services criteria, process, and benefits for Medi-Cal Dental members: https://www.dental.dhcs.ca.gov/MCD_documents/providers/quick_reference_for_denti-cal_dentists.pdf

B. **General Guidelines**

1. A thorough history and clinical examination leading to the evaluation of the member's general health and diagnosis of his/her oral condition must be completed prior to the establishment of an appropriate treatment plan.
2. 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:
    i. Adverse systemic factors such as diabetes and smoking
    ii. Poor oral hygiene and tissue management by the patient
    iii. Inadequate osseo-integration (movable) of the dental implant(s)
    iv. Excessive parafunction or occlusal loading
    v. Poor positioning of the dental implant(s)
    vi. Excessive loss of bone around the implant prior to its restoration
    vii. Mobility of the implant(s) prior to placement of the prosthesis
    viii. Inadequate number of implants or poor bone quality for long span prostheses
    ix. Need to restore the appearance of gingival tissues in high esthetic areas
    x. When the patient is under 16 years of age, unless unusual conditions prevail

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.

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 member.

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 prosthesis 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.
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.
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 member in the proper care and maintenance of the implant system and to evaluate the member'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 prognosis for 5-years of service.

SECTION 11. SPECIALTY CARE REFERRAL GUIDELINES

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.

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

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

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
- **Telephone**: 800-268-9012, Press Option 2
- **Mail:** LIBERTY Dental Plan, Attn: Referral Department, P.O. Box 26110, Santa Ana, CA 92799-6110

- If there is no contracted LIBERTY specialist available within a reasonable proximity to your office, the Referral Unit will provide assistance to refer the member to a non-contracted Specialist.
- If a referral is made to a non-LIBERTY specialist by the members assigned General Dentist without prior approval, the referring office may be held financially responsible for any additional costs.

Failure to use the proper forms and submit accurate information may cause delays in processingor payment of claims. The referral form can be found on the LIBERTY website at https://libertydentalplan-qa.azurewebsites.net/Providers/Provider-Resource-Library.aspx.

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. The Specialty Care Referral Request Form can be found on the LIBERTY website at https://libertydentalplan-qa.azurewebsites.net/Providers/Provider-Resource-Library.aspx.

X-ray(s) and other supporting documentation will not be returned. Please do not submit original x-ray(s). 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 **800-268-9012**, Option 2 **(TTY 877-855-8039)**.

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 following:

- 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.

Inform the member that:

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

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

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

- The LIBERTY's licensed Staff Dentist will review referral to ensure requested procedures meet referralguidelines and plan benefits.

REFERRAL GUIDELINES FOR THE ENDODONTIST:

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

- For any services, other than those listed on the original authorization form from LIBERTY, you must submit a pre-estimate 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 **800-268-9012**, **Option 2 for an emergency authorization number.**

After completion of treatment, submit your claim for payment with pre-operative and post-operative periapical x-ray(s). (To avoid delays in claim payment, please always attach a copy of the member's Authorization Form.)

X-ray(s) and other supporting documentation will not be returned. Please do not submit original x-ray(S). X-ray copies of diagnostic quality or paper copies of digitized images, are acceptable.

The following page provides an outline of LIBERTY's endodontic referral guidelines. Some procedures listed below are not usually approved for specialty referral care.

Emergency referrals are available in the presence of swelling, bleeding and/or pain and the General Dentist has attempted palliative treatment. If and emergency referral is required contact LIBERTY's Referral Unit at **800-268-9012**, **Option 2 for an emergency authorization number.**

Teeth must have a good prognosis and be restorable to meet the following criteria:

Endodontic Referral General Dentist/Specialty Care Guidelines (subject to plan benefits)					
Procedures		**Approved For Referral?**	**Criteria**	**ER Referral Criteria**	**Qualifies for ER Referral?**
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	Excessive root curvature or calcification evident on x-rays.		Extraordinary circumstances considered on a case-by-case basis
D3320	Root canal – bicuspid (excluding final restoration)	No			
D3321	Pulpal Debridement	No	Only a benefit for General Dentists who refer to an Endodontist to continue treatment		No
D3330	Root canal - molar (excluding final restoration)	Yes	General Dentist documents procedure to be "outside the scope" of his or her skills		Yes
D3331	Treatment of root canal obstruction; non-surgicalaccess	No	Claims for this procedure evaluated on a case-by-case		No

Endodontic Referral General Dentist/Specialty Care Guidelines (subject to plan benefits)					
Procedures		**Approved For Referral?**	**Criteria**	**ER Referral Criteria**	**Qualifies for Emergency Referral?**
D3332	Incomplete endodontic therapy; inoperable, non-restorable or fractured tooth	No	Not applicable	Swelling, bleeding and/or pain and the General Dentist has attempted palliative treatment	No
D3333	Internal root repair ofperforation defects	Yes*	Case-By-Case		Yes
D3346	Retreatment of previous root canal therapy - anterior	Yes			Yes
D3347	Retreatment of previousroot 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 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			

Endodontic Referral General Dentist/Specialty Care Guidelines (subject to plan benefits)					
Procedures		Approved For Referral?	Criteria	ER Referral Criteria	Qualifies for Emergency Referral?
D3450	Root Amputation - per root	Yes	Case-By-Case	Swelling, bleeding and/or pain and the General Dentist has attempted palliative treatment	Extraordinary circumstances on a case-by-case basis
D3910	Surgical procedure for isolation of tooth with rubberdam	No			
D3920	Hemisection (including any root removal), not includingroot 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

***referrals may be approved by report**

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 following:

- 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:

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

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

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

- The Plan Staff Dentist will review referral to ensure requested procedures meet referral guidelines and plan benefits.

REFERAL GUIDELINES FOR THE ORAL SURGEON:

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

- For any services, other than those listed on the referral from the patient's General Dentist, you must submit a preauthorization request to the Plan with a copy of pre-operative periapical radiograph(s) or panoramic radiograph and of the member's LIBERTY Specialty Care Authorization.
- If an emergency oral surgery service is needed but has not been listed by the General Dentist onthe LIBERTY Specialty Care Authorization, the Oral Surgeon should contact LIBERTY's Referral Unit at **800-268-9012**, **Option 2 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 documentationwill not be returned. Please do not submit original X-rays. X-ray copies of diagnostic quality or paper copies of digitized images are acceptable.**

The following page provides an outline of LIBERTY's oral surgery guidelines. Some procedures listed below are not usually approved for specialty referral care.

Emergency referrals are available in the presence of swelling, bleeding and/or pain and the General Dentist has attempted palliative treatment. If and emergency referral is required contact LIBERTY's Referral Unit at **800-268-9012**, **Option 2 for an emergency authorization number.**

Teeth must exhibit active pathology and be outside the scope of the General Dentist to meet the following criteria:

Oral Surgery Referral General Dentist/Specialty Care Guidelines (subject to plan benefits)					
Procedures		**Approved For Referral?**	**Criteria**	**ER Referral Criteria**	**Qualified for ER Referral?**
D0220	Intraoral - periapical first film	Yes*	Non-diagnostic x-rays sent by referring dentist	Swelling, bleeding and/or pain and the General Dentist has attempted palliative treatment	Yes*
D0330	Panoramic film	Yes*	Non-diagnostic x-ray(s) sent by referring dentist		Yes*
D7111	Extraction, coronal remnants - deciduous tooth	No	Not applicable		No
D7210	Surgical removal of erupted tooth requiring elevation of mucoperiosteal flap & removal of bone and/orsection of tooth	Yes*	Five (5) or more teeth to be extracted		Yes*
D7220	Removal of impacted tooth - soft tissue	Yes	Most plans only allow benefit with documented active pathology		Yes
D7230	Removal of impacted tooth - partially bony	Yes			Yes
D7240	Removal of impacted tooth - completely bony	Yes			Yes
D7241	Removal of impacted tooth - completely bony, with unusual surgical complications	Yes			Yes

Oral Surgery Referral General Dentist/Specialty Care Guidelines (subject to plan benefits)					
Procedures		**Approved For Referral?**	**Criteria**	**ER Referral Criteria**	**Qualified for ER Referral?**
D7250	Surgical removal of residual tooth roots (cutting procedure)	Yes*	X-ray must support the use of this code	Swelling, bleeding and/or pain and the General Dentist has attempted palliative treatment	Yes
D7280	Surgical access of an unerupted tooth	Yes			Yes
D7282	Mobilization of erupted or malpositioned tooth to aid eruption	Yes	Not covered under most plans		Yes
D7283	Placement of device to facilitate eruption of impacted tooth	Yes			Yes
D7285	Biopsy of oral tissue – hard (bone, tooth)	Yes			Yes
D7286	Biopsy of oral tissue - soft	Yes			Yes
D7310	Alveoloplasty in conjunction with extractions - 4 or more teeth or tooth spaces, per quadrant	Yes*	May be included in multiple surgical extractions		Yes
D7311	Alveoloplasty in conjunction with extractions - 1 to 3 teeth or tooth spaces, per quadrant	Yes*			Yes

Oral Surgery Referral General Dentist/Specialty Care Guidelines (subject to plan benefits)					
Procedures		**Approved For Referral?**	**Criteria**	**ER Referral Criteria**	**Qualified for ER Referral?**
D7320	Alveoloplasty not in conjunction with extractions - 4 or more teeth or tooth spaces, per quadrant	Yes*	Yes*	Swelling, bleeding and/or pain and the General Dentist has attempted palliative treatment	Yes
D7321	Alveoloplasty not in conjunction with extractions 1 to 3 teeth or tooth spaces, per quadrant	Yes*	Yes*		Yes
D7471	Removal of lateral exostosis (maxilla or mandible)	Yes	Yes*		Yes
D7960	Frenulectomy (frenectomy or frenotomy) - separate procedure	Yes	Yes*		Yes
D7970	Excision of hyperplastic tissue - per arch	Yes	Yes*		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

***referrals may be approved by report**

ORTHODONTICS

Referral Guidelines for the General Dentist:

Confirm the need for a referral and that the Referral Criteria listed below are met. Complete a LIBERTY Specialty Care Authorization and provide the:

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

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

Contact the Plan's Membership Service department at 800-268-9012 to obtain member's copayments and plan-specific benefits, limitations, and exclusions for:

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

After the pre-treatment visit, arrangements for initial records should be made. If the patient requires further general dentistry prior to banding, refer them back to the assigned General Dentist. After patient is banded, submit your claim to the Plan for payment*.

- *Net payable claim amounts in excess of $300.00 will be paid over the period of active orthodontic treatment over 24 months.

Please reference the Orthodontic General Policies (D8000-D8999) in Section 5. Manual of Criteria and Schedule of Maximum Allowance for more information on the orthodontic treatment criteria for Medi-Cal Dental members.

The following provides an outline of LIBERTY's orthodontic guidelines. Some procedures listed below are not usually approved for specialty referral care.

Orthodontic Referral General Dentist/Specialty Care Guidelines (subject to plan benefits)			
Procedures		**Approved For Referral?**	**Referral Criteria**
D8010	Limited orthodontic treatment of the primary dentition	Yes	General Dentist feels orthodontic treatment may be appropriate for patient. Specific criteria must be met to allow orthodontic benefits for some plans.
D8020	Limited orthodontic treatment of the transitional dentition	Yes	
D8030	Limited orthodontic treatment of the adolescent dentition	Yes	
D8040	Limited orthodontic treatment of the adult dentition	Yes	
D8050	Interceptive orthodontictreatment of the primary dentition	Yes	
D8060	Interceptive orthodontic treatment of the transitional dentition	Yes	
D8070	Comprehensive orthodontic treatment of the transitional dentition	Yes	
D8080	Comprehensive orthodontic treatment of the adolescent dentition	Yes	
D8090	Comprehensive orthodontic treatment of the adult dentition	Yes	
D8210	Removable appliance therapy	Yes	
D8220	Fixed appliance therapy	Yes	
D8660	Pre-orthodontic treatment visit	Yes	
D8670	Periodic orthodontic treatment visit (as part of contract)	Yes	
D8680	Orthodontic retention (removal of appliances, construction and placement of retainer(s) - to age 18	Yes	
D8690	Orthodontic treatment (alternative billing to a contractfee)	Yes	
D8691	Repair of orthodontic appliance	Yes	
D8692	Replacement of lost or broken retainer	Yes	

Orthodontic Referral General Dentist/Specialty Care Guidelines (subject to plan benefits)			
Procedures		**Approved For Referral?**	**Referral Criteria**
D8693	Rebonding or recementing; and/or repair, as required, of fixed retainers	Yes	
D0210	Intraoral - complete series	Yes	
D0330	Panoramic Film	Yes	Not Applicable
D0340	Cephalometric Film	Yes	
D0350	Oral / facial photographicmages	Yes	
D0470	Diagnostic casts	Yes	

PEDIATRIC DENTISTRY

Referral Guidelines for the General Dentist:

Confirm the need for a referral and that the Referral Criteria listed below are met. Complete a Specialty Care Authorization and provide the following:

- Patient's name, the Primary Member's name, LIBERTY identification number, group name and group number
- Name, address and telephone number of the contracted LIBERTY network Pediatric Dentist
- Procedure code, tooth number/quadrant and member copayments for each service, which requires referral. **If the General Dentist is unable to perform an adequate examination due to limited patient cooperation, the procedure codes for an examination and x-ray(s) should be listed**.

Inform the member that:

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

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

For non-emergency referrals, submit referral to LIBERTY with appropriate documentation/x-rays through i-Transact or via standard mail service. The Plan Staff Dentist will review the referral to ensure requested procedures meet referral guidelines and plan benefits.

Referral Guidelines for the Pediatric Dentist:
Obtain the LIBERTY Specialty Care Authorization and appropriate radiograph(s) from LIBERTY, General Dentist or member.

For any services, other than those listed on the referral from the patient's assigned General Dentist, you must submit a pre-estimate 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 pediatric service is needed but has not been listed by the General Dentist on the LIBERTY Specialty Care Authorization, the Pediatric Dentist should contact the LIBERTY's **Referral Unit** at **800-268-9012**, Option 2 for an emergency authorization number.

After completion of treatment, submit your claim for payment with pre and post periapical x-ray(s). To avoid delays in claim payment, please always attach a copy of the LIBERTY Specialty Care Authorization or the Plan's authorization for treatment when applicable.

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

The following page provides an outline of LIBERTY's pediatric referral guidelines. Some procedures listed below are not usually approved for specialty referral care.

Emergency referrals are available in the presence of swelling, bleeding and/or pain and the General Dentist has attempted palliative treatment. If and emergency referral is required contact LIBERTY's Referral Unit at **800-268-9012**, **Option 2 for an emergency authorization number.**

General dentists must make at least one attempt to see children ages 0-4 and at least two attempts for children ages 4-7.

Pediatric Referral General Dentist Specialty Care Guidelines (subject to plan benefits)					
Procedures		**Approved For Referral?**	**Criteria**	**ER Referral Criteria**	**Qualifies for Emergency Referral?**
D0145	Oral evaluation for a patient under 3 years of age	Yes	Pediatric Referrals are limited to Children under the age of 7, under some plans, unless the child qualifies under Americans with Disabilities Act "ADA"	Swelling, bleeding and/or pain and the General Dentist has attempted palliative treatment	Yes
D0150	Comp oral evaluation – new or established patient	Yes			Yes
D0210	Intraoral - complete series	Yes			No
D0220	Intraoral - periapical first film	Yes			Yes
D0230	Intraoral - periapical each additional film	Yes			Yes
D1120	Prophylaxis – child	Yes			Yes
D1203	Topical application of fluoride –child	Yes			Yes
D3110	Pulp Cap – direct	Yes			Yes
D3120	Pulp Cap – indirect	Yes			Yes
D3220	Therapeutic pulpotomy	Yes			Yes

Pediatric Referral General Dentist Specialty Care Guidelines (subject to plan benefits)					
Procedures		**Approved For Referral?**	**Criteria**	**ER Referral Criteria**	**Qualifies for Emergency Referral?**
D3221	Pulpal debridement primary and permanent teeth	Yes	Pediatric Referrals are limited to Children under the age of 7, under some plans, unless the child qualifies under Americans with Disabilities Act "ADA"	Swelling, bleeding and/or pain and the General Dentist has attempted palliative treatment	Yes
D3230	Pulpal therapy - anteriorprimary tooth	Yes			Yes
D3240	Pulpal therapy - posteriorprimary tooth	Yes			Yes
D7140	Extraction erupted tooth or exposed root	Yes			Yes
D9310	Consultation - diagnostic service provided by dentist or physician other than requesting dentist or physician	Yes			Yes

PERIODONTICS

Referral Guidelines for the General Dentist:

Confirm the need for a referral and that the Referral Criteria listed below are met. Complete a LIBERTY Specialty Care Authorization and provide the following:

- 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:

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

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

Submit referral to LIBERTY with appropriate documentation/x-rays through i-Transact or via standard mail service. The Plan's Staff Dentist will review referral to ensure requested procedures meet referral guidelines and plan benefits.

Referral Guidelines for the Periodontist:

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

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

- Pre-operative x-ray(s)
- 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.

The following page provides an outline of LIBERTY's periodontal referral guidelines. Some procedures listed below are not usually approved for specialty referral care.

The below provides an outline of LIBERTY's periodontal referral guidelines. General Dentist is required to complete non-surgical services and necessary follow-up evaluations.

Periodontal Referral General Dentist Specialty Care Guidelines (subject to plan benefits)				
Procedure code		**Usually Approved For Referral?**	**Criteria**	**Records to be sent to LIBERTY and specialist**
D0180	Comprehensive periodontal evaluation	Yes	Patients must exhibits good motivation and oral hygiene habits	Diagnostic full mouth x-rays & full mouth periodontal probings
D0210	Intraoral - complete series (including bitewings)	No	Not applicable	Yes
D4210	Gingivectomy or gingivoplasty - 4 or more contiguous teeth or bounded teeth spaces per quadrant	Yes*	Diagnostic full mouthx-rays & full mouth periodontal probings	Diagnostic full mouth x-rays & full mouth periodontal probings
D4211	Gingivectomy or gingivoplasty - 1 to 3 contiguous teeth or bounded teeth spaces per quadrant	Yes*		
D4240	Gingival flap procedure, including root planing - 4 or morecontiguous teeth or bounded teeth spaces per quadrant	Yes*		
D4241	Gingival flap procedure, including root planing - 1 to 3 contiguous teeth or bounded teeth spaces per quadrant	Yes*		
D4245	Apically positioned flap	Yes*		

Periodontal Referral General Dentist Specialty Care Guidelines (subject to plan benefits)				
Procedure code		**Usually Approved For Referral?**	**Criteria**	**Records needed by LIBERTY and Specialist**
D4249	Clinical crown lengthening - hard tissue	Yes*	PA x-ray confirms necessity to retain a crown on a restorable tooth	PA x-ray showing entire root
D4260	Osseous surgery (including flap entry & closure) - 4 or more contiguous teeth or bounded teeth spaces per quadrant	Yes*	Some plans limited to no more than two quadrants on the same date of service	Full Mouth x-rays, Full mouth periodontal probing's, dates of periodontal scaling/root planing and follow-up exam
D4261	Osseous surgery (including flap entry & closure) - 1 to 3 contiguous teeth or bounded teeth spaces per quadrant	Yes*	Yes*	
D4264	Bone replacement graft - each additional site in quadrant	Yes*	Yes*	
D4270	Pedicle soft tissue graft procedure	Yes*	Most plans do not benefit this procedure	
D4271	Free soft tissue graft procedure (including donor site surgery)	Yes*	Yes*	

Periodontal Referral General Dentist Specialty Care Guidelines (subject to plan benefits)				
Procedure code		**Approved For Referral?**	**Criteria**	**Records needed by LIBERTY and Specialist**
D4274	Distal or proximal wedge procedure (when not performed in conjunction with surgical procedures in the same anatomical area)	Yes*	Yes*	Some plan limit to no more than two quadrants on the same date of service
D4341	Periodontal scaling & root planing - 4 or more teeth per quadrant	No	Moderate to severe periodontitis, "may" be considered for referral	
D4342	Periodontal scaling & root planing - 1 to 3 teeth per quadrant			
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	Yes*

***referrals may be approved by report**

PERIODONTICS GUIDELINES

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.

A. **Referral Coverage Based on Diagnosis** Gingivitis associates with dental plaque
   1. Sulcus depths of 1 – 3 mm with the possibility of an occasional 4 mm pseudopocket.
   2. Some bleeding upon probing; and
   3. 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).

B. Slight Chronic/Aggressive Periodontitis (localized or generalized)

1. 4 - 5 mm pockets and possibly an occasional 6 mm pocket with 1 - 2 mm of clinical attachment loss.
2. Moderate bleeding upon probing, which is more generalized than in gingivitis.
3. Normal tooth mobility with possibly some Class 1 (0.5 mm - 1.0 mm) mobility.
4. No furcation involvement or an isolated Grade 1 involvement (i.e., can probe into the concavity of a root trunk); and
5. Radiographic evidence of localized loss crestal lamina dura and early to very moderate (10% - 20%) bone loss, which is usually localized.

C. Moderate Chronic/Aggressive Periodontitis, (localized or generalized)

1. Pocket depths of 4 – 6 mm with the possibility of localized greater pocket depths with 3 - 4 mm of clinical attachment loss
2. Generalized bleeding upon probing
3. Possible Class 1 to Class 2 (1 – 2 mm) tooth mobility
4. Class I furcation involvement with the possibility of some early Class II (i.e., can probe between the roots); and
5. Radiographic evidence of moderate (20%-40%) bone loss, which is usually horizontal in nature
6. Referral to a Periodontist covered for a problem-focused examination and possible periodontal surgery
7. Moderate Chronic/Aggressive Periodontitis is eligible for direct specialty referral
8. Referral to a Periodontist covered, after scaling and root planing by the assigned General Dentist, for a problem-focused examination and possible periodontal surgery.

D. Severe Chronic/Aggressive Periodontitis (localized or generalized)

1. Pocket depths are generally greater than 6 mm with 5 mm or greater clinical attachment loss.
2. Generalized bleeding upon probing.
3. Possible Class 1, Class 2 or Class 3 (>2 mm or depressibility) tooth mobility.
4. Grades I and II furcation involvements with possibly Grade III involvement (i.e., "through and through" access between the roots); and
5. Radiographic evidence of severe (over 40%) bone loss, which may be horizontal and vertical in nature.
6. Severe Chronic/Aggressive Periodontitis is eligible for direct specialty referral.

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

E. <u>Refractory Chronic/Aggressive Periodontitis</u>

1. 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
2. Refractory Chronic/Aggressive Periodontitis is eligible for direct specialty referral
3. Referral to a Periodontist covered to confirm the diagnosis of Refractory Chronic/Aggressive Periodontitis and to advise you on the patient's management and care.

PROSTHODONTIST

Referrals for this type of specialist are typically not covered under LIBERTY's benefits plans.

SECTION 12. QUALITY MANAGEMENT

PROGRAM DESCRIPTION

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

QMI PROGRAM POLICY

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

QMI PROGRAM SCOPE

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

QMI PROGRAM GOALS AND OBJECTIVES

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

The process may include:

- Standards and criteria development
- Problem and trend identification and assessment
- Development and implementation of QMI Program studies, performance, measuring, monitoring and member/provider surveys.
- Credentialing and Recredentialing of providers
- Monitoring of dental office staff and provider performance
- Infection control monitoring
- Facility review audits
- Dental chart audits
- Utilization management and monitoring of over- and under-utilization
- Monitoring of member and provider grievance/appeals and follow-up
- Disenrollment, enrollment, and primary care dentist transfer request tracking
- Provider/member education
- Staff orientation
- Corrective action plan development, implementation and monitoring effectiveness, including disciplinary actions and terminations of any provider for serious quality deficiencies, and reporting the same to the appropriate authorities.
- Other QMI Program activities identified during monitoring process

COMMITTEES

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

- Quality Management & Improvement Committee
- Credentialing Committee
- Access & Availability Committee
- Peer Review Committee
- Utilization Management Committee
- Grievances and Appeals Committee

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

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

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

Dentists are recredentialed on a 3 year cycle and as needed. 60 days before the provider's assigned recredentialing date, the dentist will receive a written request to submit required documents to LIBERTY's Credentialing Verification Organization (CVO). If the dentist does not respond, a report is generated by the CVO for LIBERTY to assist in obtaining the missing or expired information. Failure to comply with recredentialing requests will result in termination from the network.

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

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

The PRC is responsible for:

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

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

- The UMC evaluates a summary of treatment provided by the entire contracted General Dentist network. The analysis is intended to provide an indication of the numbers of members seeking treatment and the types of treatment they receive. Further evaluation of specific provider offices allows a determination of how those offices compare to the overall experience of the entire network and how individual provider offices compare to the established network standards.
- The Dental Director assesses over- and under-utilization of specialty referral trends and reports the findings to the UMC. From these reports, the UMC can also monitor trends in specialty referral denials and make recommendations to the QMI Committee.
- The UMC also reviews access and availability and continuity of care issues by the reviewing reports of appointment availability, wait times, and the number of actual appointments kept by the members. This will also include evaluation of the number and location of the general and specialty dentist providers. The UMC addresses negative trends in these areas and makes recommendations for improvements that are forwarded to the QMI Committee.

The Grievances and Appeals Committee (G&A) reviews member and provider grievances, appeals, and disputes. The member grievances and appeals process encompass investigation, review, and resolution of member issues associated with LIBERTY and/or contracted providers. The G&A committee accepts issues via telephone, fax, e-mail, letter, or member grievances and appeals form.

- All member grievances, including but not limited to, quality of care concerns, benefit complaints, and appeals are received and processed by the G&A Committee and are not delegated to any other provider group.
- LIBERTY's G&A Analysts records and reviews all member issues involving potential complaints, G&A appeals and is responsible for the collection of all necessary and appropriate documentation needed to reach a fair and accurate resolution. Any issue relating to technical quality of dentistry rendered by a network provider is reviewed by a dentist member of the PRC.
    - In order to identify systemic deficiencies, the G&A Analyst completes the case investigation and then a G&A history review is performed. If there are two or more complaints of a similar nature in a 6 month period, the provider is referred to the G&A Committee for review. If the G&A Committee determines that a corrective action plan is necessary, it will be referred to the Dental Director for implementation.
- The G&A Committee also monitors patterns of disputes and makes recommendations to the Dental Director regarding a doctor, member or group. The G&A Committee will meet on a quarterly basis or more frequently if problems have been identified. Quarterly reports on member complaints, grievances, and appeal activities are made to the Dental Director.
- Providers may register a complaint in writing to LIBERTY Dental's G&A Department. The complaint should include any supporting documentation that may help yield a satisfactory resolution. Issues relating to contracted or formerly contracted providers who believe they have been adversely impacted by the policies, procedures, decisions, or actions of LIBERTY may also be submitted to the G&A Grievance Committee notifies the Provider Relations Department which handles all provider disputes and in turn will log them in and process them according to plan policy.
    - LIBERTY will respond in writing within 45 business days of receipt of all information necessary to make a fair and accurate decision. Both providers and members may appeal any resolutions made by LIBERTY.
- All appeals are logged and monitored for timely and adequate resolution. An appeal is considered to be a type of complaint and handled with the same procedures as with grievance resolutions.

SURVEYS:

A. **Provider Access Surveys:**
   - For all Provider offices, LIBERTY conducts quarterly random office contacts to assess availability of appointments.

B. **Member Satisfaction Surveys:**
   - Surveys can be generated to members in response to trending information or reports or potential access problems with specific dental offices.

GRIEVANCES AND APPEALS (G&A) SYSTEM:

The G&A Committee reports the summary of the quarterly findings of access issues reported through member grievances, complaints and office transfers to alternate facilities.

The PRC reviews member G&A related to LIBERTY, provider, or benefits. The PRC is responsible for hearing and resolving G&A by monitoring patterns or trends in order to formulate policy changes and generate recommendations as needed.

CORRECTIVE ACTION PLANS

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

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

PROVIDER QMI PROGRAM RESPONSIBILITIES

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

CREDENTIALING/RECREDENTIALING

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

- Current State dental license for each participating dentist
- Current DEA license (does not apply to Orthodontists)
- Current evidence of malpractice insurance for at least one million ($1,000,000) per incident and three million ($3,000,000) annual aggregate for each participating dentist
- Current certificate of a recognized training residency program with completion (forspecialists)
- Current permit of general anesthesia or conscious oral sedation, if administered, for the appropriate dentist.
- Immediate notification of any professional liability claims, suits, or disciplinary actions
- Verification is made by referencing the State Dental Board and National Practitioner Data Bank.

All provider credentials are continually monitored and updated on an on-going basis. Providers will receive notification of license/credential expiration from LIBERTY's delegated Certified Verification Organization (CVO), 60 days prior to expiration to allow time to submit current copies.

RECORDS REVIEW

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

- **Chart Selection**: A minimum of 10 randomly selected patient charts will be reviewed.

MEMBER GRIEVANCES AND APPEALS (G&A)

The LIBERTY member G&A process encompasses investigation, review, and resolution of member issues to LIBERTY and/or contracted providers. As part of our commitment, LIBERTY works to ensure that all members have every opportunity to exercise their rights to a fair and timely resolution to any G&A.

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

G&A RECORDS REQUESTS

Providers are **contractually required** to provide LIBERTY with copies of all member records as a result of a member G&A within 3 business days of a request from the Plan.

All providers are obligated to respond to LIBERTY with a written response to the member's concerns, and all supporting documentation (clinical notes, treatment plans, financial ledgers, x-ray(s, etc.)

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

G&A CULTURAL AND LINGUISTICS

LIBERTY's G&A system also addresses the linguistic and cultural needs of its members as well as the needs of members with disabilities. The system is designed to ensure that all Plan members have access to and can fully participate in the G&A system. LIBERTY's members' participation in the G&A system, for those with linguistic, cultural or communicative impairments, is facilitated through LIBERTY's coordination of translation, interpretation and other communication services to assist in communicating the procedures, process and findings of the G&A system.

LIBERTY provides members whose primary languageis not English with translation services. We currently provide translation services in 150 languages. G&A forms can be obtained from LIBERTY's Member Services Department, from a dental provider facility, or from the LIBERTY website.

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

- The receipt of correspondence from members, in writing or by telephone
- Thorough research
- Member education on plan provisions
- Timely resolution

G&A RESOLUTION

Please see **Section 5. California Medi-Cal Dental Program** for more information on the Medicaid G&A process.

LIBERTY resolves all member G&A within the following timeframes:

- **Acknowledgement**: LIBERTY mails written notification of the receipt of the G&A to the member and provider within 5 business days of receipt.
- **Expedited/Fast Track**: Cases in which a member or provider on behalf of a member feels their health would be harmed by waiting for the standard resolution timeframe, can request an "expedited/fast track review".
- In order for a member to qualify for an expedited review, the criteria must first be met. The expedited criteria includes, but is not limited to, severe pain, bleeding, swelling, and/or loss of bodily function.
- **Standard**: Case are resolved as expeditiously as the member's condition requires but no later than 30 calendar days from the date of receipt.
- **Extensions**: Members, providers on behalf of a member, or LIBERTY, if in the members best interest, may request a 14 calendar day extension on an Expedited or Standard appeal request.
    - Appeal extension requests by LIBERTY will include verbal and written notification of the extension to the member along with their right to file a grievance, if the member is not in agreement with the Plan's extension.
    - If LIBERTY does not make a decision within the additional 14 calendar days, the internal appeal process will be considered completed and the member will qualify for the next level in the appeal process.

COMMERICAL AND EXCHANGE MEMBER G&A

LIBERTY Commercial and Exchange business members have the right to file G&A for up to 180 calendar days following any incident, action, or decision made by LIBERTY that is subject of their dissatisfaction.

Members who qualify for expedited/fast track G&A, mentioned above, will receive a decision from LIBERTY, in writing, as follows:

- **Exchange** members will receive a response within 72 hours from time of receipt.
- **Commercial** members will receive a response within 3 calendar days from the date of receipt.

G&A SUBMISSION

Members, authorized representatives, and providers on behalf of members, can submit a grievance and/or appeal via telephone by calling LIBERTY's Member Services Department toll-free at (888) 703-6999, or by fax, email, letter, or grievance and appeals form.

- **Phone**: 888-703-6999/TTY: 877-855-8039
- **Electronically**: https://www.libertydentalplan.com/Legal/Grievances.aspx
- **Writing**: LIBERTY Dental Plan, Grievances and Appeals, PO Box 26110, Santa Ana, CA 92799-6110
- **Fax**: 1-833-250-1814

PROVIDER DISPUTE RESOLUTIONS (PDR)

As a LIBERTY contracted, or non-contracted provider, you have the right to challenge, appeal, dispute or request reconsideration of a claim (or a bundled group of substantially similar multiple claims that are individually numbered), or a decision made by LIBERTY.

LIBERTY will resolve any request for appeal, dispute, or reconsideration submitted for a pre-estimate or on behalf of a member through LIBERTY's Member G&A Process. A request for an appeal, dispute, or reconsideration submitted for a pre-estimate or on behalf of a member will **not** be resolved through LIBERTY's PDR Process.

Each PDR must contain, at a minimum, the following information:

- A summary of the appeal, dispute, or reconsideration request
- The provider's name and NPI
- The claim number and date of service under dispute
- The member's name and identification number
- Reason why the initial decision should be reversed
- The name and contact information of the person associated with the submitted request

All PDRS that are not associated with a claim must include a clear explanation of the issue and the provider's position on the issue. PDRs that do not include all required information may be returned to the submitter for completion. An amended PDR, which includes the missing information, may be submitted to LIBERTY within **30 business days** of your receipt of a returned contracted provider dispute. PDRs sent to LIBERTY must include the information listed above for each contracted provider dispute.

LIBERTY will accept, acknowledge, and resolved all PDRs as follows:

Provider Dispute Resolution (PDR) Single Level			
Topic	**Non-Claim Complaints**	**Claim Complaints**	**Disputes (Appeals)**
Timely Filing Limitation	Within 365 calendar days from the date from the issue and/or denial issued by LIBERTY		
Amended Provider Disputes	Within 30 business days of receipt of a returned PDR missing information		
Standard Acknowledgement	Within 5 calendar days of receipt when received by mail		
Electronic Acknowledgement	Within 2 business days of receipt when received electronically		
Standard Resolution	Within 45 calendar days from the date of receipt		
Effectuation of payment	5 business days from the date of the resolution letter		

All contracted provider disputes must be sent the following address:

LIBERTY Dental Plan
Quality Management Department
P.O. Box 26110, Santa Ana, CA 92799-6110
Attn: Grievances and Appeals/PDR Department

CONTRACTED PDR INQURIES

All inquiries regarding the status of a contracted provider dispute or about filing a contracted provider dispute can be directed to the Member Services Department at: 800-268-9012 (TTY/TDD 877-855-8039).

SECTION 13. FRAUD, WASTE, AND ABUSE

LIBERTY 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.

Provider understands that LIBERTY is monitored by its Health Plan clients on an ongoing basis for performance of delegated activities and adherence to reporting requirements, including but notlimited to, for the purposes of identifying potential fraud, waste and abuse. Provider understands and agrees that it is likewise subject to such monitoring and that it shall comply with any related corrective action plans.

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

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

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 is defined as (but is not limited to): knowingly making or causing to be made any false or fraudulent claim for payment of a health care benefit program. Examples of fraud **may** include:

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

WASTE is defined as: the misuse of resources; the extravagant, careless or needless expenditure of health care benefits or services that result from deficient practices or decisions. Examples of waste **may** include:

- **Over-utilization of services**
- **Misuse of resources**

ABUSE is defined as: practices that, either directly or indirectly, result in unnecessary costs. Abuse includes any practice that is not consistent with the goals of providing patients with services that are medically necessary, meet professionally recognized standards, and are fairly priced: Examples of abuse **may** include:

- **Misusing codes on a claim,**
- **Charging excessively for services or supplies, and**
- **Billing for services that were not medically necessary**
- **Both fraud and abuse can expose providers to criminal and civil liability**

REPORTING

All suspected cases of FWA related to LIBERTY, including, but not limited to, Medicare and Medicaid, should be reported to LIBERTY's Special Investigation Unit. The caller will have the option of remaining anonymous.

LIBERTY's Special Investigation Unit
SIU Hotline: (888) 704-9833**Email:** hotline@libertydentalplan.com
Address: LIBERTY Dental Plan, Attn: Special Investigation Unit, P.O. Box 26110, Santa Ana, CA 92799-6110

and/or

The Department of Health Care Services
DHCS Medi-Cal Fraud Hotline: 800-822-6222
Email: stopmedicalfraud@dhcs.ca.gov
On-Line Complaint Form: https://apps.dhcs.ca.gov/AutoForm2/default.aspx?af=1828

and/or

U.S. Government Recovery Board Fraud Hotline: 877-392-3375
U.S. Mail: Recovery Accountability and Transparency BoardAttention: Hotline Operators P.O. Box 27545, Washington, D.C. 20038-7958
On-Line Complaint Form:
http://www.recovery.gov/Contact/ReportFraud/Pages/FWA.aspx

SECTION 14. ALTERNATIVE TREATMENT

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

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

Example:

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

***this does not include any upgraded treatment**

Upgraded Treatment

LIBERTY considers treatment to be an upgrade when similar, more expensive procedures are recommended using upgraded materials, and these similar procedures are not a benefit under the member's copayment schedule. When a member selects an upgraded treatment, they are responsible for the cost of the upgrades. Cost of upgraded materials should be the actual laboratory costs of such materials.

Example:

Benefit	Full Metal Crown (molar tooth)	$125.00	Member's copayment
Upgrade*	Porcelain	$75.00	Material upgrade
Upgrade*	High Noble Metal (gold)	$125.00	Material upgrade
Member's total financial responsibility		**$325.00**	

***Please refer to specific benefit plan designs for additional information**

SECTION 15. FORMS AND RESOURCES

Electronic forms are available for download from LIBERTY's Resource Library by visiting https://www.libertydentalplan.com/Providers/Provider-Resource-Library.aspx

- Select "California" from the drop-down menu
- Click "Continue" and then click on document

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

- Provider Portal (i-transact) registration
- Secure email portal access
- Annual Provider Compliance Training (mandatory)
- LIBERTY's Clinical Criteria and Guidelines
- Tele-Dentistry Resources
- Value-based Program information
- Directory Information Validation
- Americans with Disabilities Act (ADA) Survey

Accessible forms but are not limited to the following:

- ADA Claim Form
- Consent for Non-covered Treatment
- Electronic Funds Transfer (EFT)
- Informed Consent for Alternate Treatment
- Provider Dispute/Appeal Request Form
- Specialty Care Referral Form
- Written Member Grievance & Appeal Form
- Appointment of Representative Form