Florida Statewide Medicaid Managed Care Program

Provider Resource Guide

LIBERTY DENTAL PLAN®

Making members shine, one smile at a time™

www.libertydentalplan.com/FLMedicaid

Effective February 1, 2025

TABLE OF CONTENTS

Section 1. Liberty Dental Plan Information 3
Section 2. Provider Relations and Training 7
Section 3. Online Self-Service Tools 8
Section 4. Eligibility 9
Section 5. Claims and Billing 10
Section 6. Coordination of Benefits 16
Section 7. Professional Guidelines and Standards of Care 17
Section 8. Clinical Dentistry Guidelines and Practice Parameters 24
Section 9. Specialty Care Referral Guidelines Specialty Care Referral 53
Section 10. Process for Ambulatory Surgical Centers (ASC) and Hospital Call 62
Section 11. Quality Management 62
Section 12. Fraud, Waste and Abuse 66
Section 13. Florida Medicaid Program and Guidelines 78
Section 14. Forms and Guides 80
Section 15. Florida Medicaid Plan Benefits 83

Introduction

Welcome to LIBERTY Dental Plan's ("LIBERTY's") Medicaid network of Participating Providers for the Agency for Health Care Administration "AHCA" Medicaid Program. We are proud to maintain a broad network of qualified dental providers who offer both general and specialized treatment, guaranteeing widespread access to our enrollees. As an organization founded by a dentist, we understand the importance of ensuring excellent customer service and engagement of our providers in retaining the dentists in our network. LIBERTY's provider network has been developed to provide access to Dental Covered Services for Medicaid enrollees statewide (all regions). Our mission is to ensure access to high-quality primary and specialty dental care to all enrollees, regardless of where they reside in Florida. Our tenured Provider Relations Department engages in continuous provider education, assistance, and training. A provider-centric portal allows our providers to always be in touch with specific member information related to your practice.

This Provider Manual serves only as a summary of certain terms of the Provider Agreement between you (or the contracting dental office/facility) and LIBERTY, and additional terms and conditions of the Provider Agreement may apply. In the event of a conflict between a term of this Provider Manual and a term of the Provider Agreement, the term of the Provider Agreement shall control. You received a copy of the fully executed Provider Agreement when you joined LIBERTY's network or during orientation. However, you may also obtain a copy of the Provider Agreement at any time by submitting a request to flprinquiries@libertydentalplan.com, Dental Service Organizations (DSO) can submit a request to dsoupdates@libertydentalplan.com, or by contacting the Provider Relations Department at 833.276.0851.

Our Mission for the Medicaid Program and Medicaid Enrollees

LIBERTY's mission is to be the industry leader in improving access to quality oral health care services for the Florida Medicaid population. LIBERTY seeks to increase annual patient visits and improve the overall health of the Medicaid population through enrollee outreach and education. Our continued expansion is an outgrowth of our commitment to exceptional service and expertise in our industry while providing a positive, rewarding, and enjoyable professional relationship with our network providers, Medicaid enrollees and LIBERTY staff members.

Medicaid Program:

Medicaid is a crucial medical assistance program that provides access to healthcare for low-income families and individuals. It also supports elderly individuals and those with disabilities by covering expenses related to nursing facility care and other essential medical and long-term care services.

Statewide Medicaid Managed Care (SMMC) Program:

In Florida, Medicaid administration is managed by the Agency for Health Care Administration (Agency). The Agency implemented the Statewide Medicaid Managed Care (SMMC) program in 2014 to enhance and streamline Medicaid services. Through the SMMC program, most Medicaid recipients are enrolled in managed health plans. These plans are selected through a competitive procurement process and hold national accreditations, ensuring high standards of care.

The SMMC program consists of three main components:

- Long-Term Care (LTC) Program: Provides comprehensive services for individuals needing extended care, including both nursing home and home-based care.
- Managed Medical Assistance (MMA) Program: Delivers a broad spectrum of medical services to Medicaid beneficiaries, covering both routine and specialized healthcare needs.
- Dental Program: Offers dental care services, including preventive and restorative treatments, aimed at improving oral health outcomes for Medicaid recipients.

The Agency for Health Care Administration supervises the SMMC program, ensuring that Florida's Medicaid recipients receive effective and efficient care through these managed care components.

Provider Contact and Information Guide

LIBERTY provides a 24-hour help line to respond to requests for prior authorization. In addition, LIBERTY staff is available from 8 a.m. to 8 p.m. Monday through Friday to answer provider questions and respond to provider complaints, emergencies, and notifications.

After regular business hours the provider service line is answered by an automated system with the capability to provide callers with information about operating hours and instructions about how to verify enrollment for a member with an emergency or urgent medical condition. The requirement that LIBERTY provides information to providers about how to verify enrollment shall not be construed to mean that the provider must obtain verification before providing emergency services and care.

Please reference the following page for LIBERTY contact guide information.

IMPORTANT PHONE NUMBERS	GENERAL INFORMATION
CALL: 833.276.0851 • Eligibility & Benefits • Claims • Prior Authorization • Referrals • Request Materials • General Information	Hours: Monday - Friday 8:00 a.m. - 8:00 p.m. (EST) Online: Liberty Dental Plan- Click Here Mailing Address: Liberty Dental Plan P.O. Box 15149, Tampa, FL 33684-5149
PROVIDER PORTAL (i-Transact)	**ELIGIBILITY & BENEFITS**
Go to the following to create an account Provider Portal-Click Here i-Transact allows you: • Electronic Claims Submission • Claim Status & Inquiries • Real-time Eligibility Verification • Member Benefits • Referral Submission & Status	Use i-Transact for real-time status at: Provider Portal-Click Here Phone: 833.276.0851 **PROFESSIONAL RELATIONS** Email: flprinquiries@libertydentalplan.com Phone: 833.276.0851
REFERRAL SUBMISSIONS & INQUIRIES	**CLAIM SUBMISSIONS AND INQUIRIES**
Use i-Transact for submissions & to check status at: Provider Portal-Click Here • **EMERGENCY REFERRALS:** • **Mail:** use our mailing address **ATTN: REFERRALS DEPARTMENT**	Use i-Transact for submissions & to check status at: Provider Portal-Click Here • **EDI PAYOR ID# CX083** • **Phone:** 833.276.0851 • **Mail:** use our mailing address **ATTN: CLAIMS DEPARTMENT** • **Corrective Claims by Fax: 714.389.5092**

Section 2. Provider Relations and 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 Policies and Enrollee Benefits
- Provider Trainings and Orientations
- Directory Validation
- Changes in Office Demographics
- Opening, Changing, or Closing a Location
- Adding or Terminating Associates
- Credentialing and Recredentialing of an owner and an associate dentist inquiry
- Change in name or ownership
- Taxpayer Identification Number (TIN) change
- Changes in office hours

Provider Compliance Training

LIBERTY provides initial orientation and training to all new offices within thirty (30) days of executing an agreement. Additional training is provided for new staff, when changes in the program occur, or when there is a change in provider utilization and/or other activity. Further, LIBERTY provides regular training through webinars, as well as telephonic and in-person meetings, as requested.

All trainings regarding the requirements of the AHCA Medicaid Contract, including any Contract amendments and special needs of enrollees are available to providers and their staff. LIBERTY works with providers treating the Individuals with Intellectual and Developmental Disabilities (IDD) population to ensure best practices are met. Providers are trained on identifying adverse incidents and requirements to report adverse incidents to LIBERTY within 48 hours of the incident.

Training modules are available online at: Annual Compliance Training- Click Here

Training Programs include:

- Critical Incident Awareness
- Code of Business Ethics & Conduct
- Cultural Competency
- Fraud, Waste & Abuse Training
- General Compliance
- HIPAA

To ensure that your information is displayed accurately in our provider directory, and claims are processed efficiently, please submit all changes within thirty (30) days to flprinquiries@libertydentalplan.com, for Dental Service Organizations, submit an email to dsoupdates@libertydentalplan.com, or in writing. Provider Relations will address your inquiry within three (3) business days of receipt.

	LIBERTY Dental Plan Attn: Provider Relations P.O. Box 26110 Santa Ana, CA 92799-6110		Provider Relations Team M — F from 8 am – 8 pm (EST) 833.276.0851
	Email at flprinquiries@libertydentalplan.com or Dental Service Organizations at dsoupdates@libertydentalplan.com		

Section 3. Online Self-Service Tools

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

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

- Submit electronic claims
- Request prior authorizations
- Check claim status
- Review prior authorizations
- Verify enrollee 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 Provider Portal account, visit: https://providerportal.libertydentalplan.com. All contracted network dental offices are issued a unique Office Number and Access Code. These numbers can be found on your LIBERTY Welcome Letter. The designated Office Administrator should set up the account on behalf of all providers/staff. The Office Administrator will be responsible for adding, editing, and terminating additional users within the office.

View the benefits of using the Provider Portal at:
Provider Portal Benefits- Click Here

Detailed instructions on how to utilize our online services can be found in the Online Provider Portal User Guide by visiting by visiting:
Online Provider Portal User Guide

System Requirements

- Internet Connection compatible with Microsoft Edge, Google Chrome, and Mozilla Firefox
- Adobe Acrobat Reader

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 dentists that are available to Liberty enrollees.

It is required that providers ensure our provider directories are up-to-date. Any changes, including, but not limited to appointment times, office hours, address, phone number, fax number, associate dentist, etc., must be updated through our Provider Directory Information Verification (DIV) website at: Provider DIV- Click Here Additionally, even if you do not have any updates, every 90 days you are required to validate your office information and attest that no changes were made. We 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 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 Provider Relations Department for assistance at 833.276.0851.

Section 4. Eligibility

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

Providers are responsible for verifying enrollee eligibility prior to providing dental services. The enrollee's ID card does not guarantee eligibility. Checking eligibility will allow providers to complete medically necessary procedures and reduce the risk of denied claims. Enrollees must seek treatment at their assigned dental home otherwise claims may be denied (does not apply to iBudget enrollees). Enrollees assigned to a General Dentist as a Primary Dental Provider ("PDP") that need to be seen by a Pediatric Dentist should be referred to the LIBERTY Member Services to request a transfer to a Pediatric "PDP."

How to Verify Eligibility

There are several options to verify eligibility:

1. Provider Portal: Liberty Provider Portal-Click Here
   The enrollee's last name, first name, and any combination of enrollee number, policy number, or date of birth is required (Enrollee's Last Name, First Name and Date of Birth is recommended for best results).

2. Calling Member Services Department: In the event an enrollee does not appear on the monthly roster, to speak with a live representative, Monday through Friday, from 8 am to 8 pm EST.

Enrollee Identification Cards: Enrollees 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. Presentation of an ID card does not guarantee eligibility and/or payment of benefits.

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

Section 5. Claims and Billing

Provider hereby agrees that all dental services provided pursuant to the provider agreement, inclusive of laboratory services, whether provided directly or indirectly, in whole or in part, will be performed within the borders of the United States and its territories and protectorates.

As defined in the Florida Medicaid Definitions Policy, August 2017, Section 2.119, the term "Service(s)" means: "Any diagnostic or treatment procedure(s) or other medical or allied care claimed to have been furnished to a recipient and listed in an itemized claim for payment; or, in the case of a claim based on costs, any entry in the cost report, books of account, or other documents supporting such claim."

Other than laboratory services, Dental Services must be provided to the recipient at the location of the enrollee. Thus, given that LIBERTY's dental providers must be licensed to practice dentistry in Florida and provide the services in-person to our Florida enrollees – except for laboratory services – it does not appear to be possible for dental services to be provided outside the United States.

LIBERTY will; however, include a contractual provision in all its Florida Medicaid provider contracts which expressly prohibits billing for the provision of dental services, including laboratory services, outside the borders of the United States and its territories and protectorates. LIBERTY will further require, by contract, that its network providers certify compliance with this requirement using language materially consistent with Certification Number 6 ("PERFORMANCE OF SERVICES") in AHCA ITN 012-17/18. Renewal of this Certification by each provider will be required annually, and LIBERTY's electronic and hard-copy Florida Medicaid provider invoice templates will incorporate this provision by reference so that every invoice duplicates the prohibition. The contractual provisions and certifications will alert LIBERTY's providers that LIBERTY will recoup as unauthorized any dental services that were invoiced in error in contradiction of this provision, and that additional contractual sanctions (which may include termination for cause) may also be pursued for non-compliance.

LIBERTY will further include as part of its Annual Provider Audit Plan the selection of dental laboratory service invoices to review. Lastly, education as to this prohibition will be included in LIBERTY's provider manual and in the provider onboarding and annual training materials used with all its network providers.

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

- HIPPA Compliant"873D" file
- Electronic submissions via LIBERTY's Provider Portal
- Electronic submissions via clearinghouse
- Paper claims

Reimbursement for Medical or Dental Health Record Copies

1. Reimbursement Rate: LIBERTY Dental Plan will reimburse providers for the cost of copies of medical or dental health records requested for retrospective review as permitted in Section V., Service Administration, Sub-Section H., Authorization of Services, Item 2., Utilization Management Program Description. LIBERTY will reimburse $2.00 per record.
2. Request Process:
    - Submission of Request: Providers must submit a written request for reimbursement of health record copies in form of invoice to LIBERTY at LibertyDentalPlan_InvoiceCapture@concursolutions.com. The request should include the number of pages copied, the total amount requested, and the reason for the request.
    - Verification: The Dental Plan will verify the request to ensure that it pertains to records requested for retrospective review under the Utilization Management Program Description.
    - Approval: Upon verification, LIBERTY will approve reimbursement based on the applicable rate.
    - Payment: Reimbursement will be processed and paid to the provider within 20 days of receipt of the verified request.
3. Documentation Required:
    - Invoice or Receipt: Providers must include an invoice or receipt detailing the cost of the copied records.
    - Copy of Records: A copy of the records provided to LIBERTY must be attached to the reimbursement request.
4. Dispute Resolution: Any disputes regarding the reimbursement amount or process will be resolved according to the procedures outlined in the provider agreement under the section "Dispute Resolution."

Process Summary:

1. Provider submits a written request for reimbursement with detailed invoice or receipt.
2. The Dental Plan verifies the request and ensures it complies with the retrospective review requirements.
3. Reimbursement is processed and paid within [number] days.
4. Documentation of the records and request must be provided.
5. Disputes are resolved per the agreement’s dispute resolution procedures

Required Timeframes for Timely Claims Submission

Type of Provider or Service	Timeframe for Claims Submission
Medicaid Claims	180 days from date of service
Community Health Department	365 days from date of service
Emergency Services	180 days from date of service
Non-Participating Provider	180 days from date of service
LIBERTY is the Secondary Payer (non-Medicare)	180 days after the final determination of the primary payer
Medicare Crossover Claims	Three years from date of service
All Other Claims	180 days from date of service (recommended within 45 days)

HIPPA Compliant 873D File

LIBERTY currently accepts HIPAA Compliant 837D files. If you would like to set up or inquire about this option, please contact our IT Department at (833) 276-0851.

Electronic Submission

LIBERTY strongly encourages the electronic submission of claims. This convenient feature assists in reducing costs, streamlining administrative tasks, and expediting claim payment turnaround time for providers. There are two options to submit electronically:

1. Provider Portal: Liberty Provider Portal - Sign In
2. Third Party Clearing House

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

LIBERTY EDI Vendor	Phone Number	Website	Payer ID
DentalXchange	(800) 576-6412	www.dentalxchange.com	CX083
Vyne Dental	(463) 218-6519	www.vynedental.com	CX083

All electronic submissions should be submitted in compliance with state and federal laws, as well as 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 the current ADA approved claim forms.
Please mail all paper claim/encounter forms to:

Attn: Claims Department
LIBERTY Dental Plan P.O. Box 15149 Tampa FL 33684-5149

Claims Submission Protocols and Standards

LIBERTY requires the following claims documentation:

1. All claims must be submitted to LIBERTY for payment for services with the enrollee ID number, first and last name and pre- or post-treatment documentation, if required.

2. Your National Provider Identifier (NPI) number and tax ID are required on all claims. Claims submitted without these numbers will be rejected. All health care providers, health plans and clearinghouses are required to use the National Provider Identifier number (NPI) as the ONLY identifier in electronic health care claims and other transactions.

    - If you do not have an NPI number, you must register for one at the following website: http://nppes.cms.hhd.gov

3. All claims must include the name of the program (such as Florida Medicaid) under which the enrollee is covered and all the information and documentation necessary to adjudicate the claim.

The state of Florida defines a clean claim as: A claim that can be processed without obtaining additional information from the provider of the service or from a third party. It does not include a claim from a provider who is under investigation for fraud or abuse, or a claim under review for medical necessity, pursuant to 42 CFR 447.45 – Timely Claims Payment.

For emergency services, please submit a standard claim form which must include all the appropriate information, including pre-operative x-rays and a detailed explanation of the emergency circumstances. For children under the age of eighteen years, and those who have special health care needs, inclusive of behavioral and/or complex medical conditions, who are under the age of twenty-one years, a letter of medical necessity must accompany the claim form.

For Teledentistry services, please submit a standard claim form which must include procedure code D9995 or D9996 and a detailed explanation. Providers utilizing these services must be participating network dentists in compliance with LIBERTY's Teledentistry program.

Claims Status Inquiry

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

	Provider Portal: Click Here		833.276.0851

Claims Status Explanations

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

Claims Resubmission

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

- Missing documentation
- Incorrect coding
- Processing errors

Claims Overpayment

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

Notice of Overpayment of a Claim

If LIBERTY determines that it has overpaid a claim, LIBERTY will notify the provider in writing through a separate notice clearly identifying the claim; the name of the patient, the date of service, and a clear explanation of the basis upon which LIBERTY believes the amount paid on the claim was in excess of the amount due, including interest and penalties on the claim.

Contested Notice

If the provider contests LIBERTY's notice of overpayment of a claim, the provider may dispute the notice of overpayment within 90 working days of the receipt of the notice of overpayment of a claim. Any such dispute must be received by LIBERTY in writing stating the basis upon which the provider believes that the claim was not overpaid. LIBERTY will process the contested notice in accordance with LIBERTY's Provider Complaint Resolution Process described elsewhere in this Guide.

No Contest

If the provider does not contest LIBERTY's notice of overpayment of a claim, the provider must reimburse LIBERTY within 60 working days of the provider's receipt of the notice of overpayment. If the provider fails to reimburse LIBERTY within 60 working days of receiving the notice, LIBERTY is authorized to offset the uncontested notice of overpayment of a claim from the provider's current claim submissions.

Offsets to Payments

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

Prompt Payment of Claims

LIBERTY's processing policies, payments, procedures, and guidelines follow applicable State and Federal requirements. Please reference Florida Statutes 641.3155 - Prompt Payment of Claims.

In accordance with Florida law, notification to the provider that the electronic clean claim is denied or contested must be done within 15 calendar days and be paid or denied within 90 calendar days after receipt. Clean paper claims notification will be processed within 20 calendar days from receipt of claim and paid or denied within 120 days after receipt of claim.

Electronic Funds Transfer

LIBERTY's Electronic Funds Transform Form can be located on our Provider Portal at
EFT Form- Click Here

Encounter/Claims Data Reporting Required on all Medicaid Plans

All contracted LIBERTY general dentistry providers must submit encounter/claims data for all services rendered, regardless of reimbursement methodology, on a regular basis. The information should be submitted on a current standard ADA Dental Claims Form for all services provided to the enrollee. State law requires the submission of aggregated encounter/claims data to the state on a regular basis for utilization review and analysis by Florida Medicaid Management Information System (MMIS) to ensure that the Medicaid program is properly providing care to its enrollees. LIBERTY strongly recommends that you provide claims following each visit.

Peer-to-Peer Communication

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

	Utilization Management Team M — F from 8:00 a.m. – 8:00 p.m. (EST) 888.442.3514

Please leave a detailed message including the Enrollee ID and claim number and your call will be returned.

Section 6. Coordination of Benefits

Coordination of Benefits (COB) applies when an enrollee has more than one source of dental coverage. The purpose of COB is to allow enrollees 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 enrollee's dental expenses.

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

Identifying the Primary Carrier

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

When there is a break in coverage, LIBERTY will be primary based on the LIBERTY effective date versus the new group effective date.

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

Patient is the Enrollee	Primary
Enrollee has a government-funded plan and individual or supplemental coverage through another carrier	Individual/Supplemental coverage is primary
Enrollee has two government-funded plans: Federal (Medicare) and State (Medicaid, or Medicare Advantage Value Add)	Federal coverage is primary
Enrollee has dental coverage through a group plan and a government-funded plan	Group plan is primary
Enrollee has dental coverage through a retiree plan and a government-funded plan	Government-funded plan is primary

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

Scenarios of COBs

1. When LIBERTY is the Primary Carrier LIBERTY will only be considered the primary carrier for Medicaid when the enrollee has no other dental coverage. Medicaid is always considered the payor of last resort.

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

Section 7. Professional Guidelines and Standards of Care

Primary Dental Provider Responsibilities and Rights

- Provide and/or coordinate all dental care for enrollee
- Perform an initial dental assessment including a risk assessment
- Provider has the right to dismiss a member in writing to LIBERTY and stating reasons why
- Provide a written treatment plan to enrollees that identifies covered services, non-covered services, and clearly identifies any costs associated with each treatment plan that is understandable by a prudent layperson with general knowledge of oral health issues
- Provide supporting materials for dental services and procedures which document their medical necessity
- Treatment plans and informed consent documents must be signed by the enrollee or responsible party showing understanding of the treatment plan
- A financial agreement for any non-covered service will be documented separately from any treatment plan or informed consent
- Work closely with specialty care and primary dental providers to promote continuity of care
- Cooperate with, and adhere to the LIBERTY Quality Management and Improvement Program
- Identify dependent children with special health care needs and notify LIBERTY of these needs
- Notify LIBERTY of the following:
  - An employee death
  - The performance of a surgical procedure on the wrong patient
  - Brain or spinal damage
  - The performance of a wrong surgical procedure
  - The performance of a wrong-site surgical procedure
  - The performance of a surgical procedure that is medically unnecessary or otherwise unrelated to the patient's diagnosis or medical condition
  - The surgical repair of damage resulting to a patient from a planned surgical procedure, where the damage was not a recognized specific risk, as disclosed to the patient and documented through the informed-consent process
  - The performance of procedures to remove unplanned foreign objects remaining from a surgical procedure
- Arrange coverage by another provider when away from dental facility
- Ensure that emergency dental services and/or information are available and accessible for patients of record 24 hours a day, 7 days a week
- Maintain after-hours telephone coverage (such as via an answering service, machine referral to an on-call provider) with reasonable and timely call back
- Maintain scheduled office hours
- Maintain dental records for a period of ten years
- Provide updated credentialing information when requested, upon renewal dates
- Provide requested information upon receipt of a standard patient grievance/complaint within 3 business days of receiving a notice letter
- Coordinate and provide language assistance services, which includes telephonic and onsite interpretation services for enrollees when necessary
- Submit encounter data on EDI or standard ADA claims
- Notify LIBERTY of any changes regarding the provider's practice, including location, name, telephone number, address, associate additions/terminations, change of ownership, plan terminations, etc. and
- If an enrollee chooses to transfer to another participating dental office; there will be no charge to the enrollee for copies of records maintained in chart. All copies of records must be provided to enrollee within 15 days of request

- Provide dental services in accordance with peer reviewed clinical principals, criteria, guidelines and any evidence-based parameters of care
- Providers will not discriminate or retaliate against an enrollee or attempt to disenroll an enrollee for filing a grievance and/or appeal

Specialty Care Provider Responsibilities and Rights

- Responsibilities & Rights of the PDP listed above
- Provide necessary and appropriate specialty consultation and care to enrollees
- Inform primary dental provider when treatment is complete
- Bill LIBERTY timely for all dental services that are authorized
- Pre-authorize any necessary treatment, not previously approved

Enrollees Bill of Rights and Responsibilities

Florida law requires that health care providers or health care facilities recognize patients' rights while receiving care and that patients respect the health care provider's or health care facility's right to expect certain behavior on the part of patients. Patients may request a copy of the full text of this law from their health care provider or health care facility. Patients' bill of rights and responsibilities follows in accordance with Section 381.026, Florida Statues. A copy of the Florida Patients' Bill of Rights and Responsibilities shall be available, upon request by an enrollee, at each provider's office.

- An enrollee 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
- An enrollee has the right to a prompt and reasonable response to questions and requests
- An enrollee has the right to know who is providing medical services and who is responsible for his or her care
- An enrollee has the right to know what patient support services are available, including whether an interpreter is available if he or she does not speak English
- An enrollee has the right to know what rules and regulations apply to his or her conduct
- An enrollee has the right to be given by the health care provider information concerning diagnosis, planned course of treatment, alternatives, risks, and prognosis
- An enrollee has the right to refuse any treatment, except as otherwise provided by law
- An enrollee 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
- An enrollee has the right to receive, upon request, prior to treatment, a reasonable estimate of charges for proposed dental services
- An enrollee has the right to receive a copy of a reasonably clear and understandable, itemized bill and, upon request, to have the charges explained
- An enrollee has the right to impartial access to medical treatment or accommodations, regardless of race, national origin, religion, handicap, or source of payment
- An enrollee has the right to treatment for any emergency medical condition that will deteriorate from failure to provide treatment
- An enrollee 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
- An enrollee has the right to express grievances regarding any violation of his or her rights, as stated in Florida 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
- An enrollee has the right to request an appeal of an adverse benefit determination to deny, defer or limit services or benefits either verbally or in writing

- As an enrollee of LIBERTY, each enrollee has the responsibility to behave according to the following standards:
- An enrollee 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
- An enrollee is responsible for reporting unexpected changes in his or her condition to the health care provider
- An enrollee 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
- An enrollee is responsible for following the treatment plan recommended by the health care provider
- An enrollee is responsible for keeping appointments and, when he or she is unable to do so for any reason, for notifying the health care provider or health care facility at least 24 hours in advance
- An enrollee is responsible for his or her actions if he or she refuses treatment or does not follow the health care provider's instructions
- An enrollee is responsible for assuring that the financial obligations of his or her health care are fulfilled as promptly as possible
- An enrollee is responsible for following health care facility rules and regulations affecting patient care and conduct

National Provider Identifier (NPI)

In accordance with the Health Insurance Portability and Accountability Act (HIPAA), LIBERTY requires a National Provider Identifier (NPI) for all HIPAA-related transactions, including claims, claim payment, coordination of benefits, eligibility, referrals, and claim status. The provider must ensure a type I or a type II NPI in accordance to how they are submitting claims. (If you are a solo practitioner, you are a Type 1, and if you are a group/ organization your billing NPI is Type 2. You must register NPPES with the correct information for LIBERTY to validate.

How to Apply for an NPI

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

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

Voluntary Provider Contract Termination

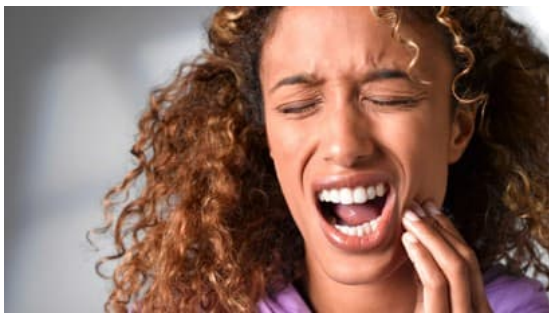
Providers must submit notice of withdrawal from the network at least 90 calendar days before the effective date of the withdrawal. Providers must continue to treat enrollees until the last day of the month following the date of termination. Affected enrollees are given advance written notification informing them of their transitional rights. Certain contractual rights survive termination, such as the agreement to furnish records during a grievance, appeal or claims review. Please consult your provider contract for your responsibilities beyond termination.

Appointment Availability and Accessibility Standard

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

Type of Appointment	Access to Care Standards
Urgent Care Services	Patient must be seen within 24 hours of a request for services that do not require prior authorization
	Patient must be seen within 48 hours for services that require authorization
Routine Sick Patient Care	Patient must be seen within seven days
Primary Dental Care	Patient must be seen within 30 days
Follow-up Dental Services	Patient must be seen within 30 days after assessment

Emergency Services and After-Hours Emergencies



According to the Department of Health Board of Dentistry Dental Practice and Principles Rule 64B5-17.004, FAC, Emergency Care it is the responsibility of every dentist practicing in the state of Florida to provide either personally, or through another licensed dentist, to provide or make arrangement for 24 hours of emergency services for all patients of record. In the event the primary dental provider is not available to see an emergency patient within 24 hours, it is his/her responsibility to ensure that emergency services are available.

If the patient is unable to access emergency care within our guidelines and must seek services outside of your facility, you may be held financially responsible for the total costs of such services. Additionally, if your office is unable to meet LIBERTY guidelines, LIBERTY has the right to transfer some or all Medicaid enrollment to another provider, close your office to new enrollment, or take other action deemed necessary by LIBERTY to ensure timely access to all enrollees.

Treatment Plan Guidelines

All enrollees must be presented with an appropriate written treatment plan containing an explanation of the prescribed treatment, the benefits available for the prescribed treatment, and any related costs. Treatment plans must include covered Medicaid services.

Non-Covered Procedures and Treatment Plans: Non-covered services may be offered and presented to Medicaid enrollees. Treatment plans and informed consents must be signed showing patient acceptance of the treatment, and for any costs for non-covered treatment. LIBERTY enrollees cannot be denied their plan benefits. Providers must not make performance of covered services contingent upon enrollees payment for non-covered services. All accepted or declined treatment plans must be signed and dated by the patient or his/her guardian and the treating dentist. A copy of current and updated treatment plans must be available to the LIBERTY Dental Plan Care Coordination Program for repository in the enrollee record at LIBERTY.

Non-Covered Procedures – Important Note: For enrollees electing non-covered services, a separate written informed consent that clearly states: 1) the treatment plan, 2) the non-covered services elected, 3) the applicable costs of the non-covered services and 4) the enrollees understanding and acceptance of the non-covered services must be obtained prior to the commencement of treatment. Please use the non-covered services document in the forms section of this Reference Guide.

Providers who perform non-covered services must obtain financial and treatment consents signed by the enrollee/patient or legal representative, as applicable, that are clear. Concise, and understandable by a prudent layperson. Failure to do so may result in non-payment by the Plan. Medicaid enrollees are protected from financial responsibility for charges that were not clearly presented prior to treatment. In such cases, Medicaid enrollees who file a grievance and can prove they did not approve such services, may not be subject to collection activity. Thus, providers will not be able to bill enrollees or collect payments for non-covered services that were not properly approved by the enrollee/patient. Please consult the plan schedule of benefits to determine covered and non-covered services. You may also send in proposed treatment for pre-approval to determine whether a proposed service is covered or not. By virtue of your signed provider agreement, you agree to cooperate with corporate business practices and quality management processes such as grievances, appeals, and providing care and service in accordance with plan documents. Enrollees age 0-20 must be provided medically necessary dental services in accordance with 42 Code of Federal Regulation §440.40(b), Early and Periodic Screening, Diagnosis and Treatment Program (EPSDT).

Second Opinions

Enrollees and/or providers may request a consultation with another network dentist for a second opinion to confirm the diagnosis and/or treatment plan. The dentist should refer these enrollees to the Member Services Department, Monday through Friday, 8 a.m. to 8 p.m. (Eastern) to make the request. Second opinions may be request for non-covered services.

Appointment Rescheduling

When a provider or enrollee must reschedule an appointment, the appointment must 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 must be scheduled according to the same standards as initial appointments. Missed or canceled appointments should be noted in the enrollee's records. Medicaid enrollees cannot be charged for broken or missed appointments.

Recall, Failed or Canceled Appointments

Contracted dentists are expected to have an active recall system for established patients who have not completed their treatment plans, for regular maintenance visits, or for patients who fail to keep or cancel their appointments.

Continuity and Coordination of Care

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

- All care rendered to LIBERTY enrollees must be properly documented in the patient's dental charts according to established documentation standards
- Communication between the Primary Dental Provider and dental specialist shall occur when enrollees are referred for specialty dental care
- Dental chart documentation standards are included in this Provider Reference Guide
- Dental chart audits will verify compliance to documentation standards
- Guidelines for adequate communications between the referring and receiving providers when enrollees are referred for specialty dental care are included in this Provider Reference Guide
- During facility on-site audits, LIBERTY monitors compliance with continuity and coordination of care standards; and
- When a referral to a specialist is authorized, with exception to enrollees with special health care needs, the Provider is responsible for evaluating the need for follow-up care after specialty care services have been rendered and scheduling the enrollee for any appropriate follow-up care
- LIBERTY's Care Coordination Program assists and supports enrollees with special needs inclusive of and not limited to behavioral and health conditions, intellectual and developmental disabilities, and those receiving consistently high dental service usage. Care coordinators implement, coordinate, monitor,

and evaluate the options and services required to meet an enrollee's dental needs using communication and resources to promote quality outcomes. Coordinators will reach out to dental homes to obtain a copy of the enrollee's treatment plan, hold discussion(s) of ongoing needs, and assist in eliminating barriers to care, as applicable.

Adverse Incidents

Providers are responsible to report adverse incidents to LIBERTY within 48 hours of the incident. Adverse incidents include enrollees who show self-harm, threat to another person, threat to LIBERTY and those listed below.

1. Is associated in whole or in part with service provision rather than the condition for which such service provision occurred; and
2. Is not consistent with or expected to be a consequence of service provision; or
3. Occurs as a result of service provision to which the patient has not given his informed consent; or
4. Occurs as the result of any other action or lack thereof on the part of the staff of the provider

Anti-Discrimination

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

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

If you need these services, please contact us at 833.276.0850, TTY: 877.855.8039.

LIBERTY is prohibited from discriminating or taking punitive action against any provider for making a complaint to AHCA or other regulatory body in good faith.

If you believe LIBERTY has failed to provide these services or has discriminated based on race, color, religion, national origin, age, disability, or sex, you can file a grievance with LIBERTY's Civil Rights Coordinator:

- Phone: (888) 704-9833
- TTY: (800) 735-2929
- Fax: (714) 389-3529
- Email: compliancehotline@libertydentalplan.com
- Online: https://www.libertydentalplan.com/About-LIBERTY-Dental/Compliance/Contact-Compliance.aspx

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

U.S. Department of Health and Human Services

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

Language Assistance Services

LIBERTY provides free language assistance services to ensure Limited English Proficient (LEP) enrollees have appropriate access to interpretation and written translation services when accessing dental care.

LIBERTY requires that services be provided in a culturally competent manner to all enrollees, including those with LEP or reading skills, and diverse cultural and ethnic backgrounds.

Interpretation Services for Limited English Proficient Patients:

- Interpreting services, including American Sign Language, are available to enrollees 24 hours a day, 7 days a week at no cost by contacting LIBERTY's Enrollee Services Department at 833.276.0580 TTY/TDD: 877.855.8039
- Enrollees who reside in the state of Florida and are enrolled in Florida Medicaid have the right to an interpreter when receiving treatment and services
- LIBERTY is offering free telephonic interpretation through our language service vendor. The enrollee must be fully informed that an interpreter is available to him or her at no cost
- If an enrollee requests to use LIBERTY's language assistance services, please document the request in the enrollee's dental record
- To engage an interpreter once the enrollee is ready to receive services, please call 833.276.0580 TTY/TDD: 877.855.8039. You will need the enrollee's LIBERTY Dental ID number, date of birth, and the enrollee'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 and strongly discourages the use of minors as interpreters for enrollees except in emergencies if the minor demonstrates the ability to interpret complex dental information
- Providers must also fully inform the enrollee that he or she has the right not to use family, friends, or minors as interpreters
- If an enrollee prefers not to use the interpretation services after s/he has been told that a trained interpreter is available free of charge, the enrollee's refusal to use the trained interpreter shall be documented in the enrollee's dental record, when in a provider setting, or the enrollee's administrative file (call tracking record) in the Enrollee Services setting
- Language preferences of enrollees will be available to directly contracted dentists upon request through telephone inquiries
- Written Enrollee Informing Materials in threshold languages and alternative formats are available to enrollees at no cost and can be requested by contacting LIBERTY's Enrollee Services Department at 833.276.0580 TTY/TDD: 877.855.8039

Identifying and Reporting Abuse, Neglect and Exploitation of Enrollees

The Florida Abuse Hotline accepts reports 24 hours a day and 7 days a week of known or suspected child abuse, neglect, or abandonment, and reports of known or suspected abuse, neglect, or exploitation of a vulnerable adult.

Florida Adult Protective Services Abuse Hotline: (800)962-2873 or (800) 96-ABUSE
Report Abuse Online: http://www.myflfamilies.com/service-programs/abuse-hotline/report-online

Definitions

- Abuse — Non-accidental infliction of physical and/or emotional harm
- Physical Abuse — Causing the infliction of physical pain or injury to an individual

- Sexual Abuse — Unwanted touching, fondling, sexual threats, sexually inappropriate remarks or other sexual activity with an adult with disabilities; touching, fondling, sexual threats, sexually inappropriate remarks or any other sexual activity with an older person when the older person is unable to understand, unwilling to consent, threatened or physically forced to engage in sexual activity
- Neglect — Repeated conduct or a single incident of carelessness that results or could reasonably be expected to result in serious physical or psychological/emotional injury or substantial risk of death (this includes self-neglect and passive neglect)
- Exploitation — Illegal use of assets or resources of an adult with disabilities. It includes, but is not limited to, misappropriation of assets or resources of the alleged victim by undue influence, by breach of fiduciary relationship, by fraud, deception, extortion or in any manner contrary to law

How to Report Human Trafficking

Human Trafficking, under both federal and Florida law, it is defined as the transporting, soliciting, recruiting, harboring, providing, or obtaining of another person for transport; for the purposes of forced labor, domestic servitude or sexual exploitation using force, fraud and/or coercion.

Florida is Zero-Tolerance for Human Trafficking
Report Human Trafficking The National Human Trafficking Hotline 1-888-373-7888 or The U.S. Department of Justice Hotline 1-888-428-7581 or Florida Abuse Hotline 1-800-96-ABUSE or Report it to your local authorities

Section 8. Clinical Dentistry Guidelines and Practice Parameters

New Patient Information

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
4. 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
5. Medical History - There should be a detailed medical history form comprised of questions which require a "yes" or "no" responses, minimally including:
   - Patient's current health status
   - Name and telephone number of physician and date of last visit
   - History of hospitalizations and/or surgeries
   - History of abnormal (high or low) blood pressure
   - Current medications, including dosages and indications
   - History of drug and medication use (including bisphosphonates)
   - Allergies and sensitivity to medications or materials (including latex)
   - Adverse reaction to local anesthetics

6. History of diseases:
    - Cardio-vascular disease, including heart attack, stroke, history of rheumatic fever, existence of pacemakers, valve replacements and/or stents and bleeding problems, etc. History of hospitalizations and/or surgeries
    - Pulmonary disorders including tuberculosis, asthma, and emphysema
    - Nervous disorders
    - Diabetes, endocrine disorders, and thyroid abnormalities
    - Liver or kidney disease, including hepatitis and kidney dialysis
    - Sexually transmitted diseases
    - Disorders of the immune system, including HIV status/AIDS
    - Other viral diseases
    - Musculoskeletal system, including prosthetic joints and when they were placed
    - Any other disease or condition that could affect the provider's determination of necessary, appropriate, and adequate dental care
7. Pregnancy
    - Document the name of the patient's obstetrician and estimated due date
    - Follow recommended guidelines in the ADA.org publication, Oral Health Topics, Oral Health Conditions During Pregnancy
8. History of cancer, including radiation or chemotherapy
9. The medical history form must be signed and dated by the patient or patient's parent or guardian
10. Dentist's notes following up on patient comments, significant medical issues and/or the need for a consultation with a physician should be documented on the medical history form or in the patient's progress notes
11. Medical alerts reflecting current significant medical conditions must be uniform and conspicuously visible on a portion of the chart used during treatment
12. The dentist must sign and date all baseline medical histories after review with the patient
13. The medical history should be updated and signed by the patient and the dentist at least annually or as dictated by the patient's history and risk factors

Continuity of Care

Dental-Medical Continuity of Care: The contracted dentist should refer a patient to his/her current physician for any condition that may require active medical attention. The referral should include any relevant evaluation noted by the treating dentist. Copies of communications should be provided to the patient and filed in their dental record.

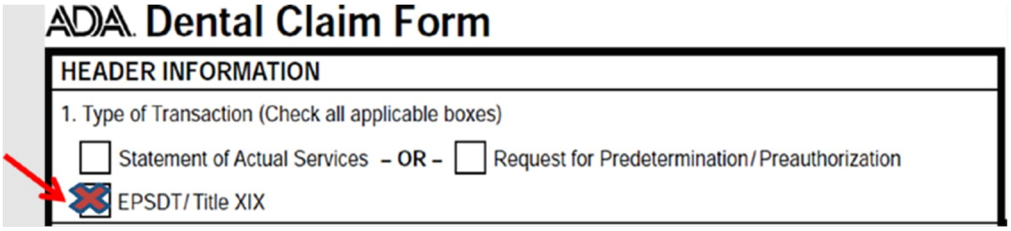
Early and Periodic Screening, Diagnostic and Treatment (EPSDT) Benefit

LIBERTY provides comprehensive, diagnostic and preventive dental services to eligible enrollees up to age 21. Services that exceed the Florida Statewide Medicaid Managed Care Program benefit or frequency limitations must be medically necessary, and may include emergency, preventive and therapeutic services for dental disease. EPSDT covered services require prior authorization.

Pre-authorization ("PA") is required for:

- Medically necessary dental services not listed in the benefits schedule and
- Medically necessary dental services listed in the benefit schedule but are in excess of frequency limitations

Providers requesting a pre-authorization or billing for EPSDT services should select the "EPSDT" box in section 1 of the ADA dental claim form:



- PA request(s) will be clinically reviewed for medical necessity; and
- Approved PA's will be reimbursed based on your current fee schedule

Who Covers What?

Type of Dental Service(s)	Dental Plan Covers	MMA Plan/FFS Covers
Emergency dental services in a facility		All emergency dental services and reimbursement to the facility, and anesthesia services. In addition, there are pre-authorization requirements surrounding ASC/Hospital facilities
Non-emergency (scheduled) dental services in a facility	Dental services by a dental provider, reimbursements to the facility, anesthesiologist and ancillary services In addition, there are pre-authorization requirements surrounding ASC/Hospital facilities	
Dental services with sedation in an office setting	Dental services by a dental provider with a required sedation permit or anesthesiologist (MD or ARNP) when required for sedation. D-codes when rendered by the dental provider	
Dental services (general or specialty) without sedation in an office setting, County Health Department, or Federally Qualified Health Center	Dental services by a dental provider	Dental services provided by a non- dental provider
Pharmacy (Prescribed Drugs)		Drugs prescribed by a health care provider or a dental provider within scope of practice
Transportation	Managed by the Health Plan for Florida Medicaid. Each health plan uses a different vendor	

Additional information can be found at:

1. Florida Medicaid Dental Services Coverage Policy
   http://ahca.myflorida.com/medicaid/review/Specific/59G-4.060_Dental_Coverage_Policy.pdf

2. American Academy of Pediatrics Periodicity Schedule
   https://www.aap.org/en-us/Documents/periodicity_schedule.pdf

Pre-Authorization or Claim Documentation Review of Dental Services

For all EPSDT covered services (ages 0-20), pre-authorization is required for any dental service that is not listed on the FL Medicaid benefit schedule and for any service(s) that are listed on the Medicaid plan schedule but are otherwise subject to frequency limitations or are subject to periodicity schedule guidelines and the service(s) being requested would otherwise exceed the listed limitations and/or guidelines. For all reviews prior to claim payment or pre-authorization requests, medical necessity will be determined based on radiographic and/or other documented rationale.

Any EPSDT service(s) that is not pre-authorized as described above, will be denied.

For Adult Dental, Adult Value Add, and Child Services, if the code requires documentation with claim submission or pre-authorization, there will be a notation as to the type of documentation that is required within the list of covered dental services. For Children under 20 if documentation is not sent in with the request, the case will be reviewed based on information that is received. You could receive a medical denial for not meeting criteria.

For all pre-authorization requests, medical necessity will be determined based on radiographic and/or other documented rationale.

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

To establish medical necessity or justification for a procedure documentation with claim submission may be required. For procedures that require documentation providers have the option to submit a “Pre-Authorization” request prior to performing the procedure. If LIBERTY approves the “Pre-Authorization” there is no need to submit documentation with claim submission.

Infection Control

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

Dental Records/Enrollee Records

Enrollee dental records must be kept and maintained in compliance with applicable state and federal regulations. Complete dental records of active or inactive patients must be accessible for a minimum of 10 years, even if the facility is no longer under contract. The provider must have a confidentiality policy to ensure privacy and security provisions according to the Health Insurance Portability and Accountability Act (HIPAA).

Dental records must be comprehensive, organized, and legible. Complete dental records must include, but are not limited to, the enrollee’s chief complaint, diagnosis, treatment plan, charting of hard and soft tissue findings, radiographs, and digital photographs. All entries should be in ink and signed and dated by the treating dentist or other licensed health care professional who performed services.

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

Health Insurance Portability and Accountability Act (HIPAA)

LIBERTY takes pride in the fact that we administer our dental plan in an effective and innovative manner while safeguarding our enrollees' 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, providers agree to abide by all HIPAA requirements, Quality Management Program requirements, and that enrollee protected Personal Health Information (PHI) may be shared with LIBERTY as per the requirement in the HIPAA laws that enable the sharing of such information for treatment, payment, and health care operations (TPO), as well as for peer review and quality management and improvement requirements of health plans. There is no need for special enrollee authorizations when submitting member PHI for these purposes.

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

Our 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 and implications of HIPAA. As a health care provider and covered entity, you and your staff must follow HIPAA guidelines regarding Protected Health Information (PHI).

LIBERTY has created and implemented internal corporate-wide policies and procedures to comply with the provisions of HIPAA. LIBERTY has and will continue to conduct employee training and education in relation to HIPAA requirements. LIBERTY 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 enrollee material.

Safeguarding Protected Health Information (PHI)

As a dental provider your office is fully aware that the Health Insurance Portability Accountability Act (HIPAA) requires the protection and confidential handling of patient Protected Health Information (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 data breaches, enforcement actions, and significant monetary penalties, and LIBERTY enrollees, is a violation of LIBERTY's provider agreement. If LIBERTY discovers that a provider has transmitted LIBERTY enrollee PHI via a potentially non-secure method, or if we are otherwise notified that a provider may not be properly safeguarding such PHI, we will contact the provider to investigate the matter. Non-compliance will result in a Corrective Action Plan and continued, or egregious non-compliance will lead to contract termination.

Safeguards which Providers must adhere to include, but are not limited to:

1. Electronic PHI

- Ensure referrals, authorization requests, medical records and other e-PHI are transmitted via a HIPAA compliant method 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 enrollee name, ID, or other identifying information) in the subject lines of emails or to name e-files is not permitted
- Use of free email service providers, like Gmail, Hotmail, or Yahoo, is not a permitted method for transmitting LIBERTY Enrollee PHI*
- Transmission of PHI via text is not permitted*
- LIBERTY providers may transmit e-phi to LIBERTY using

  LIBERTY's HIPAA compliant, secure web portal by following these simple steps:
  - Go to www.libertydentalplan.com
  - Go to Providers 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 enrollee, and that increased precautions are applied when faxing especially sensitive information (such as sensitive diagnoses).

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

- Review and adhere to LIBERTY's Secure Use & Transmission of e-PHI policy, located at https://client.libertydentalplan.com/FLMedicaid/Provider/DocumentsAndResources

2. Verbal PHI

- Do not discuss enrollee information in public areas (including waiting rooms, hallways and other common areas), even if you believe you are masking the enrollee'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 enrollee 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. Use ambient music or white noise to cover conversations in common areas
  - Arranging waiting areas to minimize one enrollee overhearing conversations with another
  - Posting a sign requesting that enrollees 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. Also, please avoid use of speaker phones

3. 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)
   - Lock away all PHI during close of business (for example, in a locked cabinet)
   - Close window blinds to prevent outside disclosure
   - Do not overstuff mailing envelopes; and print mailing addresses accurately and clearly to minimize the possibility that mail is lost in transit
   - Take precautions to ensure PHI is not lost while transporting from one location to another, and never leaving tangible PHI in vehicles unattended

Baseline Clinical Evaluation Documentation

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

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

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

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

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

Teledentistry (Telemedicine)

A. Standards of Care Requirements for use of Teledentistry: Dentists using teledentistry (D9995/D996) will be held to the same standard of care as practitioners engaging in traditional in-person care delivery, including the requirements to meet all technical, clinical, confidentiality and ethical standards required by law. Failure to conform to the standard of care, whether rendered in person or via teledentistry, may result in disciplinary action

B. For additional information on Teledentistry, you may access and view the following:
   - Provider Teledentistry Resources-Click Here
   - FL SMMC Benefits Schedule

Radiographs

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

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

C. New bitewings and Pano

D. D0210 Intraoral – complete series (including bitewings)

   1. A radiographic survey of the whole mouth, usually consisting of 14-22 periapical and posterior

bitewing images intended to display the crowns and roots of all teeth, periapical areas and alveolar bone. Frequency limitations exist for complete series of radiographs

2. Any combination of covered radiographs that meets or exceeds a provider's fee for a complete series may be adjudicated as a complete series, *for benefit purposes only*
3. In addition, any panoramic film taken in conjunction with periapical and/or bitewing radiograph(s) may be considered as a complete series, for benefit purposes only

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

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

İ. Panoramic x-ray (D0330) is not payable when taken on the same date of service as a complete series (D0210).

Consistent with industry best practices and standards of care, radiographs that are taken in conjunction with a restorative or surgical procedure are considered inclusive of such procedure and not reimbursable separately

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

H. Radiographs should exhibit good contrast

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

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

K. Any patient refusal of radiographs should be documented

L. Radiograph (X-ray), duplication fee

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

ii. If the transfer is initiated by the provider or the patient, the patient may not be charged any X-ray duplication fees.

iii. Medicaid plans do not allow a charge for x-ray duplication

Photos

A. Photos (D0350) may only be billed when used for diagnostic purposes if unable to obtain radiographs due to young age or inability to cooperate

B. Routine Photos taken for documentation or patient education purposes are not billable to the plan

C. <u>2D Oral/Facial Photographic Image obtained Intra-orally or Extra-orally (D0350)</u>

2D oral photographic images only reimbursed as a component of orthodontic records or for diagnostic purposes when radiographs cannot be taken due to a medical condition, physical ability, or cognitive function.

<u>Diagnostic Casts (D0470)</u>

Diagnostic casts are for the evaluation of orthodontic benefits only and are only payable upon approved orthodontic treatment

Prevention

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

A. Caries prevention may include the following procedures where appropriate:
   - patient education in oral hygiene and dietary instruction and tobacco cessation
   - periodic evaluations and prophylaxis procedures
   - topical or systemic fluoride treatment
   - sealants and/or preventive resin restorations

Offices can refer to the current ADA Caries Risk Assessment Form for guidance when completing services (as previous forms indicated all Medicaid eligible are considered as high risk).

   - The Caries Risk Assessment Form is not required when submitting a claim
   - Caries Risk Assessment Tools/Forms are available at:
     1. American Dental Association (ADA) https://www.ada.org/en/member-center/oral-health-topics/caries-risk-assessment-and-management
     2. American Academy of Pediatric Dentistry (AAPD) https://www.aapd.org/research/oral-health-policies--recommendations/caries-risk-assessment-and-management-for-infants-children-and-adolescents

B. Periodontal disease prevention may include a comprehensive program of plaque removal and control in addition to the following procedures:
   - oral and systemic health information including tobacco cessation
   - oral hygiene and dietary instructions
   - prophylaxis procedures on a regular basis
   - occlusal evaluation
   - correction of malocclusion and malposed teeth
   - restoration and/or replacement of broken down, missing or deformed teeth

C. D1110 and D1120 – prophylaxis procedures

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

E. D1510, D1516, D1517, D1551, D1552, D1553, D1556-D1558, D1575 Space maintenance in children where indicated for premature loss of primary molars

F. Space Maintenance intention is to prevent loss of arch length, width, and perimeter by maintaining the relative position of the existing dentition

G. Premature Loss of Second Primary Molar
   1. Unilateral Space Maintenance
      - Band and Loop, Crown and Loop, Distal Shoe may be used to preserve the space of the second primary molar
      - Root resorption and stability must be considered when selecting the first primary molar as the anchor tooth. The long-term prognosis of the anchor tooth should be good
      - Space maintenance using teeth with poor prognosis is not reimbursable

2. Bilateral Space Maintenance
    - Lower Lingual Holding Arch (LLHA), Nance appliance or Transpalatal arch appliance may be used to preserve the space of the second primary molar when there is premature bilateral loss of both second primary molars
    - LLHA will be reimbursed when there is bilateral loss of both second mandibular primary molars and complete eruption of mandibular anterior teeth
    - Nance appliance or Transpalatal arch is reimbursed when there is bilateral loss of both maxillary second primary molars
    - LLHA, Nance appliance or Transpalatal arch appliance for unilateral loss of a second primary molar is not reimbursed
    - LLHA, Nance or Transpalatal arch appliances are not reimbursed when there is impending eruption of succedaneous teeth
    - LLHA, Nance or Transpalatal arch appliances may be covered when there is unilateral loss of both primary molars

H. Premature Loss of First Primary Molar
1. Unilateral Space Maintenance
    - Band and Loop or Crown and Loop may be used to preserve the space of the first primary molar
    - Root resorption and stability must be considered when selecting the primary molar(s) as the anchor tooth. The long-term prognosis of the anchor tooth should be good
    - Space maintenance using teeth with poor prognosis are not reimbursed
    - Space maintenance for primary first molars are not reimbursed when the first permanent molar roots have been completed and in stable occlusion
2. Bilateral Space Maintenance
    - Lower Lingual Holding Arch (LLHA), Nance appliance or Transpalatal arch appliance may be used to preserve the space of the first primary molar when there is premature bilateral loss of both first primary molars
    - LLHA will be reimbursed when there is bilateral loss of both first mandibular primary molars and complete eruption of mandibular anterior teeth
    - Nance appliance or Transpalatal arch is reimbursed when there is bilateral loss of both maxillary second primary molars
    - LLHA, Nance appliance or Transpalatal arch appliance for unilateral loss of a second primary molar is not reimbursed
    - LLHA, Nance appliance or Transpalatal arch appliance is not reimbursed when there is impending eruption of succedaneous teeth
    - LLHA, Nance appliance or Transpalatal arch appliances are not reimbursed when the first permanent molar roots have been completed and in stable occlusion

I. Premature Loss of Primary Canines
1. LLHA, Nance appliance or Transpalatal arch appliances are not reimbursed for premature loss of the primary canines as it is considered a transitional orthodontic appliance

Diagnostic

Clinical Oral Evaluations

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

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

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

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

1. Observations of the initial evaluation are to be recorded in writing and charted graphically where appropriate, including missing or impacted teeth, existing restorations, prior endodontic treatment, fixed and removable appliances
2. Assessment of TMJ status (necessary for adults) and/or classification of occlusion (necessary for minors) should be documented
3. Full mouth periodontal screening must be documented for all patients; for those patients with an indication of periodontal disease, probing and diagnosis must be documented, including a radiographic evaluation of bone levels, gingival recession, inflammation, etiologic factors (e.g., plaque and calculus), mobility, and furcation involvements
4. A soft tissue/oral cancer examination of the lips, cheeks, tongue, gingiva, oral mucosal membranes, pharynx and floor of the mouth must be documented for all patients, regardless of age

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

Pre-Diagnostic Services

A. Screening of a patient, which includes a state or federal mandate, is used to determine the patient's need to see a dentist for diagnosis. (D0190)

B. Assessment of a patient is performed to identify signs of oral or systemic disease, malformation or injury and the potential need for diagnosis and treatment. (D0191)

D0190 and D0191

Florida Medicaid is striving to increase dental preventative screenings for children and adults. The inclusion of CDT codes D0190 and D0191 will allow Registered Dental Hygienists (RDH), within their scope of practice, to render oral health services to Medicaid recipients through health access settings, as defined by s. 466.003(14), F.S. These procedure codes are reimbursable when services are rendered within a school or mobile unit associated with a specific health access setting. The use of these codes allows health access settings to document screening and assessment services. Each code may be billed once per year, per recipient and may not be billed together. Please note that these codes are not evaluation codes.

Treatment Planning

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

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

C. Procedures should be sequenced in an order of need consistent with diagnostic and evaluation findings and in compliance with accepted professional standards. Normal sequencing would include relief

of pain, discomfort and/or infection, treatment of extensive caries and pulpal inflammation including endodontic procedures, periodontal procedures, restorative procedures, replacement of missing teeth, prophylaxis and preventive care and establishing an appropriate recall schedule

D. Treatment Plans for Medicaid enrollees must include covered services. Other non-covered services may be discussed. Enrollees must have access to their benefits and must not be contingent upon enrollees payment for non-covered services

Informed Consent

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

B. The patient should be advised of the likely results of doing no treatment

C. The dentist should have the enrollee sign appropriate informed consent documents and financial agreements

1. Appropriate informed consent documentation must be signed and dated by the patient and dentist for the specific treatment plan that was accepted
2. If a patient elects to proceed with a procedure that is not covered, the enrollee is financially responsible for the dentist's usual fee
3. If a patient refuses recommended procedures, the patient must sign a specific "refusal of care" document. Refusal of non-covered services in lieu of covered services is not grounds for patient dismissal

Poor Prognosis

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

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

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

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

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

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

Request for Pre-Estimate

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

Progress Notes

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

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

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

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

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

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

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

Palliative Treatment

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. Palliative treatment is reimbursed when a minor procedure has been performed. Making a diagnosis, rescheduling the enrollee for treatment, referring the enrollee to a specialist, or writing a prescription will not be reimbursed as palliative treatment.

Endodontic Pulpal Debridement and Palliative Treatment

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

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

1. Procedure D3332 is appropriate to report if, after "opening" a tooth a dentist determines that RCT is contraindicated due to a cracked tooth or poor prognosis
   - If an enrollee had a tooth chamber "opened" during an out-of-area emergency, root canal therapy may remain a covered benefit
   - If RCT was started prior to the patient's eligibility with the Plan, completion of the root canal therapy is the responsibility of the previous carrier and not be covered

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

2. Diagnostic techniques used when considering possible endodontic procedures may include an evaluation of:
   - Pain and the stimuli that induce or relieve it by the following tests:
     1. Thermal
     2. Electric
     3. Percussion
     4. Palpation
     5. Mobility
   - Non-symptomatic radiographic lesions
3. Treatment planning for endodontic procedures and prognosis may include consideration of the following:

- Strategic importance of the tooth or teeth
- Prognosis – endodontic procedures for teeth with a guarded or poor 5-year prognosis (endodontic, periodontal, or restorative) are not covered
- Presence and severity of periodontal disease
- Restorability and tooth fractures
- Excessively curved or calcified canals
- Following an appropriate informed consent process, if a patient elects to proceed with a procedure that is not covered, the enrollee is responsible for the dentist's usual fee. The dentist should have the enrollee sign appropriate informed consent documents and financial agreements
- Teeth that are predisposed to fracture following endodontic treatment should be protected with an appropriate restoration; most posterior teeth should be restored with a full coverage restoration
- Occlusion
- Patients have the right to elect extraction as an alternative to endodontic therapy

4. Clinical Guidelines
    - Diagnostic pre-operative radiographs of teeth to be endodontically treated must reveal all periapical areas and alveolar bone
    - A rubber dam should be used and documented (radiographically or in the progress notes) for most endodontic procedures. Documentation is required for any inability to use a rubber dam
    - Gutta percha is the endodontic filling material of choice and should be densely packed and sealed. All canals should be obturated
    - Post-operative radiograph(s), showing all canals and apices, must be taken immediately after completion of endodontic treatment
    - In the absence of symptoms, post-operative radiographs should be taken at appropriate periodic intervals
5. Endodontic referral necessity
    - In cases where a defect or decay is seen to be "approaching" the pulp of a tooth and the need for endodontic treatment is not clear, LIBERTY expects the General Dentist to proceed with the decay removal and possible temporization prior to any referral to an Endodontist
6. Endodontic Irrigation
    - Providers are contractually obligated to provide services for covered root canal procedures. The choice of endodontic irrigates is made by the treating dentist. Medicaid enrollees cannot be charged for endodontic irrigation materials (such as *BioPure*)
7. D3331 treatment of root canal obstruction; non-surgical access children ONLY.
    - LIBERTY acknowledges that procedure D3331 is a separate, accepted procedure code. However, this additional treatment is not automatically needed to complete routine endodontic procedure
    - May be reported to remove separated instruments, broken posts or when there is calcification of more than 50% of the length of the tooth root
    - LIBERTY will not approve a benefit for this procedure when submitted as part of a pre-determination request, prior to actual treatment
    - However, LIBERTY's licensed dental consultants will evaluate all available documentation on a case-by-case basis when this procedure is completed and submitted for payment. Providers should submit a brief narrative or copies of the patient's progress notes, in order, to document that this additional treatment was needed and performed
8. Pulpotomy
    - A pulpotomy may be indicated in a primary or permanent tooth when pulpal pathology is limited to the

coronal pulp and the tooth has a reasonable period of retention and function

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

9. Pulp Cap
    - This procedure is not to be used for bases and liners
    - Direct pulp capping is indicated for mechanical or accidental pulp exposures in relatively young teeth and may be indicated in the presence of a small, exposed vital or normal pulp
    - Indirect pulp treatment is a procedure performed to preserve the vitality of the tooth. The tooth must meet the following diagnostic criteria: reversible pulpitis and deep caries in close proximity to the pulp, no radiographic evidence of internal or external root resorption or other pathologic changes. The procedure is intended to excavate caries as close as possible to the pulp, place a caries arresting protective liner, and restore and seal the tooth bacterial contamination
    - Indirect pulp treatment in primary teeth is preferable to a pulpotomy when the pulp is normal or has a diagnosis of reversible pulpitis. Teeth with immature roots should be selected to promote continued root development and apexogenesis
10. Endodontic surgical treatment, if covered, should be considered only in special circumstances, including:
    - The root canal system cannot be instrumented and treated non-surgically
    - There is active root resorption
    - Access to the canal is obstructed
    - There is gross over-extension of the root canal filling
    - Periapical or lateral pathosis persists and cannot be treated non-surgically
    - Root fracture is present or strongly suspected
    - Restorative considerations make conventional endodontic treatment difficult or impossible
11. Endodontic procedures may not be covered when a tooth or teeth have a poor prognosis due to:
    - Untreated or advanced periodontal disease
    - Gross destruction of the clinical crown and/or root decay at or below the alveolar bone
    - A poor crown/root ratio

Oral Surgery

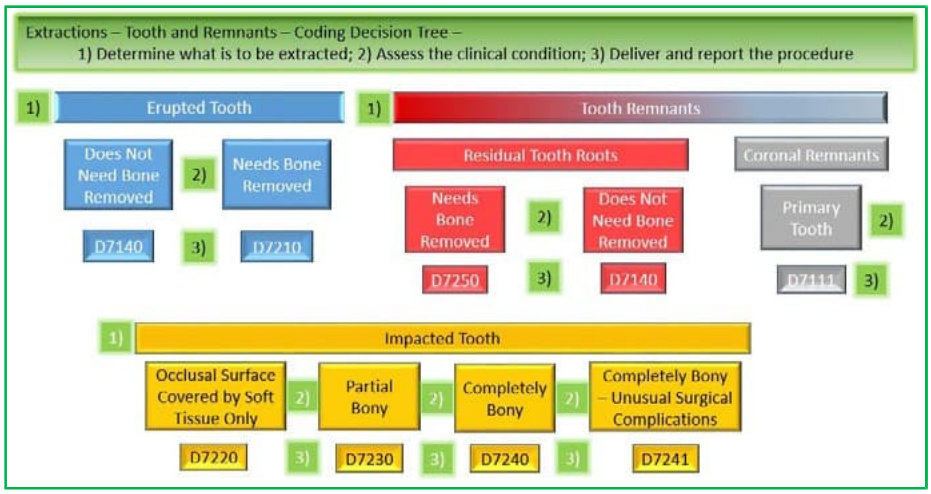
Each dental extraction should be based on a clearly recorded diagnosis for which extraction is the treatment of choice of the dentist and the patient.

A. General dentists are expected to provide routine oral surgery, including:
    1. uncomplicated extractions and emergency palliative care
    2. routine surgical extractions
    3. incision and drainage of intra-oral abscesses
    4. minor surgical procedures and postoperative services

B. Extractions may be indicated in the presence of non-restorable caries, untreatable periodontal disease, pulpal and periapical disease not amendable to endodontic therapy, to facilitate surgical removal of a cyst or neoplasm, or when overriding medical conditions exist, providing compelling justification to eliminate existing or potential sources of oral infection
    1. The removal of teeth solely for ortho purposes are only covered when comprehensive ortho treatment has been approved by LIBERTY
    2. When teeth are extracted, all portions of the teeth should be removed. If any portion of a tooth

(or teeth) is not removed, patient notification must be documented

3. Post extraction socket irrigation, regardless of the type of material used, is inclusive with the extraction. Medicaid enrollees cannot be charged for oral surgery irrigation materials
4. Local anesthesia is preferred in the absence of specific indications for the use of general anesthesia.
5. Minor contouring of bone and soft tissues during a surgical extraction are considered a part of and included in a surgical extraction, D7210
6. Documentation of a surgical procedure should include the tooth number, tissue removed, a description of the surgical method used, a record of unanticipated complications such as failure to remove planned tissue/root tips, displacement of tissue to abnormal sites, unusual blood loss, presence of lacerations and other surgical or non-surgical defects
7. All extractions must be coded in accordance with the current CDT manual in addition to guidelines developed by the ADA:



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

   A surgical extraction includes local anesthesia, suturing if needed, and postoperative care following extraction (e.g., dry socket, infection, bleeding, re-suturing)

   1. For extraction of a deciduous tooth (Codes D7111 and D7140) there must be evidence of medical necessity showing that the tooth has pathology and will not exfoliate soon (within the next six months) or a patient complaint of acute pain. A D7210 is not an appropriate code for extractions of deciduous teeth unless there is evidence of ankylosis or supporting documentation that bone removal was required
   2. During our clinical review of requests for extraction of impacted and/or erupted teeth, LIBERTY may determine that treatment better fits the description of a different, more appropriate procedure code. In that situation, LIBERTY may approve the extraction under a different code

Third Molar Extractions and Benefit Determination

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

B. Third molar extractions are only covered when listed as a Plan Benefit and there is active pathology present

C. Definition of Active Pathology: Pain, swelling, bleeding, or infection that is a result of congenital or behavioral disease (i.e. severe oral caries, benign or malignant growths, persistent pericoronitis, non-restorable caries, etc.) and not a result of normal developmental processes (i.e. eruption). Each tooth must qualify individually

D. Definition of Impacted Tooth: An unerupted or partially erupted tooth that is positioned against another

tooth, bone, or soft tissue so that complete eruption is unlikely

The ADA's position is that when coding for removal of impacted teeth the selection of either D7230 or D7240 is dependent on the definition of an "anatomical crown". The full entries for these codes, as published in the CDT Manual, are:

- D7230 removal of impacted tooth – partially bony Part of crown covered by bone; requires mucoperiosteal flap elevation and bone removal
- D7240 removal of impacted tooth – completely bony Most or all of crown covered by bone; requires mucoperiosteal flap elevation and bone removal. An "anatomical crown" as defined by the *ADA's Glossary of Dental Clinical and Administrative Terms* is as follows: anatomical crown: That portion of tooth normally covered by, and including, enamel

Given this definition, the "crown" referenced in these codes' descriptors are the portion of the tooth above the cemento-enamel junction. It follows that "part of the crown" should be interpreted as "less than 50% of the entire crown" and "most or all of the crown" should be interpreted as "at least or more than 50% of the entire crown."

E. The prophylactic removal of a tooth or teeth that appear to exhibit an unimpeded path of eruption and/or exhibit no active pathology is not covered. Removal of third molars to prevent future crowding or misalignment is not covered

F. The removal of asymptomatic, unerupted, third molars in the absence of active pathology is not covered

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

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

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

I. All suspicious lesions should be biopsied and examined microscopically

Deep sedation/general anesthesia - Pre-authorization is required, however if treatment is approved separate from deep sedation/general anesthesia payment is subject to documentation review prior to payment. Refer Section 7 above for process to obtain a medically necessary review for an acute care hospital, sedation or surgery center service, by LIBERTY. Refer to section for New Process for Ambulatory Surgical Centers and Hospital Call for preauthorization requirements when treatment is done in an ASC or hospital.

Other Surgical Procedures

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

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

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

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

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

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

G. Excision of bone tissue (Codes D7472 and D7473) (an exostosis) requires documentation that a bony growth

interferes with the ability to function or wear a prosthesis

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

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

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

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

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

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

N. Lingual Frenum Documentation Requirements:

   a. For infants: Must be accompanied by documentation from the Lactation Specialists or Pediatrician that indicates inability to latch, causing malnourishment, failure to thrive, pain or physical trauma to mother

   b. Children: Must be accompanied by documentation from the Pediatrician or Speech Pathologist that indicates speech impediment or there must be evidence of loss of gingival attachment or recession

O. Maxillary Frenum Documentation Requirements:

   a. Orthodontic Referral for Diastema Closure for Persistent diastema or Potential Persistent Diastema after orthodontia and after eruption of canines

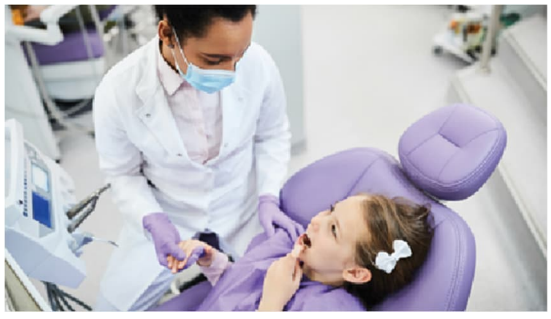
   b. Must be accompanied by documentation from the Pediatrician or Speech Pathologist that indicates speech impediment or there must be evidence of loss of gingival attachment or recession

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

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

Periodontics

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



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

Periodontal Treatment Sequencing

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

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

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

A full mouth debridement is not intended for a "difficult cleaning" or to be used "because it has been a long time since the last cleaning."

This procedure:

1. must be supported by radiographic evidence of heavy calculus
2. is not a replacement code for procedure D1110
3. is not generally appropriate in children under age 21. A detailed narrative of medically necessity for this unique circumstance is required for consideration of payment
4. Is not appropriate when a D0150, D0160, or D0180 has been completed

D4341/D4342 – Periodontal Scaling and Root Planing (SRP)

Refer to Plan Benefits for Pre-approval Guidelines

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

- Considered to be within the scope of a general dentist or a dental hygienist
- Supported when full mouth periodontal pocket charting demonstrates at least 4 mm pocket depths. It is common for radiographs to reveal evidence of bone loss and/or the presence of interproximal calculus
- Scaling and root planing procedures (D4341/D4342) are generally not performed in the same quadrants or areas for 2 years following initial completion of these services. In the interim, any localized scaling and root planing would be included within periodontal maintenance procedure D4910
- In general, only 2 quadrants may be performed on any date of service
- Sufficient time to properly and judiciously perform meticulous calculus and plaque removal on all aspects of the root must be allowed

SRP is not intended for a "difficult cleaning" or to be used "because it has been a long time since the last cleaning." Rather it is a judicious and meticulous treatment procedure to clean the roots of the tooth. Evidence of bone and attachment loss must be present. Radiographic evidence of bone loss must be present. A full mouth perio chart is recommended to demonstrate attachment loss.

Definitive Treatment vs. Pre-Surgical Scaling and Root Planing

1. For early stages of periodontal disease, this procedure is used as definitive treatment and the patient may not need to be referred to a Periodontist, again based on tissue response and the patient's oral hygiene
2. For later stages of periodontal disease, the procedure may be considered pre-surgical treatment and the patient may need to be referred to a Periodontist, again based on tissue response and the

patient's oral hygiene

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

Two Quadrants Per Appointment

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

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

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

D1110 and D4341/D4342

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

D4346-scaling in presence of generalized moderate or severe gingival inflammation-full mouth, after oral evaluation (all bold).

The removal of plaque, calculus and stains from supra-and sub-gingival tooth surfaces when there is generalized moderate or severe gingival inflammation in the absence of periodontitis (bone loss). It is indicated for patients who have swollen, inflamed gingiva, generalized suprabony pockets, and moderate to severe bleeding on probing.

This procedure:

- should not be reported in conjunction with D1110, D4341, D4342 or D4355
- must be supported by a perio chart or photos
- must not show evidence of radiographic bone loss

Soft Tissue Management Programs (STMP)

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

Periodontal Surgical Procedures

- The patient must exhibit a willingness to accept periodontal treatment and practice an appropriate oral hygiene regimen prior to consideration for periodontal surgical procedures
- Case history, including patient motivation to comply with treatment and oral hygiene status, must be documented
- Patient motivation may be documented in a narrative by the attending dentist and/or by a copy of patient's progress notes documenting patient follow through on recommended regimens
- In most cases, there must be evidence of scrupulous oral hygiene for at least three months prior to the

periodontal surgery, documentation with submission of claim will be required

- Consideration for a direct referral to a Periodontist would be considered on a by-report basis
- Periodontal surgical procedures are covered only in cases that exhibit a favorable long-term prognosis. Surgical procedures for the retention of teeth that are being used as prosthetic abutments is covered only when the teeth would exhibit adequate bone support for the forces to which they are, or will be, subjected
- Periodontal pocket reduction surgical procedures may be covered in cases where the pocket depths are 5 mm's or deeper, following soft tissue responses to scaling and root planing
- Osseous surgery procedures may not be covered if:
  - Pocket depths are 4 mm's or less and appear to be maintainable by non-surgical means (i.e. periodontal maintenance and root planing)
  - Osseous surgery and regenerative procedures should also correct and reshape deformities in the alveolar bone where indicated
  - Soft tissue gingival grafting should be done to correct gingival deficiencies where appropriate
- Osseous Surgery (D4260,D4261)
- No more than 2 quadrants of osseous surgery will be payable by the plan when completed on the same date of service unless a medical or other condition is present that would justify such.

Restorative

Diagnosis and Treatment Planning

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

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

Treatment results, including margins, contours and contacts, should be clinically acceptable. The long-term

A. prognosis for continued function should be good (estimated at 5 years or more). Restorative dentistry includes the restoration of hard tooth structure lost as a result of caries, fracture or trauma
B. Restorative procedures in operative dentistry include amalgam, composites, crowns, and other cast or milled restorations, as well as the use of various temporary materials

Operative Dentistry Guidelines

Placement of restoration includes:

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

Amalgam Fillings, Safety & Benefits

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

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

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

Primary objective of restorative dentistry is to remove caries conservatively, preserve tooth structure, and maintain tooth vitality.

Restoration of teeth is appropriate when there is radiographic evidence of caries, loss of tooth structure, defective or missing restorations, and/or for post-endodontic purposes.

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

A filling cannot be billed in cases where decay or a fracture does not extend into dentin.

Clinical/Coverage Guidelines

A. Restorative procedures in operative dentistry include silver amalgam; resin-based composites; direct or indirectly fabricated inlays, onlays, and crowns of various materials; certain prefabricated restorations (i.e. stainless steel or polycarbonate type crowns), as well as the use of various temporary material.

B. The choice of restorative materials depends on the nature and extent of the defect to be restored, location in the mouth, stress distribution expected during mastication and esthetic requirements
   - The procedures of choice for treating caries or the replacement of an existing restoration not involving or undermining the cusps of posterior teeth is generally amalgam or composite
   - The procedures of choice for treating caries or the replacement of an existing restoration not involving or undermining the incisal edges of an anterior tooth is composite. Decay limited to the Incisal edge only, may still be a candidate for a filling restoration if little to no other surfaces exhibit caries or breakdown

Expectations of Treatment: Treatment results, including margins, contours, and contacts, should be clinically acceptable. Restorative dentistry includes the restoration of hard tooth structure lost, as a result of caries, fracture, or trauma. The long-term prognosis of the tooth should be good.

Restorative procedures on teeth with poor prognosis are not reimbursed. Criteria for determining teeth with poor prognosis:

- Caries involving root furcation or below the bone level
- Teeth with severe periodontal support (less 50% bone support)
- Exfoliating Primary teeth
- Presence of apical pathology

Payment is based on the number of surfaces restored, not on the number of restorations per tooth, per day; all restorative surfaces shall be considered connected.

The provider will not receive reimbursement, if replacement of a restoration is billed by the provider who placed the original restoration within first 36 months of initial placement.

Restorations for altering occlusion involving vertical dimension and the replacement of tooth structure lost due to attrition, erosion, abrasion, abfraction, and corrosion are not covered. Exception: A class V Facial/Buccal or Lingual surface is allowed in the presence of caries, pathology or documented medical necessity.

- Teeth where exfoliation is imminent will not be reimbursed. Reimbursement will include bases or liners, tooth desensitizing materials and local anesthesia
- Reimbursement for one restoration in each tooth surface irrespective of the number or combination of restorations placed or if restoration is on non-contiguous surfaces
- Reimbursement for occlusal surface restorations includes extensions onto the occlusal 1/3 of the buccal or lingual surfaces
- Reimbursement for interproximal restorations extending onto the buccal or lingual surfaces must have margins that extend 1/3 onto those surfaces and supported by radiographic evidence
- Restorations for cervical abrasion or incisal wear due to bruxism will not be covered without documented medical necessity
- The replacement of clinically acceptable amalgam fillings with an alternative material (composite, crown, etc.) is considered cosmetic and is not covered unless decay or fracture is present

Restorative procedures in operative dentistry include silver amalgam; resin-based composites; direct or indirectly fabricated inlays, onlays, and crowns of various materials; certain prefabricated restorations (i.e. stainless steel or polycarbonate type crowns), as well as the use of various temporary material.

- Pulpotomies and pre-formed crowns for primary teeth are covered only if the tooth is expected to be present for at least six months
- For posterior primary teeth that have had extensive loss of tooth structure, the appropriate treatment is generally a prefabricated stainless-steel crown or for anterior primary teeth, a stainless steel or prefabricated resin crown
- 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
- An onlay should be considered when there is sufficient tooth structure, but cusp support is needed
- An inlay is an intracoronal restoration and should have the same indications as a filling. It may not be practical due to the cost and limited use in current clinical dentistry practices but may be considered for dental schools and residency programs

A. The choice of restorative materials depends on the nature and extent of the defect to be restored, location in the mouth, stress distribution expected during mastication and esthetic requirements
    1. The procedures of choice for treating caries or the replacement of an existing restoration not involving or undermining the cusps of posterior teeth is generally amalgam or composite
    2. 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
    3. Restorations for chipped teeth may be covered
    4. The replacement of clinically acceptable amalgam fillings with alternative materials (composite, crown, etc.) is considered cosmetic and is not covered
    5. 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

6. Pulpotomies and pre-formed crowns for primary teeth are covered only if the tooth is expected to be present for at least six months
7. For posterior primary teeth that have had extensive loss of tooth structure, the appropriate treatment is generally a prefabricated stainless-steel crown or for anterior teeth, a stainless steel or prefabricated resin crown
8. When incisal edges of anterior teeth are undermined because of caries or replacement of a restoration undermining the incisal edges or a fracture, the procedures of choice may include crowns
9. Crowns should only be considered when cusp support is needed, and tooth cannot be treated with a filling restoration
10. Inlays and Onlays are not covered on FL Medicaid plans

B. 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

Behavior Management

A. D9920 is to be used for situations when the client is developmentally disabled, mentally ill, or especially uncooperative and difficult to manage resulting in dental staff providing additional time, skill, and/or assistance to render treatment. Providers should not bill for Behavior Management, D9920, for basic behavior guidance techniques such as tell-show-do, positive reinforcement, parental presence or absence, or voice control methods of behavior management

1. Narratives explaining the need for Behavior Management as well as the behavior management techniques used under Medicaid plans must accompany claims submitted for procedure code D9920
    - The narrative must clearly indicate the unique severe behavior, the medical or behavioral condition and/or the complexity of the treatment provided
2. The following documentation should be submitted with the claim:
    - Describe the highest level of behavior management technique used for the member in the comments field of your paper or electronic claim. Comments such as "additional staff and time", "papoose board", "protective stabilization" as well as duration of application, indication for stabilization and behavior management technique used

B. Payment for behavior management when billed with preventive and diagnostic procedures is generally not covered

C. For children above the age of 9, the narrative must clearly indicate the unique severe behavior, the medical or behavioral condition and/or the complexity of the treatment provided

D. Behavior management is not billable on the same day of service as the acclimation visit code.

Nitrous Oxide

- The use Nitrous Oxide for anxiolysis must be guided by the complexity of medical and behavioral conditions, the difficulty of the dental treatment, and the utilization of alternative behavioral modification strategies
- For children above the age of 12, the narrative must clearly indicate the unique severe behavior, the medical or behavioral condition and/or the complexity of the treatment provided

Orthodontics

A. Orthodontic procedures are limited to recipients under the age of 21 who meet the orthodontic requirements as stated in the Florida Medicaid Dental Services Coverage Policy

B. Orthodontic care is only payable when orthodontist performs the services

C. When removable appliance (D8210) and fixed appliance (D8220) therapy is needed, it is inclusive of comprehensive transitional, adolescent, and adult dentition treatment of D8070, D8080, D8090

- 24 units within a 36-month period, which includes the removal of the appliances and retainers at the end of treatment. Covered once in a Lifetime

D. Pre-authorization including Florida Medicaid Orthodontic Handicapping Labio-Lingual Deviations (HLD), cephalometric and panoramic image is required for all orthodontic services. If you are requesting a benefit which exceeds the standard orthodontic benefit, please submit the request on an ADA Dental Claim Form with a narrative explaining why the additional service is needed. A copy of the current ADA Dental Claim Form can be found at ADA Claim Form -Click Here

Restorative Code Guidelines

D1351-Sealant – per tooth

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

- Sealants on permanent molars are a covered benefit if the incipient caries and resin restoration does not penetrate dentin(sealants for premolars are not a covered benefit)

B. Not covered for primary teeth

C. Not covered for 3rd molars with the exception of instances where the 3rd molar has erupted into the place of the 2nd molar if the 2nd molar is not present

D2140-D2161 and 2330-2335 and D2391-D2394 – Amalgam Restorations and Resin-Based Composite Restorations

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

Silver Diamide Fluoride (SDF D1354)

It is generally accepted that two applications of SDF are necessary to ensure the arrest of active carious lesions. Once it has been determined after the two treatments that caries has been arrested, restorative care is generally not necessary in the primary dentition. The two applications may be placed in intervals at the discretion of the treating dentist, and the benefit will be allowed up to two services per tooth in a lifetime.

Caries Preventive Medicament Application (D1355)

A. Preventive procedure contingent on provider diagnosis of member's clinical condition for primary prevention or remineralization

B. Per tooth preventive procedure (not similar to D1206 / 1208 Fl applications which are full mouth procedures). A D1355 is not payable on the same day as D1206, D1208

C. Applicable to both Primary and permanent teeth
   1. Not payable on 3rd molars or primary teeth that are about to exfoliate

D. Tooth must have no evidence of a carious lesion

E. Prompted by documented Caries Risk Assessment finding of:
   1. High Caries Risk D0603
   2. Moderate Caries Risk D0602

F. Not payable for more than 4 teeth per visit

G. Payable once per tooth every 3 years

H. Narrative Required

I. Cannot be applied to a tooth with an existing restoration
   1. Not payable with history of restorations on applicable tooth with the following CDT codes:
      - D2140-D2161
      - D2330-D2335
      - D2390-D2394
      - D2510-D2941
      - D2960-D2962

J. Not payable in conjunction with the following codes:
   - D1351
   - D1354

Crowns

Single Crowns – Refer to Plan Benefits for Pre-Approval Requirements

A. When bicuspid and anterior crowns are covered, the Medicaid benefit includes a porcelain-fused-to-base-metal crown or a porcelain/ceramic substrate crown
   1. For crowns to be covered, any of the following criteria must be met:
      a. more than 50% of the tooth must be damaged due to decay, fracture or injury
      b. have had root canal treatment with a good endodontic prognosis
      c. have an existing defective crown

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

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

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

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

Core Buildups D2950

A. Buildups are considered inclusive with crowns. A separate fee may be allowed when submitted with supporting documentation:
   1. Documentation must show that without a build-up, there is insufficient tooth structure remaining to retain and support a crown. A core buildup is not a filler to eliminate any undercut, box form or concave irregularity in a preparation. Likewise, a core buildup is not appropriate due to shallow caries that are likely to be removed during crown preparation.

Post and Core Procedures Include Buildups

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

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

Outcomes

A. Margins, contours, and contacts must be clinically acceptable

B. Prognosis for continued function should be good for a minimum of 5-years

Removable Prosthodontics

A. Partial Dentures (Codes D5211 – D5281)

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

Florida Medicaid allows one partial, complete, or interim denture per arch per lifetime. For example: If a member receives a partial or interim denture the benefit has been exhausted and will not be eligible for a future complete denture for the same arch.

Determination of Functional Occlusion: To determine if a removable prosthetic is essential, eight posterior natural or prosthetic molars and/or bicuspids in occlusion will be considered adequate for functional purposes. Four maxillary and four mandibular teeth in functional contact are considered adequate. If it is determined that the enrollee has eight posterior natural or prosthetic molars and/or bicuspids in occlusion, then the removable prosthetic may not be considered necessary.

1. Removable partial denture is normally not indicated for a single tooth replacement of non-functional second or third molars (i.e., no opposing occlusion), except when an anterior tooth is missing
2. Removable partial dentures are covered when posterior teeth require replacement on both sides of the same arch or multiple edentulous areas are present (excluding non-functional second or third molars). Remaining teeth must have a good endodontic prognosis, a good restorative prognosis and a good periodontal prognosis
3. An interim partial denture may be needed when the remaining teeth have a good prognosis
4. A partial denture may be covered if the patient has an existing partial denture that is not serviceable, or an initial partial denture is being performed and the patient has several missing teeth on both sides of the same arch
5. For a treatment plan that includes both a fixed bridge and a removable partial denture in the same arch, the removable partial denture is considered the covered service
6. A unilateral removable partial denture is rarely appropriate. Best practices include replacing unilateral missing teeth with a fixed bridge or implant
7. Endodontic, periodontal, and restorative treatment should be completed prior to fabrication of a removable partial denture
8. Abutment teeth should be restored prior to the fabrication of a removable partial denture and would be covered if the teeth meet the same standalone benefit requirements of a single crown
9. Removable partial dentures should be designed so that they do not harm the remaining teeth and/or periodontal tissues, and to facilitate oral hygiene
10. Materials used for removable partial dentures must be strong enough to resist breakage during normal function, nonporous, color stable, esthetically pleasing, non-toxic and non-abrading to the opposing or supporting dentition

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

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

C. Replacement of an Existing Complete or Partial Denture:

1. Removable complete or partial dentures are not covered for replacement if an existing appliance can be made satisfactory by reline or repair
2. Complete or partial dentures are not a covered if a clinical evaluation reveals the presence of a satisfactory appliance, even if a patient demands replacement due to their own perceived functional and/or cosmetic concerns

D. Complete or Partial Denture Adjustments (Codes D5410 – 5422)

1. An immediate complete or removable partial denture includes routine post-delivery care, adjustments, and soft liners for six months
2. A conventional complete or removable partial denture includes routine post-delivery care and adjustments for three months
3. A prospective or retrospective request for a complete or partial denture adjustment must include documentation that the appliance is ill-fitting

E. Repairs to Complete and Partial Removable Dentures (Codes D5511 – D5671) must include documentation that demonstrates the appliance is broken or in need of repair

F. Relines for Complete and Partial Removable Dentures (Codes D5730 – D5761)

1. Supporting soft tissues and bone shrink over time, resulting in decreased retention and/or stability of the appliance
2. A rebase or reline of a partial or complete denture would be covered (subject to plan limitations) if documentation demonstrates that the appliance is ill-fitting and may be corrected by rebasing or relining, resulting in a serviceable appliance

G. Interim Removable Partial Dentures (Codes D5820 and D5821)

1. These appliances are only intended to temporarily replace extracted teeth during the healing period, prior to fabrication of a subsequent, covered, fixed or removable partial denture. Benefits may not exist for both an interim and definitive partial denture
2. The submitted documentation must show that the existing partial denture is unserviceable
3. Removable partial dentures are covered when posterior teeth require replacement on both sides of the same arch or multiple edentulous areas are present (excluding non-functional second or third molars) and the remaining teeth have a good prognosis

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

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

1. Full or partial dentures are not covered for replacement if an existing appliance can be made satisfactory by relining or repair
2. 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
3. Abutment teeth should be restored prior to the fabrication of a removable appliance and may be

covered if such teeth meet the same stand-alone benefit requirements of a single crown

4. Partials should be designed to minimize any harm to the remaining natural teeth
5. Materials used for removable partial dentures should be strong enough to resist breakage during normal function, nonporous, color stable, esthetically pleasing, non-toxic and non-abrading to the opposing or supporting dentition
6. Appliances should be designed to minimize any harm to abutment teeth and/or periodontal tissues, and to facilitate oral hygiene

J. Complete Dentures Codes D5110 and D5120

1. Florida Medicaid allows one partial, complete, or interim denture per arch per lifetime. For example: If a member receives a partial or interim denture the benefit has been exhausted and will not be eligible for a future complete denture for the same arch
2. Complete dentures are the appliances of last resort, particularly in the mandibular arch. Patients should be fully informed of their significant limitations. A complete denture may not be covered if some teeth are still present in the arch and extraction of the remaining teeth is not necessary
3. Establishing vertical dimension is considered a part of and included in the fee/process for fabricating a complete denture (standard, interim or immediate). Therefore, benefits for a complete denture are not limited or excluded in any way simply because of the necessity to establish vertical dimension
4. An immediate complete or removable partial denture includes routine post-delivery care, adjustments, and soft liners for six months. A conventional complete or removable partial denture includes routine post-delivery care and adjustments and soft liners for three months
5. Proper patient education and orientation to the use of removable complete dentures should be part of the diagnosis and treatment plan. Educational materials regarding these prostheses are highly encouraged to avoid misunderstandings and grievances, and to manage patient expectation
6. Florida Medicaid covers prosthetic services to diagnose, plan, rehabilitate, fabricate, and maintain dentures as follows:
   - One of the following per recipient:
     - One complete set of full dentures
     - One complete set of removable partial dentures
     - Combination of complete or partial dentures not to exceed one appliance per arch per lifetime
   - One reline, per denture, per 366 days, per recipient
   - One all-acrylic interim partial (flipper) for the anterior teeth, per recipient under the age of 21 years

K. Interim Complete Dentures (Code D5130 and D5140)

1. FL Medicaid allows one partial, complete, or interim denture per arch per lifetime. For example: If a member receives a partial or complete denture the benefit has been exhausted and will not be eligible for a future interim denture for the same arch
2. These 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
3. An immediate complete denture includes routine post-delivery care, adjustments, and soft liners for six months
4. An immediate complete denture is not a benefit as a temporary denture

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

However, the management of patient expectation must be performed by the treating dentist to ensure that the enrollee understands the need for replacement dentures so soon after having the first set, including the acceptance of any additional cost.

L. Repairs and Relines

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

Section 9. Specialty Care Referral Guidelines

Specialty Care Referral

The following guidelines outline the specialty care referral process (but does not apply to iBudget enrollees). Failure to follow any of these guidelines may result in financial penalties against your office. The specialty referral form can be found at www.libertydentalplan.com under "Provider Resources." *All codes listed in this section may not be covered under all benefit plans. Referrals are subject to an enrollee's plan-specific benefits, limitations, and exclusions. Please refer to the Enrollees-specific Florida Medicaid Plan Benefit Schedule to determine plan-specific details regarding procedure codes and benefit coverage.

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

Enrollees with special health care needs do not require a Referral to a specialist. Either your office or the enrollee can contact LIBERTY's Member Services Department directly for assistance in locating a specialist that can treat the enrollee's dental needs, as well as any special health care needs.

Non-Emergency Referral Submission and Inquiries

Primary Dental Providers must submit a referral request to the Plan for prior approval. There are three options to submit a specialty care referral:

Provider Portal	Fax	Mail
Provider Portal Sign In -Click Here	714.389.5092	LIBERTY Dental Plan Attn: Referral Department P.O. Box 15149 Tampa, FL 33684-5149

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

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

The LIBERTY Specialty Care Referral Request Form or an Attending Dentist Statement must be completed and

used when making a referral. The form may be photocopied and duplicated in your office as needed.

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

Emergency Referral

If emergency specialty care is needed, perform palliative care to ameliorate the member's pain and submit a referral on the web as urgent.

Endodontics

Referral Guidelines for the Primary Dental Provider: Confirm the need for a referral, including that the tooth has a good prognosis and is restorable. The Primary Dental Provider "PDP" or the Enrollee, may direct refer to a LIBERTY contracted endodontist. The following must be provided:

- Enrollee's name, LIBERTY identification number, group name and group number
- Name, address and telephone number of the contracted LIBERTY network Endodontist
- Procedure code(s) and tooth number(s), treatment recommended and supporting documentation for the covered endodontic treatment

Inform the enrollee that:

- Payment by the Plan is subject to eligibility at the time services are rendered

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

Referral Guidelines for the Endodontist: Endodontist can see a LIBERTY enrollee based on a direct referral from either the PDP or the enrollee. Consultation and medically necessary diagnostic records are covered at initial visit.

For any services, other than initial consultation and medically necessary diagnostic records, a preauthorization request to the Plan with a copy of pre-operative periapical radiograph(s) is required. Root canal therapy will only be approved when the tooth has a good periodontal and restorable prognosis.

After completion of treatment, submit your claim for payment with pre-operative and post-operative periapical radiographs. X-rays and other supporting documentation will not be returned. Please do not submit original x-rays. X-ray copies of diagnostic quality or paper copies of digitized images are acceptable.

Oral Surgery

Referral Guidelines for the Primary Dental Provider: 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:

- Enrollee'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 enrollee that:

- Only services approved by LIBERTY will be covered
- Payment by the Plan is subject to eligibility at the time services are rendered

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

LIBERTY Staff Dental Consultant will review referral to ensure requested procedures meet referral guidelines and plan benefits.

Referral Guidelines for the Oral Surgeon: Obtain the LIBERTY Specialty Care Authorization and appropriate radiograph(s) from LIBERTY, Primary Dental Provider, or enrollee.

For any services, other than those listed on the original authorization form from LIBERTY, submit a preauthorization request to the Plan with a copy of pre-operative periapical radiograph(s) and of the enrollee's LIBERTY Specialty Care Authorization Payment will be based on the services meeting medical necessity and specialty referral guidelines of the plan.

If an emergency oral surgery service is needed but has not been listed by the Primary Dental Provider on the LIBERTY Specialty Care Authorization, the Oral Surgeon should perform the medically necessary services on the member and send in a narrative stating what the emergency was and why the service was added. This information will be reviewed for medical necessity on the claim.

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

Oral Surgery Referral Guidelines

Oral Surgery Referrals (Subject to Plan Benefits)		Procedures Usually Approved for Referral	Referral Criteria	Qualified for Emergency Referral
D0220	Intraoral - periapical first radiographic image	By Report	Non-diagnostic x-rays sent by referring dentist	By Report
D0330	Panoramic radiographic image	By Report	Non-diagnostic x-ray(s) sent by General Dentist	By Report
D7111	Extraction, coronal remnants - primary tooth	No	N/A	No
D7140	Extraction, erupted tooth or exposed root (elevation and/or forceps removal)	No	N/A	No
D7210	Surgical removal of erupted tooth requiring elevation of mucoperiosteal flap & removal of bone and/or section of tooth	No	General Dentist's x-ray(s) supports the procedure to be "outside the scope" of his or her skills and/or five (5) or more teeth to be extracted.	By Report

D7220	Removal of impacted tooth - soft tissue	Yes	With documented active pathology	Yes
D7230	Removal of impacted tooth - partially bony	Yes	With documented active pathology	Yes
D7240	Removal of impacted tooth - completely bony	Yes	With documented active pathology	Yes
D7241	Removal of impacted tooth - completely bony, with unusual surgical complications	Yes	With documented active pathology	Yes
D7250	Removal of residual tooth roots (cutting procedure)	By Report	X-ray must support the use of this code	Yes
D7280	Exposure of an unerupted tooth	Yes		Yes

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

Oral Surgery Referral Guidelines

Oral Surgery Referrals (Subject to Plan Benefits)		Procedures Usually Approved for Referral	Referral Criteria	Qualified for Emergency Referral
D7283	Placement of device to facilitate eruption of impacted tooth	Yes		Yes
D7285	Incisional biopsy of oral tissue - hard (bone, tooth)	Yes		Yes
D7286	Incisional biopsy of oral tissue - soft	Yes		Yes
D7310	Alveoloplasty in conjunction with extractions - 4 or more teeth or tooth spaces, per quadrant	By Report	May be included in multiple surgical extractions	No
D7311	Alveoloplasty in conjunction with extractions - 1 to 3 teeth or tooth spaces, per quadrant	By Report	May be included in multiple surgical extractions	By Report
D7320	Removal of impacted tooth - soft tissue	By Report	With documented active pathology	Yes
D7321	Removal of impacted tooth - partially bony	By Report	With documented active pathology	Yes
D7321	Removal of impacted tooth - completely bony	By Report	With documented active pathology	Yes
D7471	Removal of impacted tooth - completely bony, with unusual surgical complications	Yes	By Report	Yes
D7960	Removal of residual tooth roots (cutting procedure)	Yes	By Report	Yes
D7970	Excision of hyperplastic tissue - per arch	Yes	By Report	Yes
D9310	Consultation - other than requesting dentist	Yes	Not payable one same day as treatment	Yes

Orthodontics

Referral Guidelines for the Primary Dental Provider: Primary Dental Provider "PDP" or the Enrollees may direct refer to a LIBERTY contracted orthodontist, or the "PDP" can complete a LIBERTY Specialty Care Authorization and provide the:

Complete a LIBERTY Specialty Care Authorization and provide the:

- Patient's name, LIBERTY identification number, group name and group number
- Name, address and telephone number of the contracted LIBERTY network Orthodontist
- Comments concerning the enrollee's malocclusion

Referral Guidelines for the Orthodontist: Pre-authorization must be obtained prior to banding.
To be eligible for orthodontia services, the recipient must meet all the following general requirements:

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

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

Periodontics

Referral Guidelines for the Primary Dental Provider: 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, LIBERTY identification number, group name and group number
- Name, address and telephone number of the contracted LIBERTY network Periodontist
- Procedure code(s) and tooth number/quadrant(s) for the covered periodontal treatment, which require referral

Inform the enrollee that:

- Only services approved by LIBERTY will be covered
- The enrollee will be financially responsible for non-covered and non-approved services provided by the Periodontist
- Payment by the Plan is subject to eligibility at the time services are rendered
- Submit referral to LIBERTY with appropriate documentation/x-rays through i-Transact, fax, or via standard mail service
- The Plan's Staff Dental Consultant will review referral to ensure requested procedures meet referral guidelines and plan benefits

Referral Guidelines for the Periodontist: Obtain the LIBERTY Specialty Care Authorization and appropriate radiograph(s) from LIBERTY, Primary Dental Provider, or enrollee.

For any services, other than those listed on the original authorization form from LIBERTY, you may submit a preauthorization request to the Plan with a copy of pre-operative periapical radiograph(s) and of the enrollee's LIBERTY Specialty Care Authorization or you can perform the services and submit with documentation for review prior to payment. Payment will be based on the services meeting medical necessity and specialty referral guidelines of the plan.

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

- Pre-operative radiographs
- Complete periodontal charting showing six-point probing of each natural tooth and any furcation involvements, abnormal mobility, or areas of recession. Submit x-rays that were enclosed with original authorization form (or copies)
- The enrollee's LIBERTY Specialty Care Authorization

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

Prior to any treatment, please verify enrollee eligibility, plan benefits and exclusions and limitations.

Periodontal Referral Guidelines

Periodontal Referrals Primary Dental Provider Specialty Care Guidelines (Subject to Plan Benefits)		Procedures Usually Approved for Referral	Referral Criteria	Items to be sent to LDP and specialist
D0210	Intraoral - complete series of radiographic images	No	No	Yes
D4210	Gingivectomy or gingivoplasty - 4 or more contiguous teeth or bounded teeth spaces per quadrant	By Report	Diagnostic Full Mouth x-rays & Full Mouth periodontal probings	Diagnostic Full Mouth x-rays & Full Mouth probings
D4211	Gingivectomy or gingivoplasty - 1 to 3 contiguous teeth or bounded teeth spaces per quadrant	By Report		
D4240	Gingival flap procedure, including root planing - 4 or more contiguous teeth or bounded teeth spaces per quadrant	By Report	Diagnostic Full Mouth x-rays & Full Mouth periodontal probings	Diagnostic Full Mouth x-rays & Full Mouth probings
D4241	Gingival flap procedure, including root planing - 1 to 3 contiguous teeth or bounded teeth spaces per quadrant	By Report		
D4260	Osseous surgery (including elevation of a full thickness flap and closure) - 4 or more contiguous teeth or tooth bounded spaces per quadrant	By Report	When approved, limited to no more than two quadrants on the same date of service	Full Mouth x-rays, Full mouth periodontal probing's, dates of SRP's & follow-up evaluation
D4261	Osseous surgery (including elevation of a full thickness flap and closure) - 1 to 3 contiguous teeth or tooth bounded spaces per quadrant	By Report	By Report	
D4341	Periodontal scaling & root planing - 4 or more teeth per quadrant	No	For moderate to severe periodontitis, "may" be considered for referral	
D4342	Removal of impacted tooth - completely bony, with unusual surgical complications	No	For moderate to severe periodontitis, "may" be considered for referral	If approved, limited to no more than two quadrants on the same date of service
D9310	Consultation - d other than requesting dentist	Yes	Not payable on same day as other treatment	By Report

Periodontic Referral Coverage Based on Diagnosis

Gingivitis associates with dental plaque

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

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

Slight Chronic/Aggressive Periodontitis (localized or generalized)

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

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

Moderate Chronic/Aggressive Periodontitis, (localized or generalized)

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

Referral to a Periodontist is covered, after scaling and root planing by the assigned Primary Dental Provider, for a problem-focused examination and possible periodontal surgery.

Severe Chronic/Aggressive Periodontitis (localized or generalized)

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

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

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

Refractory Chronic Aggressive Periodontitis

- Defined as a periodontitis case that treatment fails to arrest the progression of periodontitis – whatever the thoroughness or frequency – as well as patients with recurrent disease at single or multiple sites
- Refractory Chronic/Aggressive Periodontitis is eligible for direct specialty referral. Referral to a Periodontist covered to confirm the diagnosis of Refractory Chronic/Aggressive Periodontitis and to advise you on the patient's management and care

Section 10. Process for Ambulatory Surgical Centers (ASC) and Hospital Call

Code D9420 will require a Medical Necessity Review to include an ASC/Hospital Assessment form, narrative and treatment plan.

1. D9420 is to be used for situations when the client is developmentally disabled, mentally ill, or especially uncooperative and difficult to manage AND has experienced failed attempts at advanced behavior management techniques in the traditional office setting.
2. Preauthorization's must include:
   - ASC/Hospital Assessment Form. This form should capture the patient's age (range), number of teeth to be treated, a narrative which clearly indicates the unique severe behavioral or medical conditions, complexity of treatment, and any previous advanced behavior management techniques or documented failed attempts at treatment in the dental setting.

     Liberty ASC/Hospital Assessment Form-Click Here
   - Treatment plan. The treatment plan should include all related services. If a treatment plan cannot be submitted, the provider may document in the narrative how a treatment plan will be developed, along with a detailed narrative of why no treatment plan is being submitted, and a detailed narrative outlining medical necessity for dental treatment to be performed in an ambulatory surgical canter or hospital facility setting.
   - Radiographs/Clinical Photos. The photos should help demonstrate medical necessity of care. If radiographs or clinical photos are unable to be captured. Provider should include a unique and descriptive narrative regarding member's oral health conditions and provide radiographs for prepayment review if services were conditionally
3. Code D9420 will be denied if the assessment form and narrative provided do not meet the threshold of medical necessity,
4. Code D9420 will be denied if no eligible services are approved or proposed (i.e. member receiving at least one covered service).
5. Code D9420 is generally not covered when billed with preventive and diagnostic procedures only.

Section 11. Quality Management

Program Description

LIBERTY's Quality Management and Improvement (QMI) Program is designed to ensure that licensed dentists are reviewing the quality of dental care provided, that quality of care problems are identified and corrected, and follow-up is planned when indicated. The QMI Program continuously and objectively assesses dental patient care services and systems for all enrollees, including enrollees with special healthcare needs. Ongoing monitoring of compliance with prescribed standards ensures a constant process of quality improvement that encompasses clinical and non-clinical functions.

LIBERTY's QMI Program provides a structured and comprehensive review of the quality and appropriateness of care delivered by the entire network of dental providers. LIBERTY documents all quality improvement initiatives, processes, and procedures in a formal QMI Plan. The Dental Director, or his/her designee, oversees the QMI Program and ensures that day-to-day quality assurance functions are carried out in compliance with dental program contracts and applicable requirements.

QMI Program Goals and Objectives

The goal of the QMI Program is to comprehensively identify and address the quality of dental care and service to our enrollees. The QMI Program provides a review of the entire range of care to establish, support, maintain, and document improvement in dental care. These goals are achieved through the ongoing, objective assessment of services, systems, issues, concerns, and problems that directly and indirectly influence the enrollee's dental health care.

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

Program Scope

LIBERTY's QMI Program includes the following components: dental management, credentialing, standards of care, dental records, utilization review, peer review, environmental health and safety/infection control, enrollee rights and responsibility, and enrollee and provider grievances and appeals. The QMI document describes the programs, processes and activities that make up this integrated effort.

- Providing immediate and responsive feedback to enrollees, providers and the public as appropriate
- Policy and procedure development
- Annual QMI evaluation and report
- Annual QMI Work Plan development
- Identification of quality issues and trends
- Monitoring of quality measurements
- Quality-of-care focus studies
- Monitoring of the provider network
- Review of acceptable standards of dental care
- Continuing provider education
- Enrollee health education

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

- Accessibility of Care: the degree to which dental providers and specialty providers are available within a designated service area
- Availability of Care: ease and timeliness to which patients can obtain the care that they need. The degree to which the correct care is provided, given the current community standards

- Continuity of Care: the degree to which the quality of care is coordinated from one setting of care or provider of care to another within a given timeframe
- Quality of Care: the degree to which the dental care provided and achieves the expected improvement in dental health consistent with the current community standard
- Safety of the care environment: the degree to which the environment is free from hazard and danger to the enrollee

Quality Management Program Content and Committees

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

- Quality Management and Improvement Committee: The Committee reviews, formulates, and approves all aspects of dental care provided by LIBERTY's Network Providers, including the structure under which care is delivered, the process and outcome of care, utilization and access to care, availability, referrals to specialists, continuity of care, safety, appropriateness, and any problem resolution in the dental delivery system identified by the Peer Review and Utilization Management Committees.
- Quality Assurance Review: The Quality Assurance Review process is intended to assess the structure, process, and outcome of dental care provided under LIBERTY's programs. The quality assessment's goal is to identify any significant deficient areas, so quality improvement actions may be taken to ensure the office meets professionally recognized standards
- Pre-Contractual Facility Review: When required by client or regulation, a pre-contractual facility audit is conducted as a part of the initial contracting process. An applicable On-Site Assessment Structural Review audit tool will be used, and the audit will be performed by a trained Network Manager. A non-passing score must be reviewed by the Dental Director, or designee, to determine whether a Corrective Action Plan (CAP) must be implemented before active provider status is received
- Focus Reviews: The Dental Director or designee may determine the need for focus reviews triggered by various findings such as PQIs, grievances, utilization outlier status, potential fraud, waste or abuse, or other administrative reasons

Upon identification of a PQI, LIBERTY's Dental Director, or designee, may apply corrective action plans as necessary to ensure offices are following the QM Guidelines and Standards. The offices are monitored to ensure providers attain a sufficient level of compliance and follow up activities are undertaken at least quarterly or more frequently if warranted. If deficiencies and issues remain, LIBERTY's QMI Committee will determine additional corrective actions and refer to Peer Review for recommendations for the office terminated from the network.

- Access and Availability: LIBERTY's AA Committee has established standards for geographic access and for timeliness of preventive care appointments, routine appointments, urgent appointments, emergency care, after hours care access, wait time in the provider office, and elements of telephone service. Opportunities for improvement are identified, decisions are made, and specific interventions are implemented to improve performance where needed. Compliance with access and availability standards is monitored and CAPs are developed if deficiencies occur. Activities are reviewed by the QMI Committee quarterly, or more frequently, if necessary

- Credentialing: Our Credentialing Program includes initial credentialing and re-credentialing at 36-month intervals of all primary and specialty care dentists listed in the Provider Directories. Pertinent findings are reviewed quarterly or more frequently if deemed necessary during Credentialing Committee meetings. Quality-of-care issues are then referred to the Peer Review Committee for recommendations and further action.
- Cultural and Linguistic Competency (CLC): LIBERTY establishes processes and procedures for providing support, maintaining compliance, and creating cultural awareness for all enrollees, providers, and associates. As part of the CLC Program, information about language (spoken and written), race and ethnicity information are gathered and analyzed. LIBERTY monitors and assures that its delegated entities provide all services, conform to regulations, and develop all reports and assessments as specified by applicable regulations and agencies
- Dental Disease Management: LIBERTY's innovative Disease Management Program is designed to support the clinician-patient relationship plan of care and help bridge the gap between oral health and systemic health. Our program emphasizes prevention of disease-related exacerbations and complications using evidence-based practice guidelines and patient empowerment tools. The goals of this program include improving patient self-care through education, monitoring, and communication; improving communication and coordination of services between patient, dentist, physician, and plan; and improving access to care, including prevention services. As part of our quality initiative, LIBERTY works closely with our client partners to coordinate and implement this program
- Health Education and Promotion/Outreach: LIBERTY's Health Education Department communicates with and educates its participating dental providers about available health education and improvement services and programs. On a regular basis, the Health Education Department communicates a summary of health education and promotion activities to the QMI Committee
- Peer Review Committee (PRC): The Peer Review Committee is responsible for identification and resolution of quality of care issues. PQIs are identified through various means, including but not limited to the review of grievance and appeal patterns, onsite audit scores, as well as provider utilization data. The PRC is focused improving care to enrollees and minimizing potential risk cases, identifying trends of questionable care, and developing corrective action plans to ensure resolutions. The PRC identifies opportunities for improvement, with the goal of examining complex cases and options for treatment across the spectrum of care. LIBERTY's Peer Review activities routinely include the participation of providers and specialists when appropriate
- Potential Quality Issues (PQIs): As part of the QMI Program, LIBERTY has policies and procedures in place that allow us to investigate PQIs from a variety of sources, and then routinely collate quality information about providers. LIBERTY commonly investigates PQIs from grievances ruled against the dental provider utilization patterns, significant departure from expected contractual behavior or compliance, external vendor and business partner identification, and others. The Dental Director or designee reviews each case to assess the quality of care/service provided and provides a determination for corrective action based on the severity of an individual case. Follow-up actions, including provider counseling and/or CAPs are required of all involved providers for whom a quality-of-care or service issue is confirmed
- Grievances and Appeals: The Grievance and Appeals Department investigates and resolves issues for the services or operations that are the subject of concern and ensures that issues presented by LIBERTY enrollees and providers are resolved in a fair and timely manner. LIBERTY's grievance and appeal program, policies and procedures are consistent with applicable program, state and/or federal requirements
- Utilization Data Review: The goal of the UM Committee is to maximize the effectiveness of care provided to the enrollee. The UM Committee monitors over- and under-utilization of services, identifies treatment patterns for analysis and ensures that utilization decisions are made in a timely manner which accommodate the urgency of the situation and minimizes any disruption in the provision of care

Section 12. Dental Provider Incentive Program (DPIP)

- ### What is the DPIP Program?

  The Dental Provider Incentive Program (DPIP) is designed to enhance the quality of dental care for Medicaid recipients under the age of 21. It provides financial incentives to dental providers who meet specific performance benchmarks related to preventive and diagnostic dental services.

- ### Program Goals:
  - Improve oral health outcomes for children and adolescents.
  - Increase access to high-quality dental care.
  - Reward providers who deliver superior care based on key performance measures.

- ### Eligibility for Incentives:

  General Dentists and Pediatric Dentists who are participating in Medicaid and meet the qualifying criteria. Excluded providers include Federally Qualified Health Centers (FQHCs), Rural Health Clinics (RHCs), County Health Departments (CHDs), and Faculty Plans of Florida Dental School Faculty Physician Groups.

- ### Qualifying Criteria:

  To qualify for DPIP incentives, providers must achieve or exceed benchmarks in the following areas:
  - Preventive Dental Services: Percent of children who receive preventive dental services.
  - Oral Evaluations: Percent of children who receive comprehensive or periodic oral evaluations.
  - Caries Risk Assessment: Documentation of caries risk for enrolled children.
  - Sealants on Permanent Molars: Percentage of children who receive sealants on permanent first molar teeth.
  - Topical Fluoride Applications: Number of children who receive at least two topical fluoride applications within the reporting year.

- ### Payment Structure:

  Providers who meet the DPIP criteria will receive enhanced payments equivalent to 140% of the Florida Medicaid fee-for-service rate for eligible preventive and diagnostic services.
  Payments are made either through a capitated arrangement or fee-for-service, as defined in the provider agreement.

Procedure	Description	FFY 2024-2025 DPIP Rate
D0120	Periodic oral evaluation – established patient	$31.35
D0150	Comprehensive oral evaluation – new or established patient	$33.43
D1354	Interim caries arresting medication application. Silver Diamine Fluoride	$9.06
D0145	Oral evaluation for a patient under three years of age and counseling with a primary caregiver	$33.43
D1330	Oral Hygiene Instruction	$12.54
D1120	Prophylaxis - Child	$29.26
D1208	Topical application of fluoride – excluding varnish	$22.99
D1351	Sealant – Per tooth	$27.17
D1206	Topical application of fluoride varnish	$22.99
D1999	Unspecified preventive procedure by report	$20.63

- ## How to Get Started:

  Review the DPIP Requirements: Familiarize yourself with the performance benchmarks and payment structure.

  Track Your Performance: Monitor your adherence to the qualifying criteria and performance metrics.

  Submit Reports on Time: Ensure timely submission of required reports to LIBERTY.

  Utilize Resources: [left blank intentionally, until internal processes are finalized]

- ## Contact Information:

  For questions or assistance regarding the DPIP program, contact your Network Manager or visit the Liberty provider portal for additional resources and support.

LIBERTY Dental Plan's Community Partnership to Improve Outcomes (CPIO) Programs

Overview of CPIO Program:

LIBERTY's Community Partnerships to Improve Outcomes (CPIO) program is designed to enhance oral health awareness and improve access to dental care within the community. The program focuses on collaborating with various community organizations to promote preventive dental services and encourage utilization of dental benefits.

Key Components:

- Community Events and Health Fairs: LIBERTY participates in local events and health fairs to raise awareness about the importance of oral health.
- Preventive Dental Services: Provides dental services at public events and partners with Community-Based Organizations (CBOs), Head Start programs, schools, and daycares to deliver preventive care.
- Outbound Calls: Conducts outreach to non-utilizer members to offer oral hygiene instructions, encourage benefit utilization, provide information about their assigned dental home, and assist in scheduling dental appointments.
- Partnerships: Collaborates with CBOs, Head Start programs, schools, and daycares to expand the reach and impact of preventive dental services.

For suggestions, questions, or additional information about the CPIO program and potential community partners, contact the Community Outreach Team at: FLcommunitysmilesoutreach@libertydentalplan.com.

Platinum Practice/Gold Card

Metrics	
Outliers Identified	Total Medicaid Network
Exempt Grievances	SIU Cases
Members Seen Threshold	Medical Necessity Denials
Partnership With LIBERTY	Grievances / PQIs /Appeals
Accessibility/Availability (appointment times)	

The benefits conferred when achieving Gold Card Status

- Physical plaque for presentation in the office
- Waiving prior authorization and pre-payment review
- Providing prominent directory placement
- Awarding favorable new enrollee assignment (auto-assigned and priority scheduling)
- Participation on advisory boards and other committees
- Participation in quality and VBP programs

Utilization Management

LIBERTY's Utilization Management (UM) Program is designed to meet AHCA's contractual requirements and Florida and federal regulations, while providing enrollees access to high-quality, cost-effective medically necessary care. Monitor over – and under-utilization of services, identify treatment patterns for analysis, and ensures that utilization decision is made in a timely manner which accommodate the urgency of the situation and minimizes any disruption in the provision of care.

The focus of the UM program is on:

- Evaluating requests for dental care services by determining whether the service or good is Medical Necessary consistent with the Enrollee's diagnosis and level of care required
- Providing access to medically appropriate, cost-effective dental care services in a culturally sensitive manner and facilitating timely communication of clinical information among Providers
- Reducing overall expenditures by developing and implementing programs that encourage preventive oral health care behaviors and Enrollee partnership
- Facilitating communication and partnerships among Enrollees, families, Dental Providers, Medicaid health plans, other Medicaid dental plans, AHCA, and LIBERTY to enhance cooperation and appropriate utilization of dental care services
- Reviewing, revising, and developing dental services coverage policies to ensure Enrollees have appropriate access to new and emerging care and technology
- Enhancing the coordination and minimizing barriers in the delivery of dental care services

LIBERTY does not:

- Delegate any UM responsibility to a third party. We conduct all reviews in-house by our state Dental Directors and our appropriately licensed, experienced Staff Dentists and Dental Consultants
- Reward its employees or any or other individuals or entities performing UM activities for issuing denials of coverage, services, or care
- Provide financial incentives to encourage or promote underutilization

Medically Necessary Services

Medicaid dental services or goods provided, ordered, or reimbursed by LIBERTY must be medically necessary. Medical Necessity is defined in section 2.83 of the Florida Medicaid Definitions Policy, August 2017, as adopted into Rule by reference in Florida Administrative Code, Rule 59G-1.010. In accordance with AHCA's definition of Medical Necessity, such dental services or goods must:

- Be necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain (This requirement applies only to recipients age 21 years or older).
- Be individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess, of the patient's needs

- Be consistent with generally accepted professional medical standards as determined by the Medicaid program, and not experimental or investigational
- Be reflective of the level of service that can be safely furnished, and for which not equally effective and more conservative or less costly treatment is available statewide
- Be furnished in a manner not primarily intended for the convenience of the recipient, the recipient's caretaker, or the provider The fact that a provider has prescribed, recommended, or approved dental care, goods, or services does not make such care, goods or services medically necessary or a medical necessity or a covered service. Medically necessary or medical necessity for inpatient hospital services requires that those services furnished in a hospital on an inpatient basis could not, consistent with the provisions of appropriate medical care, be effectively furnished more economically on an outpatient basis or in an inpatient facility of a different type. In addition, pursuant to 42 C.F.R. § 440.230, each Medically Necessary service must be sufficient in amount, duration, and scope to reasonably achieve its purpose.

LIBERTY's UM program includes components of pre-authorization and prospective, concurrent, and retrospective review activities. Each component is designed to provide for the evaluation of dental care and services based on LIBERTY's Enrollees' coverage, and the appropriateness of such care and services, and to determine the extent of coverage and payment to Providers of care.

Criteria for UM Decisions

LIBERTY's UM program uses nationally recognized review criteria based on sound scientific medical evidence. Dentists with an unrestricted license in the state of Florida and professional knowledge and/or clinical expertise in the related dental care specialty actively participate in the discussion, adoption, application, and annual review and approval of all utilization decision-making criteria.

The UM program uses numerous sources of information including, but not limited to, the following when making coverage determinations:

- Medical Necessity
- LIBERTY's Clinical Coverage Guidelines
- AHCA Medicaid Dental Plan Contract
- Florida Medicaid Dental Services Coverage Policy, as appropriate
- Florida and federal statutes and laws
- Medicaid guidelines

LIBERTY's Florida Dental Director or other qualified clinical reviewers involved in the UM process apply AHCA's definition of Medical Necessity criteria in context with the enrollee's individual circumstance and the capacity of the local dental services provider delivery system. When the above criteria do not address the individual enrollee's needs or unique circumstance, the Dental Director will use clinical judgment in making the determination, consistent with Medical Necessity.
The review criteria and guidelines are available to the Providers upon request. Providers may request a copy of the criteria used for specific determination of Medical Necessity by contacting LIBERTY's Utilization Management Department via Provider Services. The phone number is listed on LIBERTY's website at www.libertydentalplan.com.

Care Management/Care Coordination

A Special Health Care Needs Enrollee faces physical, behavioral, or environmental challenges daily, that place at risk their health and ability to function fully in society. This includes individuals with intellectual and developmental disabilities or related conditions; individuals with serious chronic illnesses, such as human immunodeficiency virus (HIV), schizophrenia or degenerative neurological disorders; individuals with disabilities resulting from many years of chronic illness such as arthritis, emphysema or diabetes; and children/adolescents and adults with certain environmental risk factors such as homelessness or family problems that lead to the need for placement in foster care.

We offer care management services to children and adults with special health care needs that include complex/chronic medical conditions requiring specialized health care services and persons with physical, mental/substance abuse, and/or developmental disabilities, persons who are eligible for the MLTSS program and require dental care.

Our care management programs are offered but not limited to members who:

- With Individual Developmental Disabilities (IDD)
- With high dental services utilization
- With intensive dental health care needs
- Who reside in a nursing facility
- Who consistently access services at the highest level of care
- Are home-bound
- Are homeless
- Are identified as needing assistance in accessing or using services
- Have complex medical (like asthma, diabetes, HIV/AIDS and high-risk pregnancy or behavioral health issues who have associated dental related comorbidities

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

Our care management program offers our members (children and adults) a care manager, care coordinator, and other outreach workers. They will work one-on-one to help coordinate oral health care needs.
To do this, they:

- May ask questions to get more information about a member's medical and dental health condition(s)
- Will work with PCPs and PDPs to arrange services needed and to help members understand their illness
- Will provide information to help members understand how to care for themselves and how to access services, including local resources

Measurement Monitoring

LIBERTY assesses clinical and non-clinical aspects of quality activities and performance improvement. We monitor and evaluate performance using objective quality indicators which identify required measures and corresponding opportunities for improvement. LIBERTY also complies with standards developed by NCQA and the American Dental Association to ensure that measures reflect best practices of dental health care. LIBERTY conducts annual enrollee and provider satisfaction surveys. Enrollee satisfaction surveys assess the quality and appropriateness of care to enrollees, while provider satisfaction surveys summarize and provide analysis of opportunities for improvement. Other opportunities to improve enrollee and provider input include:

- Enrollee
  - Correspondence sent to our Member Services Department
  - Grievance and appeal actions
  - Call center interaction with enrollees

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

Provider Collaboration

LIBERTY's goal is to join forces with providers to actively improve the quality of care provided. Providers are

contractually required to cooperate with the signed provider agreement as well as ongoing QMI goals. Timely collaboration is expected regarding the following activities:

- Completion of a Participating Provider Agreement
- Distribution of a LIBERTY Provider Reference Guide to each provider
- Each applying dentist's completion of a provider profile form, which gives us the information needed to conduct a first-level assessment of the dentist's qualifications
- A comprehensive credentialing process that adheres to NCQA standards
- Targeted structural and/or process audits of providers who have been identified through utilization analysis and grievance and satisfaction data as having potential quality issues
- Random structural reviews that assess the provider's physical facility, as well as the provider's office protocols regarding emergencies, booking appointments, sterilization, and related procedures
- Chart audits that assess the provider's process of care and conformity with professional dental practice, appropriate dental management, and quality of care standards
- Re-credentialing of each network provider every 36 months
- A formal provider complaint resolution process
- Establishing quality improvement goals in areas where the provider does not meet LIBERTY's standards or improvement goals

Quality assurance activities are continuously communicated to providers through our PR staff. Communication methods include:

- Initial and continuing training programs
- Provider newsletters and fax blasts
- Online notices
- Local and regional meetings to discuss and identify issues relating to claims, enrollment and any other issues that the provider can identify
- Provider satisfaction surveys
- Onsite office visits

For more information and access to LIBERTY's Network Management policies, please visit the Provider Resource Library on our website at: Provider Resource Library- Click Here

Corrective Action Plans (CAP)

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

- Clinical peer review
- Special claims review
- Referral to the applicable state dental board
- Onsite assessments
- Mandatory pre-authorization
- Enrollee enrollment restrictions
- Termination of the provider agreement

Provider QMI Program Responsibilities

LIBERTY's QMI Program handles all audits of LIBERTY by external agencies as well as conducts internal audits of various activities. LIBERTY performs chart audits and quality assessments of provider offices as part of this program. Providers may become involved in such audits due to random assignment or, as a result of, a focused report which identified a need for research into the provider's practice. These activities are performed as part of LIBERTY's requirement to ensure that enrollees receive necessary and adequate care in accordance with professionally recognized standards, and to ensure that the enrollees receive and enjoy the full range of their covered benefits. In addition, LIBERTY is concerned that continuity of care for covered enrollees is ensured including access to specialty referrals and services. LIBERTY appreciates the fact that its general dentists and specialty providers work diligently to meet these various responsibilities.

Credentialing/Recredentialing

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

- Current State dental license for each participating dentist
- Current DEA license, DEA Waiver, (required if no DEA or SDC, even for Orthos)
- Current evidence of malpractice insurance for at least $1,000,000 per incident and $3,000,000 annual aggregate for each participating dentist
- Current certificate of a recognized training internship or residency program with completion, (for specialists or General Dentists who have participated in a GPR or AEGD)
- Current permit of general anesthesia or conscious oral sedation, if administered, for the appropriate dentist; as applicable
- Immediate notification of any professional liability claims, suits, or disciplinary actions; to be Answered in the attestation going back at least five years
- Verification is made under NCQA, CMS and URAC guidelines including the by referencing the State Dental Board and National Practitioner Data Bank. As well as sanctions run on each provider with the OIG, CMS opt out, State LEIE, SAM, SSDMF and ACHA

All provider credentials are continually monitored at least monthly and updated on an on-going basis. Providers will receive notification of planned or pending re-credentialing activities at least 120 days prior to the end of the 36-month period since the last credentialing approval date. This lead time allows providers an opportunity to submit current copies of the requested documents and new attestations as required.

Florida Medicaid Provider Enrollment Requirements

LIBERTY shall comply with Florida Medicaid enrollment requirements.

In order, to receive Medicaid reimbursement, a provider must be enrolled in Medicaid and meet all provider requirements at the time the service is rendered. Every entity that provides Medicaid services to recipients or billing services of any kind to Medicaid must enroll as a Medicaid provider at: Florida Medicaid Web Portal- Click Here

Fully Enrolled Provider: An enrollment type that is furnished to a provider that meets the full eligibility credentialing for participation in Florida Medicaid. Enrolled providers are eligible to provide services to recipients enrolled in either the FFS delivery system or the managed care delivery system.

Limited Enrolled Provider: An enrollment type that is furnished to a provider that meets the basic eligibility credentialing for participation in Florida Medicaid. Limited Enrollment providers are only eligible to provide services to recipients enrolled in managed care.

It is AHCA's expectation that all individual dentists who wish to participate in FL Medicaid have an active enrolled individual Medicaid ID and a type 1 NPI. All provider groups who wish to participate in Florida Medicaid must be actively enrolled as a group and have been issued a group Medicaid ID. All Group Medicaid ID's must have a separate unique organizational type 2 NPI for each service location address.

- LIBERTY will check the Provider Master List (PML) and Pending Provider List (PPL) to verify correct AHCA enrollment with Florida Medicaid, as LIBERTY will deny claims if a registered provider does not initiate enrollment

The PML contains a listing of all Medicaid providers who are currently enrolled in the Florida Medicaid Program and have an active contract status, within the last 18 months. For additional information concerning the contents of the PML, please review the Provider Master List Tip Sheet at the following link: Florida Medicaid Web Portal Provider Master List- Click Here

If you are a sole proprietor, you will need a Medicaid ID and an individual type 1 NPI. If you are a dental group, you will need a group Medicaid ID and a type 2 organizational NPI. You will also need to disclose all your service locations and utilize a unique NPI for each service location.

Dental Groups and Provider Groups will need to enroll all their rendering individual dentists and then link them to the corresponding group locations. Please note: If the provider is limited enrolled, they don't need to worry about linking, and they won't be able to use the NLC form. If they are fully enrolled, the provider must link and submit NLCs.

1. Concerning the addition of provider locations, the provider can request additional locations via the New Service Type or Address Form. The form can be found on the Florida Medicaid Web Portal in the Provider Services/Enrollment/Enrollment Forms page at the following link: http://portal.flmmis.com/FLPublic/Provider_ProviderServices/Provider_Enrollment/Provider_Enrollment_EnrollmentForms/tabId/58/Default.aspx
2. Additional information for uploading the form for processing can be found in the Provider File Maintenance Quick Reference Guide at the following link: http://portal.flmmis.com/FLPublic/Provider_ProviderServices/Provider_Enrollment/Provider_Enrollment_EnrollmentForms/tabId/58/Default.aspx
3. Concerning the Group link request for an individual provider to link to a group, please refer to the provider to the Group Linking and Delinking Quick Reference Guide at the following link: http://portal.flmmis.com/FLPublic/Portals/0/StaticContent/Public/PUBLIC%20MISC%20FILES/Group%20Linking_QRG.pdf

Provider Enrollment Requirements/Background Screening

1. Proof of each provider's current license or authority to do business, including documentation of provider qualifications, as specified in the service-specific policy; if the provider is located in Georgia or Alabama, the provider's license and permit must be current and applicable to the respective state in which the provider is located
2. No revocation, moratorium, or suspension of the provider's license by the licensing authority in this or any state, if applicable
3. No sanctions imposed on the provider by Medicare or Medicaid, without proof of reinstatement or other documentation that all obligations under the sanction have been met
4. Disclosure related to ownership and management (42 CFR 455.104), business transactions (42 CFR 455.105) and conviction of crimes (42 CFR 455.106)
5. LIBERTY will verify that a level II background check was performed to validate the eligibility of LIBERTY Provider Network providers who were not limited or fully enrolled as a Florida Medicaid provider at the time of credentialing

6. In order, to receive payment for covered services, non-participating providers must have a Medicaid provider identification number in the FMMIS;
7. LIBERTY may execute network provider agreements, pending the outcome of screening, enrollment, and revalidation, of up to 60 days. LIBERTY must terminate a network provider immediately upon notification from the state that the network provider cannot be enrolled, or the expiration of the sixty-day period without enrollment of the provider and notify affected enrollees. (42 CFR 438.602(b)(2)
8. LIBERTY is authorized to recoup any Medicaid payments if the provider does not successfully complete the credentialing process within 60 days and LIBERTY is not the cause of the delay

Provider Onboarding and Orientation

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

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

Grievances, Provider Claims Complaints and Appeals

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

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

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

LIBERTY does not discriminate, penalize, or retaliate against providers who request an appeal with LIBERTY or support a member in requesting a grievance or appeal, including a request to expedite the appeal process.

Enrollee Grievances (Complaints)

Grievance Definition: Any enrollee written or oral expression of dissatisfaction that is not a request for a review of an initial adverse benefit determination.

IMPORTANT: Medicaid enrollee grievances can be submitted at any time and do not have a timely filing limitation in accordance with federal regulations.

The LIBERTY grievance and appeals process ensures that all enrollees can exercise their right to a fair and timely review and resolution of any grievance or appeal. Providers are contractually obligated to provide LIBERTY with copies of all enrollee records requested, because of an enrollee grievance or appeal. All providers are required to respond to LIBERTY with a written response to the member's concerns, including any supporting documentation, i.e. progress notes, treatment plans, financial ledgers, x-ray(s), etc. Failure to cooperate/ comply with LIBERTY's request for records with the grievance or appeal may lead to disciplinary actions, including but not limited to, claims or capitation deductions, referral to the PQI Unit or termination from the LIBERTY network.

LIBERTY's Grievances and Appeals Analyst records and reviews all enrollee issues involving complaints, grievances, or appeals and is responsible for the collection of all necessary and appropriate documentation needed to reach a fair and accurate resolution. Any issue relating to technical quality of dentistry rendered by a network provider is reviewed by a Dental Director or Staff Dental Consultant, licensed dentist(s). In order to identify systemic deficiencies, the Grievances and Appeals Analyst completes the case investigation and then a grievance history review is performed.

LIBERTY's grievance and appeals process encompasses the investigation, review, and resolution of enrollee issues, including cultural and linguistic needs, as well as the needs of enrollees with disabilities. The process is designed to ensure that all LIBERTY enrollees have access to and can fully participate in the grievance and appeals process. LIBERTY makes available translation services for enrollees whose primary language is not English. We currently provide translation services in 150 languages. Enrollees may obtain a grievance form from LIBERTY's website, a contracted Provider office or by calling the Member Services Department. All contracted provider offices are required to provide enrollees with a copy of the LIBERTY grievance form, and any necessary assistance, upon request.

Enrollee Appeals

Appeals Definition: A request made to LIBERTY by an enrollee, authorized representative or a provider acting on behalf of an enrollee (with the member's written consent) to review an action by the Plan, including, but not limited to, a delay, modification or denial of services or coverage.

IMPORTANT: Medicaid enrollees are allowed a single level appeal process and may appeal any resolution, authorization, or claim determination made by LIBERTY. The request for appeal must be received by LIBERTY within 60 calendar days of receipt of the initial adverse determination.

LIBERTY accepts enrollee grievances and appeals in all manners of communication. LIBERTY processes all enrollee grievances and appeals in accordance with state and federal regulation. Please reference the member grievance and appeals turnaround times outlined in the chart below.

Topic	Enrollee Grievances	Enrollee Standard Appeals	Enrollee Expedited Appeals
Filing Limitation	No filing limitation; can be filed at any time	60 calendar days from the date of the NABD	60 calendar days from the date of the NABD
Acknowledgement	5 business days	5 business days	Included as part of resolution
Resolution	30 calendar days	30 calendar days	As quickly as the dental condition requires. Oral notice by close of business day on day of resolution; written notice within 48 hours from time of receipt
Extension	14 calendar days	14 calendar days	14 calendar days

Provider Complaints

Contracted and non-contracted providers may submit any concern, including but not limited to, Plan quality of service, policy and procedure issues and any other concern not associated with a claim dispute to LIBERTY's Quality Management Department.

Providers may also submit claim disputes/appeals of a claim that has been denied, adjusted, or contested or of a request for reimbursement of an overpayment of a claim. Providers may not file a Grievance or an Appeal on behalf of an enrollee without written consent from the enrollee as the authorized representative.

Pre-service appeals submitted on behalf of enrollees will be processed in accordance with the enrollee appeal process. Providers may submit requests for expedited pre-service appeals on behalf of an enrollee, with written consent, in the event there is an imminent and serious threat to the enrollee's health, including, but not limited to, severe pain, potential loss of life or when taking the time for a standard resolution could seriously jeopardize the enrollee's ability to attain, maintain or regain maximum function. Qualifying cases will be resolved within the enrollee expedited appeal timeframes referenced above.

Provider Complaints can be submitted telephonically, electronically, via regular mail, or in person and must be submitted within the below timeframes:

Topic	Provider Complaints (Non-Claim Related)	Provider Complaints (Claims Related)
Filing Limitation	45 calendar days from the date of issue	90 calendar days from the date of the EOP
Acknowledgement	3 business days	3 business days
Resolution	90 calendar days, with written notice of status every 30 calendar days	60 calendar days, with written notice of status every 30 calendar days

- Issues relating to contracted or formerly contracted providers who believe they have been adversely impacted by the policies, procedures, decisions, or actions of LIBERTY may also be submitted to the Grievances and Appeals Department in accordance with LIBERTY's Provider Complaint Resolution Policy.
- All provider complaints and appeals must contain, at a minimum, the following information:
  - Provider's name and license number
  - Provider's contact information, i.e. telephone number
  - A clear identification of the issue that is subject of the complaint or appeal, i.e. date of service, procedures, etc.
  - A clear explanation/summary of the provider's position on the issue
  - Copies of all documentation relative to the subject in support of the provider's position

The Statewide Provider and Health Plan Claims Dispute Resolution Program is a statutorily created program to assist providers and plans in resolving claims disputes. Capital Bridge is AHCA's contracted independent dispute resolution organization and serves as the arbitrator of claims disputes between providers and plans. The program provides a lower cost dispute resolution option to formal litigation. Provider participation in this Program is not mandatory.

Dispute resolution is also available to the health plans. In order to initiate the process of filing a dispute, contact Capitol Bridge at FLCDR@capitolbridge.com or call (800) 889-0549.

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

	LIBERTY Dental Plan Grievances and Appeals P.O. Box 26110 Santa Ana, CA 92799-6110		Grievance & Appeals Team M-F from 8 am – 8 pm (EST) 833.276.0851
	Online at www.libertydentalplan.com		

Advance Directives

The Patient Self-Determination Act (PSDA), under Florida Law, requires that every able adult (18 years or older) must be given the right to make decisions about their medical care. The law recognizes the right of a competent adult to make an advance directive that:

- Instructs his or her dentist to provide, withhold, or withdraw life-prolonging procedures
- Allows the patient the right to participate in and direct their own healthcare decisions
- Designates another individual to make treatment decisions if the person becomes unable to make his or her own decisions
- Indicates the desire to make an anatomical donation after death

Enrollees can make an advance directive by completing a Living Will or a Designation of Health Care Surrogate form.

Providers can never discriminate against enrollees based on whether they have an advance directive.

Thus, providers are encouraged to discuss advance directives with enrollees and document in the dental record that education was provided. If the enrollee has an advance directive, the provider should include a copy of it in the enrollee's dental record.

Provider-Based Marketing Activities

Providers may:

- Announce a new affiliation with a dental plan and give their patients a list of plans with which they contract within 30 days
- Co-sponsor event, such as health fairs, and advertise with LIBERTY in indirect ways, such as television, radio, posters, fliers and print advertisements
- Distribute information about non-specific healthcare services and the provisions of health, welfare, and social services by the State of Florida or local communities if any inquiries from prospective enrollees are referred to the Agency for Health Care Administration's (AHCA's) choice counselor/enrollment broker
- Display LIBERTY specific materials in their own offices, as long as the provider does so for all plans with which the provider participates

Providers are prohibited from:

- Orally or in writing comparing benefits or provider networks among dental plans, other than to confirm whether they participate in a dental network
- Furnishing lists of their Medicaid patients to a dental plan with which they contract, or any other entity, nor can providers furnish their LIBERTY enrollee lists to another dental plan or assist with Medicaid enrollment
- Offer marketing/appointment forms

- Make phone calls or direct, urge or attempt to persuade potential enrollees to enroll in a plan based on financial or any other interests of the provider
- Offer anything of value to persuade potential enrollees to select them as their provider
- Accept compensation directly or indirectly from the Dental Plan for marketing activities

Section 13. Fraud, Waste and Abuse

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

Reporting Fraud, Waste and Abuse

LIBERTY has established several options which allow for confidential reporting of violations to LIBERTY, Medicaid Program Integrity "MPI", and HHS-OIG. These options include the following internal mechanisms:

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

In support of the federal Whistleblower Protection Act, LIBERTY has included AHCA's Fraud and Abuse toll-free hotline to report issues confidentially.

- AHCA Consumer Complaint Hotline: (888) 419-3456
- Florida Attorney General's Office: (866) 966-7226
- The Florida Medicaid Program Integrity Office: (850) 412-4600
- AHCA Complaint Form at:
  Medicaid Fraud and Abuse Complaint Form - Office of the Medicaid Program Integrity (myflorida.com)
  FWA may be confidentially reported to the U.S. Department of Health & Human Services, Office of Inspector General (HHS-OIG) Whistle Phone number at 1-800-HHS-TIPS 1-800-377-4950 or TTY 1-800-377-4950.

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

Fraud is knowingly and willfully executing, or attempting to execute, a scheme or artifice to defraud any health care benefit program or to obtain, by means of false or fraudulent pretenses, representations, or promises, any of the money or property owned by, or under the custody or control of, any health care benefit program.

Examples of fraud may include:

- Billing for services not furnished
- Misrepresenting the services performed (e.g., upcoding to increase reimbursement)
- Soliciting, offering, or receiving a kickback, bribe, or rebate

Waste includes practices that, directly or indirectly, result in unnecessary costs to the Medicare Program, such as overusing services. Waste is generally not considered to be caused by criminally negligent actions but rather by the misuse of resources.

Examples of waste may include:

- Over-utilization of services
- Misuse of resources

Abuse includes actions that may, directly or indirectly, result in unnecessary costs to the Medicare Program. Abuse involves paying for items or services when there is no legal entitlement to that payment, and the

provider has not knowingly or intentionally misrepresented facts to obtain payment.

Examples of abuse may include:

- Misusing codes on a claim
- Charging excessively for services or supplies
- Billing for services that were not medically necessary

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

LIBERTY expects all providers and subcontractors to comply with applicable laws and regulations, including but not limited to the following:

- Federal and State False Claims Act
- Qui Tam Provision (Whistleblower)
- Anti-Kickback Statue
- Physician Self-Referral Law (Stark Law)
- HIPAA
- Social Security Act
- US Criminal Codes

State & Federal False Claims Laws:

Federal False Claims Act (31 U.S.C. §§ 3729 - 3733) & Florida False Claims Act, Florida Statute (F.S. 68.081-68.09)

The Federal False Claims Act is a law that prohibits a person or entity, from “knowingly” presenting or causing to be presented a false or fraudulent claim for payment or approval to the Federal government, and from “knowingly” making, using or causing to be made a false record or statement to get a false or fraudulent claim paid or approved by the Federal government. The Act also prohibits a person or entity from conspiring to defraud the government by getting a false or fraudulent claim allowed or paid. These prohibitions extend to claims submitted to Federal health care programs, such as Medicare or Medicaid.

The Federal False Claims Act broadly defines the terms “knowing” and “knowingly.” Specifically, knowledge will have been proven for purposes of the Federal False Claims Act if the person or entity: (1) has actual knowledge of the information; (2) acts in deliberate ignorance of the truth or falsity of the information; or (3) acts in reckless disregard of the truth or falsity of the information. The law specifically provides that a specific intent to defraud is not required in order to prove that the law has been violated.

Whistle Blower Protection Act”: Private persons are permitted to bring civil actions for violations of the Federal False Claims Act on behalf of the United States (also known as "qui tam" actions) and are entitled to receive percentages of monies obtained through settlements, penalties and/or fines collected. Persons bringing these claims, also known as relators or whistleblowers, are granted protection under the law.

Specifically, any whistleblower who is discharged, demoted, suspended, threatened, harassed, or in any other manner discriminated against by his or her employer because of reporting violations of the Federal False Claims Act will be entitled to reinstatement with seniority, double back pay, interest, special damages sustained as a result of discriminatory treatment, and attorneys' fees and costs.

Anti-Kickback Statute: What is the Anti-Kickback Statute The Anti-Kickback Statute is the popular name for The Medicare and Medicaid Fraud and Abuse Statute, 42 U.S.C. § 1320a-7b (b). The AKS is a federal criminal law. It prohibits offering or accepting kickbacks to generate health care business.

The Anti-Kickback Statute or AKS is a healthcare law that prohibits individuals and entities from a willful and payment of “remuneration” or rewarding anything of value – such as position, property, or privileges – in

exchange for patient referrals that involve payables by the Federal healthcare programs. These payables include, but are not limited to, drugs, medical supplies, and healthcare services availed by Medicare or Medicaid beneficiaries.

Under the provisions of the Anti-Kickback Statute, the law prohibits the soliciting, receiving, offering, or paying any remuneration (including any kickback, bribe, or rebate) directly or indirectly, overtly or covertly, in cash or kind.

Stark Law Physician Self-Referral Law: The Physician Self-Referral Law- the Stark Law refers to Section 1877 of the Social Security Act (the Act) 42 U.S.C. 1395nn.

The Physician Self-Referral Law, commonly referred to as the Stark law, prohibits physicians (including dentists) from referring patients to receive "designated health/dental services" payable by Medicare or Medicaid from entities with which the physician (including dentist) or immediate family member has a financial relationship.

Law now insists that any medical professional who provides such a referral to a Medicare or Medicaid patient must concurrently provide written notice of that patient's right to go elsewhere along with a list of nearby alternatives.
Finalizing new, permanent exceptions for value-based arrangements to that will permit physicians and other health care providers to design and enter into value-based arrangements without fear that legitimate activities to coordinate and improve the quality of care for patients and lower costs would violate the physician self-referral law. This supports CMS' broader push to advance coordinated care and innovative payment models across Medicare, Medicaid, and private plans.

LIBERTY requires all its providers and subcontractors to report violations and suspected violations on the part of its employees, associates, persons, or entities providing care or services to all Medicaid enrollees. Examples of such violations include bribery, false claims, conspiracy to commit fraud, theft or embezzlement, false

statements, mail fraud, health care fraud, obstruction of a state and/or federal health care fraud investigation, money laundering, failure to provider medically necessary services, marketing schemes, illegal remuneration schemes, identity theft, or enrollees' medication fraud.

FWA Training is available via our company website – we have a training program provider can download in PDF format. We also include training for Fraud, Waste, and Abuse in our Provider Orientation packets. LIBERTY has posted LIBERTY's SIU Policy "Reporting Fraud, Waste, Abuse & Physical Abuse, Neglect, Exploitation, Unlicensed Activity" under provider compliance training resources https://www.libertydentalplan.com/Providers/Providers-1.aspx. This policy contains phone numbers for reporting fraud, waste, and abuse.

State and federal regulations require mandatory Compliance and FWA Training to be completed by providers and subcontractors, as well as their employees, within 30 days of hire/contracting and annually thereafter.

Records of the training must be maintained and readily available at the request of LIBERTY's Compliance Officer, AHCA, CMS, or agents of both agencies. Note: An attestation for the completion of the FWA Training must be submitted as part of the credentialing process.

If you or your employees have not taken the Compliance and/or FWA Training, please log onto LIBERTY website: Annual Compliance Training- Click Here

to complete the training. Please contact Provider Relations for additional instructions as needed. It is your responsibility and part of your contractual obligation to comply with all state and federal program requirements for your continued participation with LIBERTY dental plans.

Section 14. Florida Medicaid Program and Guidelines

LIBERTY follows the limitations and guidelines as stated in the Florida Medicaid Dental Services Coverage Policy. The Florida Medicaid Dental Services Coverage Policy explains Medicaid covered services and limitations.

Children's Dental Services are for eligible children ages 0 – 20 years of age.

The following federal and state laws govern Florida Medicaid as stated in the Florida Medicaid Dental Services Policy:

- Title XIX of the Social Security Act
- Title 42 of the Code of Federal Regulations
- Chapter 409, Florida Statutes
- Chapter 59G, Florida Administrative Code

Prompt Payment of Claims

Florida Medicaid Program claims will be paid pursuant to FL Statutes 641.3155.

Enrollee Rights

42 Code of Federal Regulations (CFR), § 438.100 Enrollee rights:

a. General rule. The State must ensure that
   1. Each MCO and PIHP has written policies regarding the enrollee rights specified in this section
   2. Each MCO, PIHP, PAHP, and PCCM complies with any applicable Federal and State laws that pertain to enrollee rights and ensures that its staff and affiliated providers take those rights into account when furnishing services to enrollees

b. Specific rights —
   1. Basic requirement. The State must ensure that each managed care enrollee is guaranteed the rights as specified in paragraphs (b)(2) and (b)(3) of this section
   2. An enrollee of an MCO, PIHP, PAHP, or PCCM has the following rights: The right to —
      i. Receive information in accordance with § 438.10
      ii. Be treated with respect and with due consideration for his or her dignity and privacy
      iii. Receive information on available treatment options and alternatives, presented in a manner appropriate to the enrollee's condition and ability to understand. (The information requirements for services that are not covered under the contract because of moral or religious objections are set forth in 42 CFR, §438.10(f)(6)(xii).)
      iv. Participate in decisions regarding his or her health care, including the right to refuse treatment
      v. Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation, as specified in other Federal regulations on the use of restraints and seclusion
      vi. If the privacy rule, as set forth in 45 CFR parts 160 and 164 subparts A and E, applies, request and receive a copy of his or her medical records, and request that they be amended or corrected, as specified in 45 CFR §164.524 and §164.526.
   3. An enrollee of an MCO, PIHP, or PAHP (consistent with the scope of the PAHP's contracted services) has the right to be furnished health care services in accordance with §438.206 through §438.210.

c. Free exercise of rights. The State must ensure that each enrollee is free to exercise his or her rights, and that the exercise of those rights does not adversely affect the way the MCO, PIHP, PAHP, or PCCM and its providers or the State agency treat the enrollee

d. Compliance with other Federal and State laws. The State must ensure that each MCO, PIHP, PAHP, PCCM, and PCCM entity complies with any other applicable Federal and State laws (including: Title VI of the Civil Rights Act of 1964 as implemented by regulations at 45 CFR part 80; the Age Discrimination Act of 1975 as implemented by regulations at 45 CFR part 91; the Rehabilitation Act of 1973; Title IX of the Education Amendments of 1972 (regarding education programs and activities); Titles II and III of the Americans with Disabilities Act; and section 1557 of the Patient Protection and Affordable Care Act.

The address and toll-free number for Medicaid Fair Hearings

re: Agency for Health Care Administration
Medicaid Hearing Unit

P.O. Box 7237
Tallahassee, FL. 32314-7237
(877) 254-1055 (toll-free)
(239) 338-2642 (fax)
MedicaidHearingUnit@ahca.myflorida.com

Section 15. Forms and Guides

Electronic forms are available for download including, but not limited to the following from the Provider Forms tab at LIBERTY 's website at: Provider Resource Library- Click Here

- ADA Claim Form
- ASC/Hospital Assessment Form
- CMS-Outpatient Authorization Form
- Electronic Funds Transfer (EFT) Form
- Specialty Care Referral Form- Florida
- Provider Complaint and Dispute Form(fillable)
- Consent for Non-Covered Treatment
- Medicaid Behavior Management Report
- FL Medicaid Orthodontic Initial Assessment HLD Index Score
- Online Provider User Guide
- Provider Compliance Training & Attestation
- Specialty Care Referral Form Florida

Reference Guides are available for download, including, but not limited to the following from the Provider Reference Guides tab at LIBERTY 's website at: Provider

- Clinical Criteria Guidelines and Practice Parameters
- Clinical Guidelines for Prescribing Fluoride Supplements for Caries Prevention
- FL SMMC Medicaid Provider Reference Guide
- Florida Healthy Kids Provider Reference Guide

Section 15. Florida Medicaid Plan Benefits

Medicaid Program Plan Benefits

Medicaid provides medical coverage to eligible, low-income children, seniors, disabled adults, and pregnant women. The state and federal government share the costs of the Medicaid program. Medicaid services in Florida are administered by the Agency for Health Care Administration (AHCA).

The Adult and Child dental benefits schedules include diagnostic, preventive, restorative, endodontic, periodontal, prosthetic, oral and maxillofacial surgical, other adjunctive general services, coverage, limitations, and prior authorization requirements.

- The schedules are a complete list of the dental procedures for which benefits are payable under this Plan. Non-listed procedures are not covered
- This Plan does not allow alternate benefits
- Enrollees must visit a contracted provider to utilize covered benefits. Unless otherwise noted in the specialty care referral section of the Provider Reference Guide, documentation/x-rays required refers to Primary Dental Providers "PDP"
- Specialty Providers should refer to their Specialty Referral guidelines in the Provider Reference Guide

The Florida Statewide Medicaid Managed Care Program Benefits Schedule is available by contacting Provider Relations or within LIBERTY's secure document website at:

Site: Secured Documents

Password: FLorientation