Nevada Medicaid & Nevada Check Up

Provider Resource Guide

Effective January 1, 2025

LIBERTY DENTAL PLAN®

Making members shine, one smile at a time™

Table of Contents

Section 1.
Liberty Dental Plan Information

Introduction

Welcome to Liberty Dental Plan of Nevada Inc.'s ("Liberty's") Medicaid network of Participating Providers for the Nevada Medicaid and Check Up 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 members.

This Provider Reference Guide (PRG) serves only as a summary of certain terms of the Provider Agreement, including the Nevada Medicaid Program Addendum, between you (or the contracting provider entity or office) and Liberty. Additional terms and conditions of the Provider Agreement may apply. In the event of a conflict between a term within this Provider Reference Guide 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. You may also obtain a copy of the Provider Agreement at any time by contacting your assigned Network Manager, submitting a request to provider@Libertydentalplan.com, or by contacting the Provider Relations Department at 888-700-0643.

Liberty shall not refuse to contract with, or pay, an otherwise eligible provider for the provision of covered services solely because such provider has in good faith communicated with, or advocated on behalf of, one or more of his or her

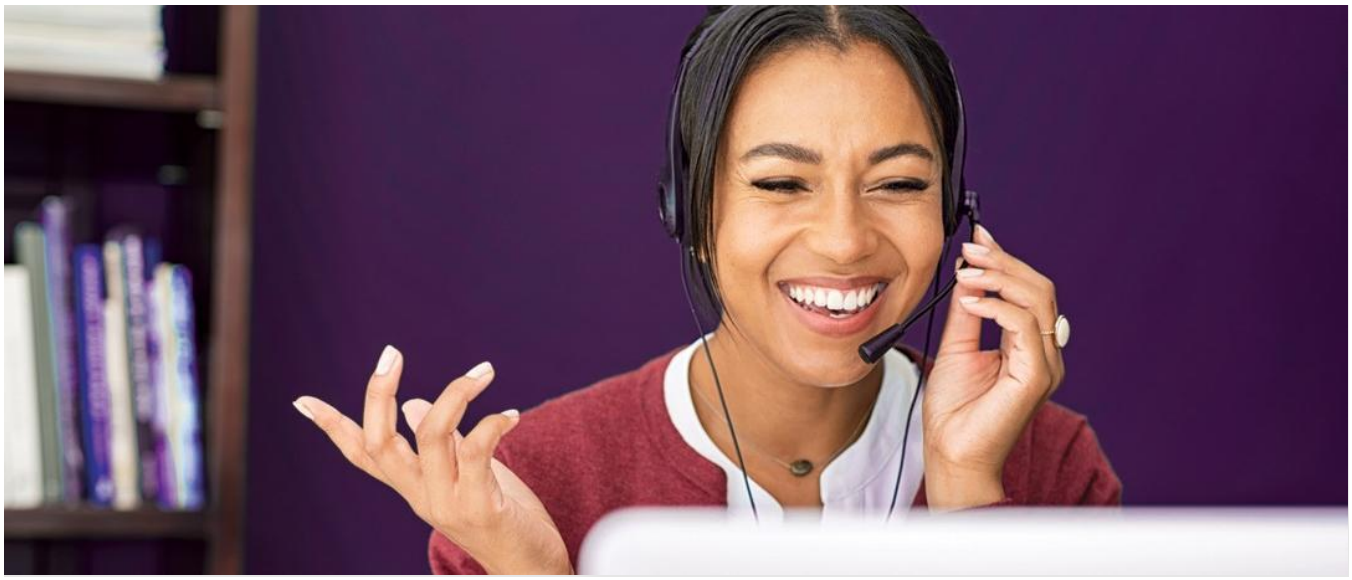
prospective, current, or former patients regarding the provisions, terms or requirements of the member's Liberty benefit plan. Liberty will not take punitive action against a Provider who requests an expedited resolution or supports an appeal by a member. Liberty does not discriminate against particular providers that serve high-risk populations or specialize in conditions that require costly treatment. To provide the most current information, updates to the Provider Reference Guide will be available by logging on to Liberty's website at Libertydentalplan.com/NVMedicaid

Our Mission for the Medicaid Program and Our Members

Liberty's mission is to be the industry leader in improving access to quality oral health care services for the Nevada Medicaid and Check Up populations. Liberty seeks to increase annual patient visits and improve the overall health of the Medicaid and Nevada Check Up populations through member 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 and Nevada Check Up members, and Liberty staff members.

Nevada Provider Contact and Information Guide

Liberty offers live assistance through our Provider Call Center during business hours and 24/7 real-time access to important information and self-help tools through our secure online Provider Portal at Libertydentalplan.com. To register as a new user and/or login, use the Access Code found in your Liberty Welcome Letter. If you need help with the log-in process, please call your designated Network Manager for assistance.



IMPORTANT PHONE NUMBERS	GENERAL INFORMATION
CALL: 888-700-0643 If you know your party's extension enter it now **For Members**: Say Member or Press 1 **For Dental Offices**: Say Office or Press 2	**HOURS**: Monday-Friday 8 am – 6 pm (PST) (After Hours Member Eligibility Verification Line) **ONLINE**: Libertydentalplan.com **MAILING ADDRESS:** Liberty Dental Plan of Nevada PO Box 401086 Las Vegas, NV 89140
PROVIDER PORTAL	**ELIGIBILITY & BENEFITS**
Create an Account: Libertydentalplan.com **24/7 Functionality Including:** Assigned Member Panel Value-Based Program Member Rosters Secure Member Records Requests Member Benefits Provider Alerts On-Demand Training	**Or Provider Portal:** 24/7 Member Eligibility **Phone:** 800-700-0643 Press 2 **PROVIDER RELATIONS** **Email:** Provider@Libertydentalplan.com **Phone:** 888-700-0643 **Fax:** 888-401-1129
REFERRAL SUBMISSIONS & INQUIRIES	**CLAIM & PRIOR AUTHORIZATION SUBMISSIONS AND INQUIRIES**
Provider Portal: Submissions and Status 24/7 **Emergency Referrals Line**: 888-359-1087 **Fax:** 888-401-1129 **Standard Referrals by Mail**: Liberty Dental Plan of Nevada PO Box 401086 Las Vegas, NV 89140 **ATTN: REFERRALS DEPARTMENT**	**Provider Portal:** Submissions and Status 24/7 **EDI PAYOR ID#:** CX083 **Email:** claims@Libertydentalplan.com **Phone:** 888-700-0643 **Fax:** 888-401-1129 **Standard and Corrected Claims by Mail:** Liberty Dental Plan of Nevada PO Box 401086 Las Vegas, NV 89140 **ATTN: CLAIMS DEPARTMENT**
PROVIDER DISPUTE RESOLUTION (PDR)	**GRIEVANCE & APPEALS (G&A)**
Provider Portal: Submissions and Status 24/7 **Phone:** 888-700-0643 **Fax:** 833-250-1814 **Mail:** Liberty Dental Plan of Nevada PO Box 401086 Las Vegas, NV 89140 **ATTN: GRIEVANCE & APPEALS DEPARTMENT**	**Provider Portal:** Forms & Submissions **Phone**: 888-700-0643 **Fax:** 888-401-1129 **Mail:** Liberty Dental Plan of Nevada PO Box 401086 Las Vegas, NV 89140 **ATTN: GRIEVANCE & APPEALS DEPARTMENT**

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 Member 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 Provider inquiry
- Change in name or ownership
- Taxpayer Identification Number (TIN) change
- Changes in office hours

To ensure that your information is displayed accurately, and claims are processed efficiently, please submit all changes within 30 days in advance by email 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 401086 Las Vegas, NV 89140		**Provider Relations** M-F from 8 am – 6 pm (PST) 888-700-0643
	Email: Provider@Libertydentalplan.com		

Provider Compliance and Training

Liberty provides initial orientation and training to all new offices within 30 days of activation. Liberty will also provide mandatory training to all Providers. Additional training is provided for new staff, when changes in the program occur, or when a need is identified through our Quality management and improvement processes (i.e., provider utilization, Provider Call Center interactions, grievances and appeals, etc.). You may access Liberty's training modules and complete the mandatory attestations of your completion online at Libertydentalplan.com/Providers/Provider-Training-1.aspx

Training topics will include, but are not limited to:

- Medicaid and Nevada Check Up Program Requirements
- Claims Submission and Common Claims Submission Errors
- Serving Members with Special Needs Including CSHCN and IDD
- Addressing Racial and Ethnic Disparities in Oral Health Care
- Culturally Competent Care
- Liberty's Code of Business Ethics & Conduct
- Fraud, Waste, and Abuse
- HIPAA and Protecting Member PHI
- Identifying and Reporting Critical and Adverse Incidents Within 48 Hours
- Reporting Abuse, Neglect, or Exploitation of Vulnerable Adults
- Liberty's Grievance System, Including Grievances, Appeals, and State Fair Hearings

Section 3. Online Self-Service Tools

Liberty is dedicated to meeting the needs of our Providers by utilizing leading technology to increase your office's efficiency by reducing administrative burdens and improving access to information about your Liberty members. Online tools are available for billing, eligibility, claim inquiries, referrals and other transactions related to the operation of your Provider practice.

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

- Verify member eligibility and benefits
- Print monthly eligibility rosters
- Conduct Directory Information Verification (DIV) and Annual Compliance Attestation
- Submit Caries Risk Assessments for BRUSH-enrolled members
- Manage Value-Based Programs
- Submit requests for prior authorizations and monitor status
- Submit referrals and check status
- Submit electronic claims and perform claim inquiries
- Securely upload records to Liberty for audits, grievances and appeals, and utilization reviews

On-Line Provider Portal Access

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

If you are unable to locate your **Office Number** and/or **Access Code**, please contact the Member Services Department for assistance. For technical assistance, email portalsupport@Libertydentalplan.com.

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

For more detailed instructions on how to utilize the Provider Portal, please reference:
Libertydentalplan.com/Resources/Documents/ma_Office_Portal_User_Guide.pdf

System Requirements

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

Directory Information Verification (DIV) Online

Liberty requires contracted network Providers to be listed in our publicly accessible Provider Directory. Listed Providers must be active, currently providing care, and accepting new Liberty members. In addition, Provider's listed demographic data must be accurate and must include the following information required by DHCFP:

- Website, URL, as applicable;
- Board certification status, as applicable;
- All street addresses where you practice;
- All telephone numbers associated with your practice sites;
- Availability of evening or weekend hours;
- Cultural and linguistic capabilities, ethnicity/race, including languages (including American Sign Language) spoken by you or a skilled medical interpreter at your office;
- Status of completion of cultural competency training;
- A photograph, if available; and
- Whether the office has accommodations for members with physical disabilities, including offices, exam rooms, and equipment.

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

Anytime you have changes, you can update your information. On a **quarterly basis**, if your information remains current, you must **attest** that no changes were made. We also **highly recommend** that you set a calendar reminder in your system to go to the website every 85 days and validate the information.

Why should I use the DIV website to update my provider information?

- Quarterly updates and/or attestation required by the State of Nevada, DHCFP
- Provides the most up-to-date practice information to existing and new members so they can make informed decisions about their network provider choices
- Prevents and minimizes costly claims payment delays
- Stops time-consuming calls to validate your directory information
- Allows you to fix what's wrong with the click of a button – no more filling out paper forms, faxing, or emailing

You will need to have your office **Access Code** to use the online feature. This number can be found in your Liberty Welcome Letter. If you are unable to locate your **Access Code,** please contact your designated Network Manager, call the Provider Relations Department at 888-700-0643, or email Provider@Libertydentalplan.com for assistance.

Section 4. Eligibility

Anti-Discrimination Notice: Providers must not discriminate against any Medicaid or Nevada Check Up recipients based on race, color, national origin, sex, sexual orientation, gender identity, or disability, and must not use any policy or practice that has the effect of discrimination based on race, color, national origin, sex, sexual orientation, gender identity, or disability.

PRIMARY CARE DENTAL HOME ASSIGNMENT

All Medicaid and Nevada Check Up members are assigned to their primary care dental home **within five business days of their effective date of enrollment with Liberty. Members with disabilities are given an additional 30 days to select their dental home.** Dental homes include general and pediatric offices also known as Primary Dental Providers (PDPs). Liberty will assign members to the nearest PDP based on such factors as previous history of the member or another family member with that Provider, language, cultural preference, if the member has special needs, and based on the PDP's quality metrics established by Liberty. Members can change PDPs at any time.
Members are assigned a dental home to establish an ongoing relationship with the provider, inclusive of all aspects of oral health care delivered in a comprehensive, continuously accessible, coordinated, and family-centered

way. The dental home should be established no later than 12 months of age to help children and their families institute a lifetime of good oral health. A dental home addresses anticipatory guidance and preventive, acute, and comprehensive oral health care and includes referral to dental specialists when appropriate.

Providers are responsible for verifying member eligibility prior to scheduling an appointment. Checking eligibility will allow providers to complete medically necessary procedures and reduce the risk of denied claims.
Options available to verify eligibility:

1. **Provider Portal:** providerportal.Libertydentalplan.com/

   (We recommend using member's Last Name, First Name and Date of Birth *for best results)*

2. **Calling Liberty's Provider Call Center** to speak with a live representative, Monday through Friday from 8 a.m. to 6 p.m. PST.

In the event a member does not appear on your monthly roster, please contact Liberty's Provider Call Center.

Eligibility Rosters

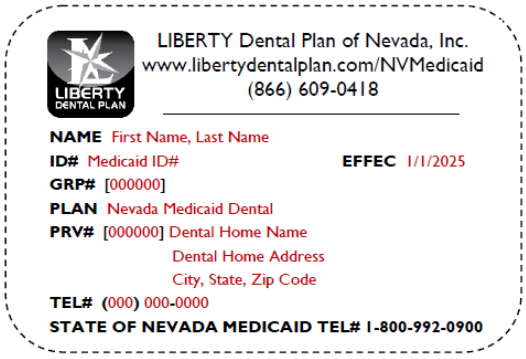
At the beginning of each month, Liberty will post a member roster in the "My Resources" section of the Provider Portal. This list will provide your office with the following information in alphabetical order:

- Member Name
- Member Telephone Number
- Member Identification Number
- Date of Birth
- Group
- Type of Coverage (Plan number/name)
- Effective Date of Coverage
- Existence of any special needs of the Member, if known

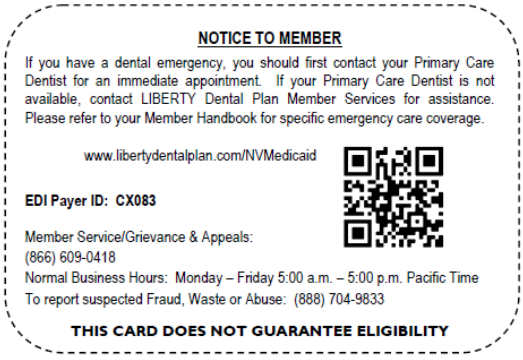
Member Identification Cards

Members should present their ID card at each appointment. Members can print an ID card from Liberty's website. Providers are encouraged to validate the identity of the person presenting an ID card by requesting some form of photo identification. The presentation of an ID card does not guarantee eligibility and/or payment of benefits. In such cases, providers should check a photo ID and check against an eligibility list or contact the Provider Call Center or visit the online Provider Portal for verification of eligibility. Please note that due to possible eligibility status changes, this information does not guarantee payment

and is subject to change without notice.


LIBERTY Dental Plan of Nevada, Inc.
www.libertydentalplan.com/NVMedicaid
(866) 609-0418

NAME First Name, Last Name
ID# Medicaid ID# **EFFEC** 1/1/2025
GRP# [000000]
PLAN Nevada Medicaid Dental
PRV# [000000] Dental Home Name
Dental Home Address
City, State, Zip Code
TEL# (000) 000-0000
STATE OF NEVADA MEDICAID TEL# 1-800-992-0900


NOTICE TO MEMBER

If you have a dental emergency, you should first contact your Primary Care Dentist for an immediate appointment. If your Primary Care Dentist is not available, contact LIBERTY Dental Plan Member Services for assistance. Please refer to your Member Handbook for specific emergency care coverage.

www.libertydentalplan.com/NVMedicaid

EDI Payer ID: CX083

Member Service/Grievance & Appeals:
(866) 609-0418
Normal Business Hours: Monday – Friday 5:00 a.m. – 5:00 p.m. Pacific Time
To report suspected Fraud, Waste or Abuse: (888) 704-9833

THIS CARD DOES NOT GUARANTEE ELIGIBILITY

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

All claims billed to Liberty must be submitted with the appropriate procedure code and correct date of service consistent with the federal and Nevada False Claims Acts, *False Claims Act (FCA), 31 U.S.C. §§ 3729 – 3733* and NRS 357. These federal and state laws prohibit a person or entity, from "knowingly" presenting or causing to be presented a false or fraudulent claim for payment or approval to the 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 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.

Medicaid and Nevada Check Up Reimbursement

Contracted Medicaid and Nevada Check Up network providers are compensated on a Medicaid fee-for-service reimbursement model. Offices are required to submit claims for all services rendered. It is recommended that claims be submitted daily or weekly to ensure timely payment. For additional information regarding payment and eligibility, please visit the website at http://www.Libertydentalplan.com/NVMedicaid.
Claims submitted to Liberty must reflect the date the actual treatment was rendered to a member. If the member was not seen, then no treatment was provided and therefore no claim should be submitted.

- The date of service indicated in Box 24 of the claim form must be the date that the service was completed and/or delivered.

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. In-state network Providers are encouraged to submit clean claims within 45 days of completion of treatment; payment will be denied for claims submitted more than 180 calendar days from the date of service. Out-of-state Providers must submit clean claims for covered services within 365 calendar days from the date of service. Liberty receives dental claims in multiple ways:

- Electronic submissions via Liberty's Provider Portal
- Electronic submissions via a clearinghouse
- Fax claims
- Paper claims

HIPPA Compliant 873D File

Liberty currently accepts HIPAA Compliant 837D files. If you would like to set up or inquire about this file, please contact our IT Department at 888-700-0643.

Electronic Submission

Liberty strongly encourages the electronic submission of claims. This convenient feature helps reduce costs, streamline administrative tasks and expedite claim payment turnaround time for providers. There are two options to submit electronically - directly through the Provider Portal or by using a clearinghouse.

1. **Provider Portal:** https://providerportal.Libertydentalplan.com/
2. **Third-Party Clearinghouse**

Liberty currently accepts electronic claims/encounters from providers through the clearinghouses listed below. If you do not have an existing relationship with a clearinghouse, please contact one of the companies below to begin electronic claims submission. The EDI vendors Liberty accepts 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, and Liberty's policies and procedures.

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

Paper Claims

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

Attn: Claims Department
LIBERTY Dental Plan P.O. Box 401086 Las Vegas, NV 89140

"Clean" Claims

A "clean claim" is a claim submitted on a Standard ADA form that can be processed without obtaining additional information from the provider of service or a third party. A "clean claim" includes all attachments and supplemental information or documentation which provides reasonably relevant information or information necessary to determine payer liability.
The following information must be included on every claim form for the claim to be considered complete:

- Provider name and address
- Member name, date of birth, and Member ID number
- Date(s) of service
- CDT and ICD-11 diagnoses code(s)
- Revenue
- Billed charges for each service or item provided
- Provider Tax ID number and/or social security number, and
- Name and state license number of attending provider

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

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

CLAIMS SUBMISSION PROTOCOLS AND STANDARDS

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

1. All claims must be submitted to Liberty for payment for services no later than 6 months or (180 calendar days) after the date of service for in-state network Providers, and 1 year or (365 calendar days) after the date of service for out-of-state Providers.
2. Your National Provider Identifier (NPI) number and tax ID are required on all claims. Claims submitted without these numbers will be rejected.
3. All health care providers, health plans and clearinghouses are required to use the National Provider Identifier (NPI) as the ONLY identifier in electronic health care claims and other transactions.
4. For emergency services, please submit a standard ADA claim form which must include all the appropriate information, including pre-operative radiographs and a detailed explanation of the emergency circumstances.

DATE OF INSERTION

When submitting a dental claim for reimbursement of multi-step procedures (i.e., dentures), the date of service shall be the date of insertion.

ICD-10 CODES

As a state-mandated requirement by the Division of Health Care Financing and Policy ("DHCFP"), **at least one ICD-10 code must be submitted for claims to process** and Liberty must comply. If you need assistance in identifying the appropriate ICD-10 codes, you can reference one of the following:

- CDT 2020 Coding Companion (Help Guide for the Dental Team)
- Coding & Insurance Manual (A comprehensive resource for reporting pediatric dental services)
- Please visit 2021 ICD-10 Look Up - Find ICD-10 Diagnosis Codes at **www.icdlist.com** for a complete list of all approved ICD-10 Codes

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

Exceptions (*For adult sedation please include F41.9 for anxiety)

RECORD OF SERVICES PROVIDED

	24. Procedure Date (MM/DD/CCYY)	25. Area of Oral Cavity	26. Tooth System	27. Tooth Number(s) or Letter(s)	28. Tooth Surface	29. Procedure Code	29a. Diag. Pointer	29b. Qty.	30. Description	31. Fee
1	10/01/2015					D0120	A	1		$28.00
2	10/01/2015					D1110	A	1		$55.00
3	10/01/2015			30	O	D2140	B	1		$105.00
4	10/01/2015			11		D7140	C	1		$72.00
5										
6										
7										
8										
9										
10										

33. Missing Teeth Information (Place an "X" on each missing tooth.)	34. Diagnosis Code List Qualifier [A] [B] (ICD-9 = B; ICD-10 = AB)	31a. Other Fee(s)	
1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16	34a. Diagnosis Code(s) A Z01.21 C K03.81		
32 31 30 29 28 27 26 25 24 23 22 21 20 19 18 17	(Primary diagnosis in "A") B K02.62 D	32. Total Fee	$260.00
35. Remarks			

Provider Portal:
https://providerportal.Libertydentalplan.com

888-700-0643
Select Option 2

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 180 calendar 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

If Liberty or the State of Nevada 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.

Notice of Overpayment of a Claim

If Liberty or the State of Nevada 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, within 30 business days of receiving the notice of overpayment, must send written notice to Liberty stating the basis upon which the provider believes the claim was not overpaid. Liberty will process the contested notice in accordance with Liberty's contracted provider dispute resolution process described in the section titled Provider Dispute Resolution Process.

No Contest

If the provider does not contest Liberty's notice of overpayment of a claim, the provider must reimburse Liberty within 45 working days of the provider's receipt of the notice of overpayment. If the provider fails to reimburse Liberty within 45 working days of receiving the notice, Liberty is authorized to offset the uncontested notice of overpayment of a claim from the provider's current and future 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) Liberty has the right to offset an uncontested notice of overpayment of a claim form the provider's current claims submissions. If an overpayment of a claim or claims is offset against the provider's current claim or claims pursuant to this section, Liberty will give the provider a detailed written explanation identifying the specific overpayment or payments that have been offset against the specific current claim(s).

Prompt Payment of Claims

Liberty's processing policies, payments, procedures, and guidelines follow applicable State and Federal requirements.

Electronic Funds Transfer

Liberty offers a payment solution through ECHO Health, Inc. (ECHO®). You can enroll in EFT/ACH by logging into: https://enrollments.echohealthinc.com/efteradirect/LibertyDental

EFT enrollment is verified after banking account information is provided to ECHO. **PLEASE NOTE: If you do not sign up for ECHO Health EFT/ACH, you will be enrolled in Virtual Card Services.** Virtual Cards allow your office to process payments as credit card transactions. Your office will receive fax notifications, each containing a virtual card number unique to that payment transaction. Once the number is received, you simply enter the code into your office's credit card terminal to process the payment as a regular card transaction. Normal transaction fees apply based on your merchant acquirer relationship.

- There are no fees to enroll and receive EFT payments **if you select the Liberty only option**: https://enrollments.echohealthinc.com/efteradirect/LibertyDental
- If your office opts to enroll in EFT payments through the above link, you will need to wait for the first payment to be issued as virtual card and reference the draft number provided on the virtual card.
- You may register at ProviderPayments.com to access a detailed explanation of payment for each transaction, to elect to receive email notifications of payments, and to access ERAs (835s) associated with your payments.
- If you have any questions or need further information regarding this notification, please contact ECHO Health, Inc. at (833) 629-9725 or email EDI@ECHOHealthInc.com

Paper Checks

If you prefer to receive paper checks, and a paper explanation of payment you must elect to opt out of Virtual Card Services. To opt out, of virtual cards or EFT payments, please call (833) 629-9725.

Peer-to-Peer Communication

If you have questions or concerns about a referral, prior authorization and/or claim determination and would like to speak to a licensed clinical reviewer, you may contact:

Liberty Dental Plan
Attn: Provider Relations
P.O. Box 401086
Las Vegas, NV 89140

Quality Management Team
M-F from 8 am – 6 pm (PST)
888-700-0643
umpeertopeer@Libertydentalplan.com

Please leave a detailed message and your call will be returned by a licensed clinical reviewer.

Section 6. Coordination of Benefits

Coordination of Benefits (COB) applies when a member has more than one source of dental coverage. The purpose of COB is to allow members to receive the highest level of benefits, up to 100 percent of the cost of covered services. COB also ensures that no one collects more than the actual cost of the member's dental expenses.

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

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 a member.
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
Member has a government-funded plan and individual or supplemental coverage through another carrier	Individual/Supplemental coverage is primary
Member has two government-funded plans: Federal (Medicare) and State (Medicaid, Nevada Check Up, or Medicare Advantage Value Add)	Federal coverage is primary
Member has dental coverage through a group plan and a government-funded plan	Group plan is primary
Member has dental coverage through a retiree plan and a government-funded plan	Government-funded plan is primary
Member has two Medicare plans	The Plan with the earliest effective date is considered primary

If a member has other dental coverage it will always be primary. Medicaid and Nevada Check Up are always the payers of last resort. Medicaid and Nevada Check Up coverage is secondary to any other coverage a member might have.

Scenarios of COBs

1. **When Liberty is the Primary Carrier** Liberty will only be considered the primary carrier for Medicaid and Nevada Check UP when the enrollee has no other dental coverage. Medicaid and Nevada Check Up is generally 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) must be sent with the claim to Liberty. Liberty will take into consideration the provider's participation status with the primary carrier and coordinate the claim with the EOB provided.

Providers must always bill other coverage first and provide an EOB from the primary carrier with their claim to Liberty for Medicaid and Nevada Check Up coverage. The provider must submit Coordination of Benefits (COB) claims within 60 calendar days from the date of primary insurer's Explanation of Benefits (EOB) or 180 calendar days from the dates of service, whichever is later. Liberty will pay the difference up to the Medicaid fee schedule.

Section 7. Professional Guidelines and Standards of Care

THIS SECTION PREVAILS ONLY WHEN MEDICAID HAS NOT ADDRESSED A PARTICULAR CIRCUMSTANCE OR CONDITION.

PDP Responsibilities

- Provide and/or coordinate all dental care for member
- Perform an initial dental assessment
- Provide a written treatment plan to members upon request that identifies covered services and optional or non-covered services; and clearly identifies the costs associated of each option; the plan must be 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
- Provide an informed consent discussion and supporting materials for all dental services and procedures for which the member has questions or concerns
- Treatment plans and informed consent documents must be signed by the member or responsible party to show understanding of the treatment plan and agreement with the treatment plan and the financial terms
- A financial agreement for any non-covered service must be documented separately from any treatment plan or informed consent and must be signed by the member acknowledging their responsibility for payment
- Work closely with specialty care providers to promote continuity of care
- Maintain adherence to Liberty's Quality Improvement Oral Health Equity Program
- Identify members with special needs including Children with Special Healthcare Needs (CSHNC) and Intellectual Development Disabilities (IDD) and notify Liberty of these needs
- Notify Liberty of a member death
- Arrange coverage by another provider when away from dental facility

- Ensure that emergency dental services are available and accessible 24 hours a day, 7 days a week
- Maintain scheduled office hours
- Maintain dental records for 10 years
- Provide updated credentialing information upon renewal dates
- Provide requested information upon receipt of patient grievance/appeal within the timeframe specified by Liberty on the written request
- Notify Liberty of any changes regarding practice, including location name, telephone number, address, associate additions/terminations, change of ownership, plan terminations, etc. at least 30 calendar days in advance
- Provide dental services in accordance with generally accepted clinical principles, criteria, guidelines, and any published parameters of care
- Providers will not discriminate or retaliate against a member or attempt to disenroll a member 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

Specialty Care Providers Responsibilities

- Provide specialty care to members within scope of practice
- Work closely with PDPs to ensure continuity of care
- Maintain adherence to the Liberty's QIOHEP
- Bill Liberty Dental Plan for all dental services that were authorized
- Provide credentialing information upon renewal dates

Member Rights and Responsibilities

Liberty members have the following rights and responsibilities, which are outlined below, and made available to members upon enrollment, and is posted on Liberty's website.

Liberty Nevada Medicaid and Check-up members are entitled to the following rights:

- Freedom to exercise these rights without adversely affecting how they are treated by the contractor, providers, or the state.
- To be treated with respect, giving due consideration to the member's right to privacy and the need to maintain confidentiality of the member's medical and dental information
- To receive pertinent written, and up-to-date information about Liberty, the managed care services Liberty provides, the Participating Provider and dental offices, as well as Member Rights and Responsibilities.
- To know who is providing medical services and who is responsible for his or her care.
- To request care coordination if necessary.
- To be given information about the plan and its services, including covered services
- To request a printed copy of the Member Handbook at least once per year or more frequently if necessary
- To be able to choose a PDP within Liberty's network, at any given time including upon enrollment, that meets the member's cultural, linguistic, and racial needs. Freedom to change their PDP upon request for any reason and as frequently as needed
- To participate in decision making regarding their own dental care including the member's preference about future treatment decisions, and the right to refuse treatment, except as otherwise provided by law.
- To receive information from their PDP concerning the diagnosis, planned course of treatment, alternatives, risks, and prognosis.
- 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.
- To have access to the grievance and appeal system and to file either verbally, in writing, online, or in person.
- To file a grievance verbally or in writing about Liberty, a participating provider, dental office staff, any care received, or any other aspects that are part of his or her dissatisfaction.

- To express a grievance regarding any violation of his or her rights, as stated in the applicable state laws, through the grievance process of the health care provider or heath care facility that served him or her and to the appropriate state licensing agency.
- To request an appeal of an adverse benefit determination to deny, defer, terminate or limit services or benefits; within the applicable timeframes as mandated by applicable state and federal laws, either verbally, in writing, online or in person.
- To request an expedited review of an appeal for cases involving imminent and serious threats to his or her health.
- To have access to all medically necessary dental service provided in Federally Qualified Health Centers (FQHCs), Rural Health Clinics (RHCs) or Indian Health Service (IHS) Facilities, and access to emergency dental services outside Liberty's network pursuant to federal law.
- To request a State Fair Hearing, with an Administrative Law Juge including information on the circumstances under which an expedited fair hearing is possible.
- To have access to the health information about them as provided by 42 CFR 164.524, including the right to inspect or obtain a copy, or both.
- The right to request in writing the transmission of member PHI to another person or entity they designate as specified by 45 CFR 164.524(c)(3).
- The right to amend their PHI as provided by 45 CFR 164.526.
- The right to receive an accounting of disclosures as provided by 42 CFR 164.528.
- To request the restriction of the uses, and disclosures of their information, including the right to receive confidential communications as provided by 45 CFR 164.522. To be provided with disenrollment requirements and limitations and to disenroll upon request.
- To receive impartial access to medical treatment or accommodations, regardless of race, national origin, sexual orientation, religion, handicap, or source of payment.
- To know what support services are available, including access to no cost interpretation and and translation services if the members primary language is not English.

- To receive no-cost written member-informing materials in alternative formats (including Braille, large size print, audio format, and accessible electronic formats) upon request and in a timely manner appropriate for the format being requested, including grievance and appeals notices.To prompt and reasonable responses to quests and requests, including information about the definitions of emergency care.
- To be free from any form of restraint or seclusion that is used as a means of coercion, discipline, convenience, or retaliation when making decisions about his or her care.
- To receive a copy of a reasonably clear and understandable, itemized bill and, upon request, to have the charges explained.
- To receive, upon request, full information, and necessary counseling on the availability of known financial resources for his or her care.
- To receive information on available treatment options and alternatives, presented in a manner appropriate to the member's condition and ability to understand.
- Freedom from Liberty prohibiting or restricting a provider from advocating on behalf of a member
- To have access to the contractor's health education programs and outreach services in order to improve dental health.
- To a no-cost a second opinion with a general dentist or specialist.
- To formulate an advance directive, living will, or another type of directive to provide to a medical professional.
- To know what rules and regulations apply to his or her conduct.
- Emancipated minors have the right to make decisions regarding their dental care, with the appropriate legal documentation.
- To make recommendations regarding Liberty's/Plan's Member Rights and Responsibilities policies.

Liberty members have the **following responsibilities** to behave according to the following standards:

- Provide accurate and updated information to their dental 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 health.

- Reporting any unexpected changes in his or health condition to their dental care provider.
- Ensuring that another person does not use his or her Nevada Medicaid or Check-up medical or dental identification card.
- Communicate changes in demographic or dependent information, or other changes that would affect
- eligibility to the Division of Welfare and Supportive Services
- Informing Liberty and the Division of Welfare and Supportive Services of any dual insurance coverage.
- Respect and follow the policies and guidelines given by Liberty's network Providers, provider staff and Liberty administrative staff with respect and courtesy.
- Cooperate with Liberty's network Providers in following a prescribed course of treatment; including instructions and oral health care recommendations/guidelines provided.
- Reporting to the dental care provider whether he or she comprehends the course of treatment, actions and what is expected of him or her.

- Actively participate in his or her treatment decisions, and actions if he or she refuses treatment or does not follow the dental provider's instructions.
- Ask their dental provider and other providers questions about treatment if they do not understand.
- Routinely schedule appointments for dental care and be on time to scheduled appointments.
- Keeping scheduled appointments, and when he/she is not able to do so for any reason, communicate with the dental office or health care facility at least 24 hours in advance.
- To communicate and provide feedback on their needs and expectations to their provider and to Liberty.
- Ensuring that any financial obligation of his or health dental care a fulfilled as promptly as possible
- Reporting any suspected provider fraud, waste or abuse to LIBERYT and the Division of Welfare and Supporting Services.
- Know and follow Liberty's guidelines and healthcare facility rules and regulations affecting patient care and conduct when seeking dental care.

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 on the basis of race, color, national origin, age, disability, or sex. Liberty takes affirmative action to ensure that members are provided access to covered medically necessary services without regard to race, national origin, creed, color, gender, gender identity, sexual preference, religion, age, and health status, physical or mental disability, except where medically indicated. Prohibited practices include, but are not limited to the following:

- Denying or not providing an enrolled recipient a covered service or available facility.
- Providing an enrolled member, a covered service which is different, or is provided in a different manner, or at a different time from that provided to other members, other public or private patients, or the public at large.
- Subjecting an enrolled recipient to segregation or separate treatment in any manner related to the receipt of any covered medically necessary service, except where medically indicated.
- The assignment of times or places for the provision of services on the basis of race, national origin, creed, color, gender, gender identity, sexual preference, religion, age, physical or mental disability, or health status of the recipient to be served.
- Prohibiting, or otherwise restricting, a health care professional acting within the lawful scope of practice, from advising or advocating on behalf of a recipient who is his or her patient:
    - For the recipient's health status, dental care, or treatment options, including any alternative treatment that may be self-administered.
    - For any information the recipient needs in order to decide among all relevant treatment options.
    - For the risks, benefits and consequences of treatment or non-treatment.
    - For the recipient's right to participate in decisions regarding his or her health care, including the right to refuse treatment, and to express preferences about future treatment decisions.
- Employing or contracting with providers excluded from participation in federal health care programs. [42 CFR 438.214(d)].
- Charging a fee for medically necessary covered service or attempting to collect a co-payment.

Liberty provides free aids and services to people with disabilities, and free language services to people whose primary language is not English, such as:

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

If a member needs these services, please contact us at 888-700-0643.
If you believe Liberty has failed to provide these services or has discriminated on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with Liberty's Civil Rights Coordinator:

Phone: 888-704-9833
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 complaint with the U.S. Department of Health and Human Services, Office for Civil Rights:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201

1-800-368-1019, **800-537-7697** (TDD)
Online at: https://www.hhs.gov/civil-rights/filing-a-complaint/complaint-process/index.html

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html

National Provider Identifier (NPI)

Liberty requires a National Provider Identifier (NPI) for all HIPAA-related transactions, including claims, claim payment, coordination of benefits, eligibility, referrals and claim status. As outlined in the Federal Regulation, the Health Insurance Portability and Accountability Act of 1996 (HIPAA), covered providers must also share their NPI with other providers, health plans, clearinghouses, and any entity that may need it for billing purposes.

How to Apply for an NPI

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

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

Voluntary Provider Contract Termination

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

Appointment Availability and Accessibility Standard

Liberty is committed to our members receiving timely access to care. Providers are required to schedule appointments for eligible members in accordance with the standards listed below:

PDPS:

Type of Appointment	Appointment Wait Time*
Initial Appointment	**Within 6 weeks**
Routine/Preventive Care	**Within 6 weeks**
Hygiene Appointment	**Within 14 days**
Urgent Care Appointment/Coverage	**Within 24 hours, not to exceed 2 calendar days**
Referrals to Specialty Care	**Within 30 days**
Type of Appointment	**Appointment Wait Time**

After-Hours / Emergency Availability	**24 hours a day, 7 days a week**. All providers must have at least one of the following: • Answering service that will contact provider (or provider on call) on behalf of the member • Call forwarding system that automatically directs members to call the provider (or the provider on call) • Answering system with explicit instructions on how to reach the provider and emergency instructions with assurance of a reasonable call-back (within 1-3 hours) in most cases • Calls involving life-threatening conditions or imminent loss of limb or functions may be referred to the 9-1-1, emergency medical services, emergency room or urgent care facilities in the community as per regionally available resources.
Scheduled Appointment Wait Time	**30 minutes recommended; should not exceed 60 minutes** from the scheduled appointment time, except when the Provider is unavailable due to an emergency. Offices must maintain records indicating member appointment arrival time and the actual time the member was seen by provider.
Office Hours	**Minimum of 3 working days/30 hours per week**

Specialists:

Type of Appointment	Appointment Wait Time*
Non-Urgent/Routine Care	**Within 30 days of referral**
Urgent Care Appointment	**Within 3 days of referral**
Emergency Appointments	**Within 24 hours of referral**

After-Hours / Emergency Availability	**24 hours a day, 7 days a week**. All providers must have at least one of the following: • Answering service that will contact provider (or provider on call) on behalf of the member • Call forwarding system that automatically directs members to call the provider (or the provider on call) • Answering system with explicit instructions on how to reach the provider and emergency instructions with assurance of a reasonable call-back (within 1-3 hours) in most cases Calls involving life-threatening conditions or imminent loss of limb or functions may be referred to the 9-1-1, emergency medical services, emergency room or urgent care facilities in the community as per regionally available resources.
Scheduled Appointment Wait Time	**30 minutes recommended; should not exceed 60 minutes** from the scheduled appointment time, except when the Provider is unavailable due to an emergency. Offices must maintain records indicating member appointment arrival time and the actual time the member was seen by provider.
Office Hours	**Minimum of 3 working days/30 hours per week**

*Appointment Wait Time means the time from the initial request for health care services by a member or the member's treating provider to the earliest date offered for the appointment for services inclusive of time for obtaining authorization from the plan or completing any other condition or requirement of the plan or its contracting providers.

After Hours Emergency Services Availability

The provider's after-hours response system must enable members to reach an on-call provider 24 hours a day, 7 days a week. If the PDP is not available to see an emergency patient within 24 hours, it is his/her responsibility to make arrangements to ensure that emergency services are available. A dental emergency generally means a condition that can entail uncontrollable bleeding, facial bone trauma, etc.

Dental emergencies can also be defined as a condition that may result in:

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

A member must be scheduled to a time appropriate for the emergency or urgent condition, which could be within 24 hours, or the next business day in most cases. Only the emergency will be treated at an emergency or urgent care appointment. If the patient is unable to access emergency care within our guidelines and must seek services outside your facility, you may be held financially responsible for the total costs of such services for any member for whom you are the PDP of record. Emergency dental services provided in a hospital, emergency room or ambulatory surgery center are provided as part of the medical MCO benefit.

Non-Emergency Services

Any care or services that are not considered emergency services as defined in this Contract. This does not include any services furnished in a hospital emergency department that are required to be provided as an appropriate medical screening examination or stabilizing examination and treatment under section 1867 of the Social Security Act.

Appointment Rescheduling

When a provider or member 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.

Recall, Failed, or Cancelled Appointments

Contracted providers must have an active recall system and written policy for patients who fail to keep or cancel appointments. Missed or cancelled appointments should be noted in the patient's record as well as submitted to Liberty on a claim form using the appropriate cancelled (D9987) or missed appointment (D9986) dental code. Medicaid and Nevada Check Up members cannot be charged for broken or missed appointments.

Recall, failed or Cancelled Appointments

Contracted providers must have an active recall system and written policy for

patients who fail to keep or cancel appointments. Missed or cancelled appointments should be noted in the patient's record as well as submitted to LIBERTY on a claim form using the appropriate cancelled (D9987) or missed appointment (D9986) dental code. Medicaid and Nevada Check Up members cannot be charged for broken or missed appointments.

Compliance with the Standards of Accessibility and Availability

Liberty monitors compliance to the standards set forth in this manual through Provider visits, provider/member satisfaction surveys, and other Quality Management processes. Liberty may seek corrective action for providers that are not meeting accessibility standards.

Prior authorization requests must be submitted before the member's appointment.

An approved prior authorization does not confirm eligibility nor guarantee payment of claims. It is considered best practice to submit all prior authorizations within 2 to 3 working days of the member's appointment.

Any service added to an existing prior authorization by virtue of phoning Liberty, will require pre-operative radiograph and narrative when you submit for payment. When you receive Liberty authorization, you may proceed with the services that were approved. After you complete treatment, submit your claim for payment with any post-operative radiographs, when appropriate and required. Radiographs and other supporting documentation will not be returned. Please do not submit original radiographs. Radiograph copies of diagnostic quality or paper copies of digitized images are acceptable.

Any emergency service will receive post-service clinical review by a dental consultant when it is reviewed for payment.

Facility Physical Access for the Disabled

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

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

The ADA sets requirements for new construction of, and alterations to, buildings and facilities, including health care facilities. In addition, all buildings, including those built before the ADA went into effect, are subject to accessibility

requirements for existing facilities. Detailed service and facility requirements for disabled individuals can be found by visiting www.ada.gov.

Definition of Medical Necessity

We approve care that is "medically necessary" and "appropriate". Medical necessity is defined as a health care service or product provided under the Medicaid or Nevada State Plan and is necessary and consistent with generally accepted professional standards to diagnose, treat or prevent illness or disease; regain functional capacity; or reduce or ameliorate effects of an illness, injury or disability.

What this means is that:

- The treatment or supplies are needed to evaluate, diagnose, correct, alleviate, ameliorate/prevent the worsening of, or cure a physical or mental illness or condition and meet accepted standards of provider
    - Will prevent the onset of an illness, condition, or disability
    - Will prevent the deterioration of a condition
    - Will prevent or treat a condition that endangers life or causes suffering, or pain, or results in illness or infirmity
    - Will follow accepted medical practices
- Services are patient-centered and take into account the individuals' needs, clinical and environmental factors, and personal values. The criteria do not replace clinical judgment, and every treatment decision must allow consideration of the individual's unique situation
- Services are provided in a safe, proper and cost-effective place, reflective of the services that can be safely provided consistent with the diagnosis
- Services are not performed for convenience only
- Services are provided as needed when there is no better or less costly covered care, service or place available
- Services are provided in a manner that is no more restrictive than that used in the State Medicaid and Nevada Check Up programs. as indicated in State statutes and regulations, the Title XIX (Medicaid) and Title XXI (Nevada Check Up) State Plans, and other State policy and procedures, including the Medicaid Services Manual (MSM)-Chapter 1000, Dental.

Treatment Plan Guidelines

All members must be presented with an appropriate written treatment plan. If there is more than one treatment available, the treating provider must also present those

treatment plans, and any related costs for non-covered services.

Medicaid Plan Non-Covered Services

Non-covered options can be discussed with the member. However, any non-covered option must be presented on a separate treatment plan. The treatment plan must clearly state that the service is not covered, that the member has been informed of the covered options and elects the noncovered optional service(s), and that the member understands and accepts the financial responsibility.

The patient must sign the treatment plan or the Consent for Non-Coverage Treatment form, acknowledging financial responsibility for the non-covered service. Failure to properly inform a Medicaid member of non-coverage of a particular procedure may result in the care being deemed NOT "medically necessary" by the state regulatory agency. In such cases, when the appeal determines that the member was not properly notified, you may have to provide the contested service at no charge to the Plan or the member.

Alternate and/or Elective/Non-covered Procedures and Treatment Plans

Liberty members cannot be denied their plan benefits if they do not choose "alternative or elective/non-covered" procedures. All accepted or declined treatment plans must be signed and dated by the member or his/her guardian and the treating provider.

Second Opinions

Liberty provides members with access to a second opinion from a qualified Network Provider, or if not available, we will arrange for a member to obtain one outside the Network, at no cost to the member. You may also request a second opinion on the member's behalf. All requests for second opinions are handled by Liberty within five (5) business days of receipt of the request. If you believe there is an imminent and serious threat to the member's health, let Liberty know and we will handle the request within 72 hours of receipt.

Continuity and Coordination of Care

Continuity of care between the PDP and any specialty care Provider must be available and properly documented. Communication between the PDP and dental specialist must occur when members are referred for specialty dental care. Liberty expects PDPs to follow up with the member and the specialist to ensure referrals are occurring to serve the member's best interests. Specialist providers are encouraged to send treatment reports back to the referring PDP to ensure continuity of care occurs according to generally accepted clinical criteria.

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

Value-Based Programs

Liberty's value-based programs (VBPs) focus on prevention and member-centric intervention to detect oral health problems before they occur. Liberty's move towards value-based care produces better outcomes for members while rewarding providers for helping members improve their health. All offices serving children enrolled in Medicaid and Nevada Check Up have the option to enroll in our Benefits and Rewards for Utilization, Services, and Healthy Outcomes ("BRUSH") Program. Providers can receive reimbursement for administering a Clinical Chairside Caries Risk Assessment (CRA) Form to assess caries risk and overall dental health as well as receive bonus payments for improved patient outcomes. For more information or to enroll in the program, contact your assigned Network Manager.

Caries Risk Assessment (CRA)

You are encouraged to complete a Caries Risk Assessment (CRA) to determine the patient's oral health history and needs. The ADA has developed a form to assess caries for the 0-20 population age group. Please use this form for billing a CRA. A link to the form is in Section 12 or can be download from the ADA website.

Value-Added Benefits

In addition to the dental services that Nevada Medicaid and Nevada Check Up offers, Liberty has included additional or "value adds" to the adult, child and pregnant members benefits. These benefits are subject to change and are clearly indicated with a (VA) on the schedule of benefits.

Liberty members who are pregnant and age 21 and over, can receive the following value-added benefits as long as they are determined eligible for pregnancy related services by the Welfare Division. If you submit claims for service that are only allowed during the pregnancy period and the claims are denied for no pregnancy you can refer the member to the Welfare Division to update their information. You may resubmit the claims at any time within the timely filing period.

The current additional value-added services for pregnant adults are (subject to change):

- Two additional cleanings (prophylaxis) every 12 rolling months
- 1 deep cleaning every 12 months (D4346)
- 1 root canal every 12 months

Early and Periodic Screening, Diagnostic and Treatment (EPTSDT) Benefits

Liberty provides Early Periodic Screening, Diagnosis, and Treatment (EPSDT) benefits to children and adolescents under the age of 21 who are enrolled in Medicaid and Nevada Check Up and provide enrollees with age-appropriate screening, preventive services, and treatment that are medically necessary. Through the EPSDT benefits, individuals under the age of 21 receive comprehensive dental care such as periodic and routine dental services needed for restoration of teeth, prevention of oral disease

and maintenance of dental health. The EPSDT program assures the screening of EPSDT for children receive the full range of necessary dental services, when medically necessary. EPSDT screening provider may refer children for dental services.

It is recommended by the American Academy of Pediatric Dentistry (AAPD) that a child's first dentist visit at the age of one. Subsequent dental appointment should occur every 6 months and all assessment should include:

- Radiographs
- Oral evaluation
- Routine Maintenance
- Oral Health Education

Liberty follows the American Academy of Pediatric Dentistry (AAPD) periodicity schedule for early preventions and the continuation of care based on the individual needs of children. EPSDT and Well Baby/Well Child follows recommendations set forth by the American Academy of Pediatrics and Bright Futures for preventative pediatric health care. Comprehensive dental care such as periodic and routine dental services needed for restoration of teeth, prevention, and maintenance of dental health.

Treatment of Minors

Care cannot be provided without a parent or legal guardian's consent for un-emancipated members under age 18, with the exception of emergency care. Parents or legal guardians also retain the right to access their child's dental records even if the child requests they not be shared. Members under age 18 may be emancipated minors if they are married, have a child, are pregnant or are emancipated by court order. Emancipated minors may consent to and make their own decisions about their dental care and parents or legal guardians no longer have the right to access their records without consent.

Pregnancy Related Benefits

Nevada Medicaid offers expanded dental services for pregnant women, in addition to the adult dental services. Benefits end at the birth of the child or termination of pregnancy, with the exception of services that were authorized, but not completed prior to the end of pregnancy. Eligibility for those members can be found on the secure Provider Portal and the benefits for pregnant members are found on the Benefit Fee Schedule.

Additional Covered Services for Pregnant Adult Members (Age 21+)					
Dental Service	**Per Rolling Months**				
	3	**6**	**12**	**36**	**60**
Comprehensive Exam			1		
Interim Caries Arresting Medication		1			
Teeth Cleaning		1			
Topical Fluoride		1			
Gingivectomy/ Gingivoplasty					4
Periodontal Scaling/Root Planing (Deep Cleaning)			1		
Periodontal Maintenance	1				

Infection Control

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

Dental Records Standards

Providers may upload dental records to Liberty via the secure Provider Portal or via encrypted email. Providers may set up a secure email account with Liberty at Libertydentalplan.com/Providers/Provider-Self-Service-Tools/Secure-Encrypted-Email.aspx. Your designated Network Manager will post records requests from Dental Care Management, Grievance and Appeals, or state regulators or auditors to the Portal for action. All dental records must include, at a minimum:

- Patient identification number: Each page or electronic file in the records contains the patient's name or patient ID number
- All X-rays must be labeled with the member's name, date of birth, and the date taken
- Personal/demographic data: Personal/biographical data including, but not limited to: age, sex, race, ethnicity, primary language, disability status, address, employer, home and work telephone numbers, and marital status
- Entry date: All entries are dated
- Provider identification: All entries are identified as to author

- Legibility: The record is legible to someone other than the writer. A second reviewer should evaluate any record judged illegible by one clinical reviewer
- Allergies: Medication allergies and adverse reactions are prominently noted on the record. Absence of allergies (no known allergies: NKA) is noted in an easily recognizable location
- Dental history (for patients seen three or more times): Dental history is easily identified including serious accidents, operations, and illnesses. For children, dental history relates to prenatal care and birth and preventive services
- Diagnostic information
- Medication information
- Identification of current problems: Significant illnesses, dental conditions and health maintenance concerns are identified in the dental record
- Smoking, alcohol, or substance abuse: Notation concerning cigarettes, alcohol and substance abuse is present for patients 12 years and over and seen three or more times
- Consultations, referrals, and specialist reports: Notes from any consultations are in the record. Consultation, lab, and radiograph reports filed in the chart have the ordering provider/physician's initials or other documentation signifying review. Consultation and significantly abnormal lab and imaging study results have an explicit notation in the record of follow-up plans
- Emergency care
- Advance Directive – For dental records of members age 18 and over, the dental record documents whether or not the individual has executed an Advance Directive and documents the receipt of information about Advance Directives by the member and confirms acknowledgment of the option to execute an Advance Directive. An Advance Directive is a written instruction such as a living will or durable power of attorney for health care relating to the provision of health care when the individual is incapacitated.

Dental Records Availability

Member dental records must be kept and maintained in compliance with applicable state and federal regulations. Complete dental records of active or inactive patients must be accessible for at least 10 years, even if the facility is no longer under contract with Liberty. Dental records must be furnished to

members, their representatives, or to their new PDP no later than 30 calendar days after the request has been made. If a member transfers to a new office, all records must be forwarded to the new provider within 10 working days of receipt of the request. Dental records must be comprehensive, organized and legible. All entries should be in ink, signed and dated by the treating provider or other licensed health care professional who performed services.

Contracted providers must make dental records available at no cost to Liberty or the member, and to duly authorized representatives of the State of Nevada and the Centers for Medicare and Medicaid Services (CMS) upon request. 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 of your Liberty contract.

Electronic Health Records Adoption and Nevada Health Information Exchange

Liberty participates in the Nevada statewide health information exchange (HIE) known as HealtHIE Nevada as required by our contract with DHCFP. Liberty's contracted Providers are encouraged to continue to, or begin contributing, member's clinical data to the HIE or accessing data from the HealtHIE Nevada's portal (i.e., electronic health records of your patients). You can receive additional information from your designated Network Manager, or by contacting HealtHIE Nevada at HIEsupport@healthienevada.org, or 855-4-THE-HIE. Please note that Medicaid and Nevada Check Up members **may not** opt out of having their individually identifiable health information disclosed electronically, per State law.

Culturally Competent Care

Liberty participates in and supports Nevada and federal efforts to promote the delivery of services in a culturally competent manner to all members, including those who are Limited English Proficient (LEP) and from diverse cultural and ethnic backgrounds. Liberty contracted Providers must provide effective, equitable, understandable, and respectful quality care and services that are responsive to the diverse cultural health beliefs and practices, preferred languages, health literacy, and other communication needs of our Medicaid and Nevada Check Up membership.

Language Assistance Services

Language Assistance services, including for members with hearing or visual impairments, are available from Liberty to assist Providers in insuring LEP members have appropriate access to dental care.

- Interpretation services, including American Sign Language, are available at no cost to members, 24 hours a day, 7 days a week by contacting Liberty's member Services Department at 866.609.0418.
- To engage an interpreter once the member is ready to receive services, please call 866.609.0418. You will need the member's Liberty Dental ID number, date of birth and the member's full name to confirm eligibility and access interpretation services. It is not necessary to arrange for these services in advance.
- Liberty discourages the use of family or friends as interpreters. Family members, especially children, should not be used as interpreters in assessments, therapy, and other situations where impartiality is critical.
- If a member prefers not to use the interpretation services after s/he has been told that a trained interpreter is available free of charge, the member's refusal to use the trained interpreter shall be documented in the member's dental record, when in a provider setting, or the member's administrative file (call tracking record) in the member Services setting.
- Written member Informing Materials in Spanish and alternative formats (including Braille and large font) are available to members at no cost and can be requested by contacting Liberty's member Services Department.
- Assistance in working effectively with members using in-person, telephonic interpreters, other media such as TTY/TDD and remote interpreting services can be obtained by contacting Liberty's member Services Department.

Health Insurance Portability and Accountability Act (HIPAA)

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

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

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 member materials.

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 as it concerns Liberty members, is a violation of Liberty's provider agreement. If Liberty discovers that a provider has transmitted Liberty member 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 (CAP) and continued, or egregious non-compliance will result in contract termination.
Safeguards which Providers must adhere to include, but are not limited to:

1. Electronic PHI

A. Ensure referrals, authorization requests, medical records and other e-PHI are transmitted in a HIPAA compliant manner using secure fax, secure FTP, encrypted email (which requires member authentication to access email content), or Liberty's secure web portal* Note the following:

- Use of PHI (including member name, ID, or other identifying information) 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 member 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

B. 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.

C. Maintain protocols to ensure faxes containing PHI are issued to the correct member, and that increased precautions are applied when faxing especially sensitive information (such as sensitive diagnoses).

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

D. Review and adhere to Liberty's *Secure Use & Transmission of e-PHI* policy, located online at https://www.Libertydentalplan.com/Resources/Documents/ma_Secure_Use_and_Transmission_of_Electronic_PHI.pdf.

2. Verbal PHI

Do not discuss patients in public areas (including waiting rooms, hallways and other common areas), even if you believe you are masking the patient'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 patient in an exam room or operatory.

Best practices include:

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

Section 8. Clinical Provider Practice Parameters

Liberty network Providers must adhere to the following Clinical Criteria Guidelines (CCGs) when delivering care to Liberty members. The following clinical provider criteria, processing guidelines, and practice parameters represent the view of Liberty's Peer Review Committee. They represent Liberty's processing guidelines, benefit determination guidelines and the generally acceptable clinical parameters as agreed upon by consensus of the Peer Review Committee to be professionally recognized best practices. In some cases, guidance is given about procedure code services that may not be within the scope of benefits for Nevada Medicaid and Nevada Check Up members. Please consult the benefit plan's Evidence of Coverage, Schedule of Benefits or other plan materials to determine plan-by-plan variations.

Clinical Criteria Guidelines (CCG)

For additional information please reference the CCG online at the following link:
Here: Clinical Criteria Guidelines & Practice Parameters - Clinical Criteria Guidelines & Practice Parameters

If you would like a copy of the CCG, please contact Member Services at 888-700-0643/TTY/TDD 877-855-8039.

Please reference the Nevada Medicaid Manual – DHCFP (MSM) for additional criteria, processes:
https://dhcfp.nv.gov/Resources/AdminSupport/Manuals/MSM/C1000/Chapter1000/

New Patient Information

Registration information should include:

1. Name, sex, birth date, address and telephone number, cell phone number, e-mail address, name of employer, work address and telephone number, language of preference
2. Name and telephone number of person(s) to contact in an emergency
3. For minors, name of parent(s) or guardian(s) and telephone numbers, if different from above
4. Pertinent information relative to the patient's chief complaint and dental history, including any problems or complications with previous dental treatment, previous provider/dental clinic and date of last dental examination
5. Medical History - There should be a detailed medical history form consisting of questions which require a "Yes" or "No" response, including:
    a. Patient's current health status
    b. Name and telephone number of physician and date of last visit
    c. History of hospitalizations and/or surgeries
    d. Current medications, including dosages and indications
    e. History of drug and medication use (including Fen-Phen/Redux and bisphosphonates)
    f. Allergies and sensitivity to medications (including antibiotics) or materials (including latex)
    g. Adverse reaction to local anesthetics
    h. History of diseases or conditions:
    i. Cardiovascular disease, including history of abnormal (high or low) blood pressure, heart attack, stroke, rheumatic fever or heart murmur,

existence of pacemakers, valve replacements and/or stents and bleeding problems, etc.

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

k. Nervous disorders, including psychiatric treatment iv. Diabetes, endocrine disorders, and thyroid abnormalities

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

m. Sexually transmitted diseases

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

o. Other viral diseases

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

q. History of cancer, including radiation or chemotherapy

6. Pregnancy
   a. Document the name of the patient's obstetrician and estimated due date
   b. Follow current guidelines in the ADA publication, Women's Oral Health Issues
   c. Medicaid pregnant members must register with the Division of Welfare and Supportive Services at 1-800-992-0900 for expanded benefits during pregnancy (Refer to MSM 1000)
7. The medical history form must be signed and dated by the patient or patient's parent or guardian
8. Provider's notes following up patient comments, significant medical issues and/or consultation with a physician should be documented on the medical history form or in the progress notes
9. Medical alerts for significant medical conditions must be uniform and conspicuously located on the monitor for paperless records or on a portion of the chart used and visible during treatment and should reflect current conditions

10. The provider must sign and date all baseline medical histories after review with the patient. If electronic dental records are used, indication in the progress notes that the medical history was reviewed is acceptable
11. The medical history should be updated at appropriate intervals, dictated by the patient's history and risk factors, and must be documented at least annually and signed by the patient and provider

Clinical Oral Evaluations

1. Periodic oral evaluations (Code D0120) of an established patient may only be provided for a patient of record who has had a prior comprehensive evaluation (Code D0150). 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.
2. A problem-focused limited examination (Code D0140) must document the issue substantiating the medical necessity of the examination and treatment.

3. 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:

    a. Observations of the initial evaluation are to be recorded in writing and may include records of missing or impacted teeth, existing restorations, prior endodontic treatment, fixed and removable appliances

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

1. Full-mouth periodontal screening may 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
2. 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
3. A post-operative office visit for re-evaluation should document the patient's response to the prior treatment.

Informed Consent

1. The provider must have the member sign appropriate informed consent documents and financial agreements. If informed consent is not

obtained prior to treatment completion, the Medicaid or Nevada Check Up member cannot be held financially responsible for non-covered services.

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

    a. **Medicaid and Nevada Check Up Plan Non-Covered Services:** Non-covered options can be discussed with the member, however; any non-covered option must be presented on a separate treatment plan. The treatment plan must clearly state that the service is not covered, that the member has been informed of the covered options and elects the non-covered optional service(s), and that the member understands and accepts the financial responsibility. The patient must sign the treatment plan or the Consent for Non-Coverage Treatment form, acknowledging financial responsibility for the non-covered service. Failure to properly inform a Medicaid or Nevada Check Up member of non-coverage of a particular procedure may result in the care being deemed not "medically necessary" by the state regulatory agency. In such cases, when the appeal determines that the member was not properly notified, you may have to provide the contested service at no charge to Liberty or the member.

    b. **Alternate and/or Elective/non-covered Procedures and Treatment Plans**: Liberty members cannot be denied their plan benefits if they do not choose "alternative or elective/non-covered" procedures. All accepted or declined treatment plans must be signed and dated by the member or his/her guardian and the treating provider.

Pre-Diagnostic Services

1. Patient screening, which includes a state or federal mandate, is used to determine the patient's need to see a provider for diagnosis.
2. Assessment of a patient is performed to identify signs of oral or systemic disease, malformation or injury, and the potential need for diagnosis and treatment.

Diagnostic Imaging

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

1. An attempt should be made to obtain any recent radiographic images from the previous provider.
2. An adequate number of initial radiographic images should be taken to make an appropriate diagnosis and treatment plan, per current FDA/ADA radiographic guidelines. This includes the ALARA Principle (As Low As Reasonably Achievable) to minimize the patient's exposure. It is important to limit the number of radiographic images obtained to the minimum necessary to obtain essential diagnostic information.
3. The provider should evaluate the patient to determine the radiographic images necessary for the examination before any radiographic survey.
4. Intraoral – complete series (including bitewings) (Code D0210)
5. *Note: D0210 is a radiographic survey of the whole mouth, usually consisting of 14-22 periapical and posterior bitewing images intended to display the crowns and roots of all teeth, periapical areas and alveolar bone.*
6. Benefits for this procedure are determined within each plan design.
7. Any benefits for periapical and/or bitewing radiographs taken on the same date of service will be limited to a maximum reimbursement of the provider's fee for a complete series.
8. Any panoramic film taken in conjunction with periapical and/or bitewing radiograph(s) will be considered as a complete series, for benefit purposes only.
9. Decisions about the types of recall films should also be made by the provider and based on current FDA/ADA radiographic guidelines, including the complexity of previous and proposed care, caries, periodontal susceptibility, types of procedures and time since the patient's last radiographic examination.
10. Diagnostic radiographs should reveal contact areas without cone cuts or overlapping, and periapical films should reveal periapical areas and alveolar bone.
11. Radiographs should exhibit good contrast.
12. Diagnostic digital radiographs should be submitted electronically when possible or should be printed on photographic quality paper and exhibit good clarity and brightness.
13. All radiographs must be mounted, labeled left/right and dated.
14. Intra- or extra-oral photographic images should only be taken to diagnose a condition or demonstrate a need for treatment that is not adequately visualized radiographically. Intra- or extra-oral photos are only payable as part of medically necessary, authorized orthodontic cases.

15. Any patient refusal of radiographs should be documented.
16. Radiograph duplication fees:
    a. Radiographic image duplication fees are not allowed.
17. When a patient is transferred from one contracted provider to another, diagnostic copies of all radiographic images less than two years old should be duplicated for the second provider.
18. Diagnostic casts (Code D0470) are only considered medically necessary as an aid for treatment planning for specific oral conditions.

Cone beam CT Capture and Interpretations (CDT Code D0364 – D0368)

CBCT (D0364-D0368, D0380- D0384) An adjunctive diagnostic aid to be used in conjunction with routine radiographic imagery for diagnosis and treatment planning for partial jaw (D0364, D0380) one full jaw (with or without cranium) (D0365, D0366, D0381, D0382), both jaws (with or without cranium) (D0367, D0383), or TMJ (D0368, D0384) under exceptional circumstances. These may include:

1. Non-specific clinical symptoms related to untreated or previously endodontically
   treated teeth.
2. Initial treatment of teeth with anatomic variations including additional or calcified canals, and complex morphology.
3. Re-treatment of multi rooted teeth.
4. Cases demonstrating significant risk for a complication such as nerve injury or jaw fracture as well as pathology or trauma workups.
5. For treatment involving implants or implant-related services when implants are a covered benefit.

Tests, Examinations, and Reports

1. Tests, examinations and reports may be required when medically necessary to determine a diagnosis or treatment plan for an existing or suspected oral condition or pathology.
2. Oral pathology laboratory procedure/report may be required when there is evidence of a possible oral pathology problem.

Preventive Treatment

1. Dental prophylaxis (Code D1110 and D1120) may be medically necessary when documentation shows evidence of plaque, calculus or stains on tooth structures.
2. Topical fluoride (Codes D1206 and D1208) treatment may be medically necessary when documentation

   shows evidence of the need for this preventive procedure.
3. Sealant (Code D1351) may be medically necessary to prevent decay in a pit or fissure on a posterior tooth.
   - Mechanically and/or chemically prepared enamel surfaces are sealed to prevent decay.
4. Preventive resin restoration (Code D1352) may be medically necessary to prevent decay in a pit or fissure as a conservative restoration in a cavitated lesion that has not extended into dentin on a permanent molar tooth in a moderate to high caries risk patient.
5. Sealant repairs (code D1353) may be necessary to reseal/ repair existing sealants that have chipped away or damaged after 2 years of original sealant placement
6. A space maintainer (Codes D1510 – D1525) may be medically necessary to prevent tooth movement and/or facilitate the future eruption of a permanent tooth. 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 are not reimbursed.
   a. Unilateral Space Maintenance
      - Premature loss of first or second primary molars
      - Band and Loop, Crown and Loop, Distal Shoe may be used to preserve the space of the second primary molar.

   b. Bilateral Space Maintenance
      - Upper /Lower Lingual space maintainers may be used to preserve the space of the first or second primary molars when there is premature bilateral loss of first or second primary molars or unilateral loss of both first and secondary primary molars.
7. Recognizing medical conditions that may contribute to or precipitate the need for additional prophylaxis procedures, supported by the patient's physician. Verify plan benefits before performing additional prophylaxis procedures in excess of plan limitations.
8. Application of caries arresting medicament application – per tooth (Code D1354) is the treatment of an active non symptomatic carious lesion by

topical application of a caries arresting or inhibiting medicament such as Silver Diamine Fluoride without mechanical removal of sound tooth structure. Treatment with silver diamine fluoride will not eliminate the need for restorative dentistry to repair function or aesthetics, but this alternative treatment allows clinicians to temporarily arrest caries with noninvasive methods, particularly young children with primary teeth.

a. 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 procedures may not generally be 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.

9. Caries Preventive Medicament Application (D1355)- limited to teeth with no history of D1354 Preventive procedure contingent on provider diagnosis of member's clinical condition for primary prevention or remineralization

   a. Per tooth preventive procedure (not similar to D1206/D1208 Fl applications which are full mouth procedures).

   b. D1355 is not payable on the same day as D1206, D1208

   c. Tooth must have no evidence of a carious lesion

   d. Prompted by documented Caries Risk Assessment finding of:

      - High Caries Risk D0603
      - Moderate Caries Risk D0602

Restorative Treatment

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.

1. Amalgam Restorations (Codes D2140-D2161)

   a. 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. And, in its review of the scientific literature on amalgam safety, the ADA's Council on Scientific Affairs reaffirmed that the scientific evidence continues to support amalgam as a valuable, viable and safe choice for dental patients…"

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

I. 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.

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

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

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

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

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

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

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

a. Composite is the procedure of choice for treating caries or replacing an existing restoration not involving or undermining the incisal edges of an anterior tooth. Decay limited to the incisal edge may still be a candidate for a filling restoration if little to no other surfaces manifest caries or breakdown.

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

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

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

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

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

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

h. Restorations for primary teeth are covered only if the tooth is symptomatic, proximal to permanent teeth, or expected to be present for six months or longer.

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

3. Crowns - Single Restorations Only (Codes D2712 – D2791)

- Administrative Issues

I. Providers may document the date of service for these procedures to be the date when crown restorations are delivered. (subject to review)

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

III. Crown services must be documented using valid procedure codes in the American Dental

Association's Current Dental Terminology (CDT)

2. Claim submissions must include x-rays and narrative, preferably a periapical x-ray (D0220). A crown may be medically necessary when the tooth is present and:

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

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

c. The tooth is in functional occlusion

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

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

3. Enamel "craze" lines or "imminent" or "possible" fractures: Anterior or posterior teeth that show a discolored line in the enamel indicating a non-decayed defect in the surface enamel and are not a through-and-through fracture should

be monitored for future changes. Crowns may be a benefit only when there is evidence of true decay undermining more than 50% of the remaining enamel surface, when there is a through-and-through fracture identified radiographically or photographically, or when a portion of the tooth has actually fractured off and is missing. Otherwise, there is no benefit provided for crown coverage of a tooth due to a "suspected future or possible" fracture.

4. Final crowns for teeth with a good prognosis should be sequenced after performing necessary endodontic and/or periodontal procedures and such teeth should exhibit a minimum crown/root ratio of 50%.
5. Types of Crowns
    a. When bicuspid and anterior crowns are covered, the benefit is generally porcelain fused to a base metal crown or a porcelain/ceramic substrate crown.
    b. When molar crowns and bicuspids are indicated due to caries, an undermined or fractured cusp or the necessary replacement of a restoration due to pathology, the benefit is usually a base metal crown or PFM.
    c. Porcelain/ceramic substrate crowns and porcelain fused to metal crowns on molars may be susceptible to fracture during occlusal function. Depending on the properties of the material used, it may not be consistent with good clinical practice to routinely use all-porcelain/ceramic restorations on molar teeth.
    d. Stainless steel crowns (Codes D2930 – D2933) are primarily used on deciduous teeth and only used on adult teeth due to incomplete eruption or a patient's disability/inability to withstand typical crown preparation
6. Core Buildup, including any pins when required (Code D2950), must show evidence that the tooth requires additional structure to support and retain a crown. Otherwise, the service will be considered included as part of the crown restoration.
    a. Core buildup refers to building up of coronal structure when there is insufficient retention for an extracoronal restorative procedure
    b. A core buildup is not a filler to eliminate any undercut, box form, or concave irregularity in a preparation
7. Post and core (Code D2952 and D2954) procedures for endodontically treated teeth include buildups. By CDT definitions, each of these procedures includes a "core." Therefore, a core buildup cannot be billed with either Codes D2952 or D2954 for the same tooth, during the same course of treatment.
    a. The tooth is functional, has had root canal treatment and requires additional structure to support and retain a crown
    b. Post and core in addition to crown (Code D2952), is an indirectly fabricated post and core custom fabricated as a single unit
    c. Prefabricated post and core in addition to crown (Code D2954) is built around a prefabricated post. This procedure includes the core material.

8. Pin retention or restorative foundation may be medically necessary when a tooth requires a foundation for a restoration.
9. A coping (Code D2975) or crown under a partial denture may be required when submitted documentation demonstrates the medical necessity of the procedure.
10. Repair of a restorative material failure may be medically necessary when submitted documentation establishes restorative material failure.
11. Outcomes: Standards set by the specialty boards shall apply.
    a. Margins, contours, contacts and occlusion must be clinically acceptable
    b. Tooth preparation should provide adequate retention and not infringe on the dental pulp
    c. Crowns should be designed with a minimum five- year life expectancy.

Endodontics

1. Assessment

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

   a. Pain and the stimuli that produce or relieve it by the following tests: i. Thermal
      ii. Electric
      iii. Percussion
      iv. Palpation
      v. Mobility
   b. Non-symptomatic radiographic lesions

2. Treatment planning for endodontic procedures may include consideration of the following:
   1. Strategic importance of the tooth or teeth
   2. Prognosis – endodontic procedures for teeth with a guarded or poor five-year prognosis (endodontic, periodontal or restorative) are not covered
      a. Excessively curved or calcified canals
      b. Presence and severity of periodontal disease
      c. Restorability and tooth fractures
3. Occlusion

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

Clinical Guidelines

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

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

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

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

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

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

1. The ADA defines an Indirect Pulp Cap (D3120) as a nearly exposed pulp that is covered with a protective dressing to protect the pulp from additional injury and to promote healing via secondary dentin formation. Placing a protective covering under a deep filling to help avoid sensitivity or pulpal irritation is not a billable service and is included in the fee for the restoration.

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

2. For a pulpotomy (Code D3220) or pulpal therapy (Codes D3230 and D3240), documentation is required that shows pulpal pathology and a good prognosis that the tooth has a reasonable period of retention and function.

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

   Note: Liberty may determine that a different, more appropriate procedure code better describes the endodontic treatment

performed and may make our determination based on the alternate code.

4. For apexification/recalcification (Codes D3351 – D3353), documentation is required that shows the apex of the tooth root(s) is/are incompletely developed.
5. For apical surgery (Codes D3410 – D3426), documentation is required that shows apical or lateral pathosis that cannot be treated non-surgically and that the tooth has a good periodontal and restorative prognosis.
6. Endodontic apical surgical treatment should be considered only in specific circumstances, including:
    a. The root canal system cannot be instrumented and treated non-surgically
    b. There is active root resorption
    c. Access to the canal is obstructed
    d. There is gross over-extension of the root canal filling
    e. Periapical or lateral pathosis persists and cannot be treated non-surgically
    f. Root fracture is present or strongly suspected
    g. Restorative considerations make conventional endodontic treatment difficult or impossible *Note: Liberty may determine that the apical surgery requested could have a better/equivalent outcome with a different endodontic procedure code.*
7. For a retrograde filling (Code D3430), documentation is required that shows evidence of medical necessity for a retrograde filling during periradicular surgery.
8. For a surgical or endodontic implant procedure (Code D3460), documentation is required that shows evidence of medical necessity for the procedure.
9. Endodontic irrigation
    a. Providers are contractually obligated to not charge more than the listed copayment for covered root canal procedures whether the provider uses BioPure, diluted bleach, saline, sterile water, local anesthetic and/or any other acceptable alternative to irrigate the canal.
    b. Providers may not unbundle dental procedures to increase reimbursement from Liberty or members. The provider agreement and plan addenda determine what members are to be charged for

covered dental procedures. BioPure as an alternative allowed on Liberty dental plans at no additional cost, whether or not a choice is presented to the member.

10. D3331 treatment of root canal obstruction
    a. Liberty acknowledges that procedure D3331 is a separate, accepted procedure code. However, this additional treatment is not automatically needed to complete routine endodontic procedure.
    b. Liberty will not approve a benefit for this procedure when submitted as part of a pre-determination request, prior to actual treatment.
    c. 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.

Periodontics

A. Evaluations

1. All children, adolescents and adults should be evaluated for evidence of periodontal disease. If pocket depths do not exceed 4 mm and there is no bleeding on probing or evidence of radiographic bone loss, it is appropriate to document the patient's periodontal status as being "within normal limits" (WNL).
2. In many cases a periodontal screening activity such as visual inspection, PSR® (Periodontal Screening and Recording) evaluation of each sextant or other mechanism may provide sufficient information to make a diagnosis or treatment plan.
3. Comprehensive oral evaluations should include the following:
    a. Quality and quantity of gingival tissue
    b. Documentation: six-point periodontal probing for each tooth
    c. The location of bleeding, exudate, plaque and/or calculus
    d. Significant areas of recession, mucogingival problems, level and amount of attached gingiva
    f. Open or improper contacts
    g. Furcation involvement
    h. Occlusal contacts or interferences
4. After a comprehensive evaluation, a diagnosis and treatment plan should be completed.

5. Sequential charting over time to show changes in periodontal architecture is of considerable value in determining treatment needed or evaluating the outcome of previous treatment.

B. Periodontal treatment sequencing

1. Full mouth debridement to enable comprehensive evaluation and diagnosis (Code D4355) is "The gross removal of plaque and calculus that may interfere with the ability of the provider to perform a comprehensive oral evaluation. This preliminary procedure does not preclude the need for additional procedures." (CDT) a. In most cases, this procedure may be followed by a comprehensive evaluation at a subsequent appointment. This rescheduling may allow some initial soft tissue response and shrinkage before full mouth periodontal probing is performed.

   b. This procedure must be supported by radiographic or photographic evidence of heavy calculus, is not a replacement code for a prophylaxis and is not appropriate on the same day as procedure comprehensive oral evaluation or a comprehensive periodontal evaluation (codes D0150 or D0180).

2. Scaling in the presence of generalized moderate or severe gingival inflammation (Code D4346) is "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. It is indicated for patients who have swollen, inflamed gingiva, generalized suprabony pockets, and moderate to severe bleeding on probing. It should not be reported in conjunction with prophylaxis, scaling and root planning, or debridement procedures."

   a. This procedure is for generalized moderate to severe gingival inflammation

   b. The ADA suggests that "generalized" would apply when 30% or more of the patient's teeth at one or more sites are involved, which is analogous to the AAP definition of generalized chronic periodontitis

   c. The Loe & Silness Gingival Index can be a guideline for defining "moderate to severe inflammation"

      i. Moderate inflammation - redness, edema, glazing; bleeding on probing

      ii. Severe inflammation - marked redness and edema, ulceration; tendency toward spontaneous bleeding

      iii. This is a therapeutic procedure, to treat a diagnosed disease. iv. It is based on a diagnosis, not on intensity of treatment required.

v. It is appropriate for patients who do not have periodontitis (i.e. attachment loss).

It can be performed on same date of service as the exam.

viii. It is a full-mouth procedure, not a per-quadrant procedure.

ix. Can be used for any age patient, and in any dentition stage (note that benefits vary by each member's plan design).

x. Prophylaxis and scaling and root planning procedures may be performed at a future date, after Code D4346, as long as the codes thereafter are used appropriately

xi. Periodontal Maintenance (Code D4910) is not appropriate as a follow-up to Code D4346, since

Code D4346 isn't performed to treat periodontal disease xii. Consider this procedure code when the patient's periodontium is not healthy, and the periodontal disease diagnosis is limited to soft tissue (gingivitis) and is generalized but has not progressed to the advanced disease stage with bone loss (periodontitis)

xiii. Should be submitted with documentation of periodontal chart and/or intra oral photos

3. Scaling and Root Planning or SRP (Codes D4341, D4342)

a. 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.

i. This treatment is considered to be within the scope of a general provider or a dental hygienist

ii. It is common for radiographs to reveal evidence of bone loss of attachment and/or the presence of interproximal calculus. It is supported when full mouth periodontal pocket charting demonstrates at least 4 mm pocket depths. If Liberty determines that there are too few teeth with a good prognosis in each quadrant, we may approve an alternate, more appropriate code

iii. Scaling and root planning procedures (Codes D4341, D4342) are generally not performed in the same quadrants or areas for two years following initial completion of these services. In the interim, any localized scaling and root planning would be included within periodontal maintenance procedure (Code D4910)

b. Scaling and root planning is not meant to be reported for an enhanced prophylaxis. If there is no bone loss, a more appropriate code might be selected (Codes D1110 or D4346). Rather, it is the judicious removal of deposits on the root surface in the presence of periodontal disease. In most cases some form of local anesthesia would be indicated to properly render the scaling and root planning procedure. Thus, it would not be considered good clinical practice to perform scaling and root planning in the absence of anesthetic.

c. It would not be considered good clinical practice to perform more than two quadrants of SRP at the same visit (or, in most cases, on the same date of service) unless a medical or other condition is present that would justify such AND there is demonstration of sufficient clinical treatment time to adequately perform judicious scaling and root planning of the submitted quadrants. Per clinical review, in the absence of such information, Liberty may limit the approval to no more than two quadrants on any given date of service.

d. Definitive or pre-surgical scaling and root planning:

   i. For early stages of periodontal disease, this procedure is used as definitive non-surgical treatment and the patient may not need to be referred to a periodontist based upon tissue response and the patient's oral hygiene.

   ii. 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

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

   iv. Local anesthetic is commonly used. If it is not used, the reason(s) should be documented. The use of topical anesthetics is considered to be a part of and included in this procedure

   v. Home care oral hygiene techniques should be introduced and demonstrated

   vi. A re-evaluation following scaling and root planning should be performed. This re-evaluation should be performed at least four to six weeks later and include: a description of tissue response; pocket depth changes; sites with bleeding or exudate; evaluation of the patient's homecare effectiveness.

e. It is usually not appropriate to perform Codes D1110 and D4341 on the same date of service. Liberty's licensed dental consultants

may review documented rationale for any such situations on a case-by-case basis.

4. Periodontal maintenance (Code D4910) at regular intervals should be instituted following scaling and root planning if the periodontal condition has improved to a controllable level. Periodontal pocket depths and gingival status should be recorded periodically. The patient's home care compliance and instructions should be documented.
    a. Periodontal maintenance and supportive therapy intervals should begin not less than four weeks following primary care treatment of periodontal disease, and should be individualized, although three-month recalls are common for many patients.
    b. Periodontal Maintenance (Code D4910) may be allowed for three years (or longer) when there is a history of periodontal therapy evident in the patient's treatment record (by report, by Liberty record, or by narrative).
5. Periodontal Irrigation (Code D4921)
    a. Periodontal irrigation is an elective procedure that is inclusive with and when performed with D110, D4341. D4342 and D4910 procedures. If a member chooses to not have irrigation with other procedures (i.e., Codes D1110, D4355, D4341, D4342 or D4910), contracted providers may not limit the member's access to other benefited procedures.
    b. A patient's refusal of irrigation does not constitute grounds for requesting a patient transfer
6. Localized delivery of antimicrobial agents via a controlled release vehicle into diseased crevicular tissue, per tooth (Code D4381)
    a. Locally delivered antimicrobials are defined by ADA as adjunctive to periodontal therapy and were intended for use in refractory or non-responsive periodontal pockets. It would not be considered good clinical practice within the standard application of Code D4381 to provide this service until after a clinical area was determined to be refractory or non-responsive to standard surgical or nonsurgical pocket reduction techniques.
    b. Benefits are not available for localized delivery of antimicrobial when performed with Codes D4341 or D4342 in the same quadrant on the same date of service.
    c. Providers may consider the appropriate use of local delivery antimicrobials for chronic periodontitis patients as an adjunct to periodontal scaling and root planning (Codes D4341 or D4342) AFTER the following steps:

i. A clinician has completed periodontal scaling and root planning and allowed a minimum four-week healing period. Then, the patient's pockets are re-probed and re-evaluated to determine the clinical response to the scaling and root planning.

ii. Re-evaluation confirms that several teeth have localized residual pocket depths of 5 mm or greater, plus inflammation

iii. Liberty dental consultants may approve a benefit for localized delivery of antimicrobial agents for non-responsive cases following scaling and root planning on a "by report" basis:

- In such cases, benefits may be approved for two teeth per quadrant in any 12-month period
- Other procedures, such as systemic antibiotics or surgery, should be considered when multiple teeth with 5 mm pockets or deeper exist in the same quadrant iv. Treatment alternatives such as systemic antibiotics or periodontal surgery instead of localized delivery of antimicrobial agents may be considered when:
- Multiple teeth with pocket depths of 5 mm or greater exist in the same quadrant
- Localized delivery of antimicrobial agents was completed at least four weeks after scaling and root planning but a re-evaluation of the patient's clinical response confirms that localized delivery of antimicrobial agents failed to control periodontitis (i.e., a reduction of localized pocket depths)
- Anatomical defects are present (i.e., intrabony defects)

7. Periodontal Surgical Procedures

a. Periodontal surgical procedures are covered when the following factors are present:

i. The patient should exhibit a willingness to accept periodontal treatment and practice an appropriate oral hygiene regimen before consideration for periodontal surgical procedures. (Documentation should include history, narrative and/or progress notes).

ii. Case history, including patient motivation to comply with treatment and oral hygiene status, should be documented. (Documentation should include history, narrative and/or progress notes).

iii. In most cases, there should be evidence of scrupulous oral hygiene for at least three months before the prior authorization for periodontal surgery.

iv. Consideration for a direct referral to a periodontist would be considered on a "by report" basis for complex treatment planning purposes. However, the performance of scaling and root planning, oral hygiene instructions and other pre- and non-surgical procedures should be performed by the general provider (before or after the periodontal consultation).

v. 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.

vi. Gingivectomy/gingivoplasty (Codes D4210 - D4212) periodontal pocket reduction surgical procedures may be covered when the pocket depths are five 5 mm or greater, following soft tissue responses to scaling and root planning documented at a periodontal maintenance procedure. Consideration should be given for long-standing pockets of five mm following previous surgical intervention, which may or may not require further surgical intervention. vii. Gingival flap (Codes D4240 and D4241) procedures may be covered when the pocket depths are five mm or greater, following soft tissue responses to scaling and root planning documented at a periodontal maintenance procedure, and it is necessary to allow debridement of the root surfaces and removal of granulation tissue.

viii. Periodontal osseous pocket reduction surgical procedures (Codes D4260 and D4261) may be covered when the pocket depths are five mm or greater following soft tissue responses to scaling and root planning documented at a periodontal maintenance procedure, and there is objective evidence of periodontal bone deformity. Consideration should be given for long-standing pockets of five mm following previous surgical intervention, which may or may not require further surgical intervention.

If Liberty determines that there are too few teeth with a good prognosis in each quadrant, we may approve an alternate, more appropriate code.

b. Periodontal osseous surgery pocket-reduction procedures:

i. May not be covered if:

- Pocket depths are four mm or less and appear to be maintainable by non-surgical means (i.e., periodontal maintenance and root planning)
- Patients are smokers or diabetics whose disease is not being adequately managed ii. Periodontal pocket reduction surgical procedures should result in the removal of residual calculus and granulation tissue with improved physiologic form of the gingival tissues.

iii. Osseous surgery and regenerative procedures should also correct and reshape deformities in the alveolar bone where indicated.

c. Clinical crown lengthening (hard tissue) (Code D4249)

i. This procedure is used to allow a restorative procedure or crown with little or no tooth structure exposed to the oral cavity.

ii. Crown lengthening requires reflection of a flap and is performed in a healthy periodontal environment, as opposed to osseous surgery, which is performed in the presence of periodontal disease. Where there are adjacent teeth, the flap design may involve a larger surgical area. iii. It would not be considered good clinical practice to perform a periodontal surgical procedure on the same tooth on the same date of service as a final impression for a fixed or removable prosthesis, as healing has not occurred, which could change the tooth / tissue / bone architecture, substantially affecting the outcome of the prosthesis.

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

d. Bone replacement grafting (Codes D4263 and D4264) in conjunction with osseous surgery involves the use of grafts to stimulate periodontal osseous regeneration when the disease process has led to a documented deformity of the bone surrounding a tooth or teeth.

e. Biologic materials and/or guided tissue regeneration (Codes D4265 – D4267) may be used during osseous surgery to help correct a documented deformity of the bone surrounding a tooth or teeth and is necessary to aid in osseous regeneration.

f. Soft or connective tissue grafting (Codes D4277 and D4278) may be used to correct a documented mucogingival defect when:

i. Marginal tissue is insufficient, and the tooth or teeth have a good prognosis (i.e., periodontal prognosis, endodontic prognosis and restorative prognosis)

ii. Mucogingival grafting is required in presence of gingival recession or lack of keratinized gingiva and generally requires intra-oral photographic evidence of the mucogingival defect. Affected teeth must have good endodontic prognosis, periodontal prognosis and restorative prognosis. *Note: Liberty may determine that the graft requested is better described under a different procedure code.*

8. Provisional splinting (Codes D4320 and D4321) may be necessary when documentation demonstrates the need for interim stabilization of mobile teeth.

Removable Prosthetics

Processing Guideline: Providers may only submit claims for completed procedures; therefore, removable prosthetics should only be billed to Liberty on or after the delivery date.

1. Complete Dentures (Codes D5110 and D5120)
    1. Complete dentures are the appliances of last resort, particularly in the mandibular arch. Patients should be fully informed of their significant limitations. A complete denture may not be covered if some teeth are still present in the arch and extraction of the remaining teeth is not necessary.
    2. Establishing vertical dimension is considered to be a part of and included in the fee/process for fabricating a complete denture (standard, interim or immediate). Therefore, benefits for a complete denture are not limited or excluded in any way simply because of the necessity to establish vertical dimension.
    3. An immediate complete or removable partial denture includes routine post-delivery care, adjustments and soft liners for six months. A conventional complete or removable partial denture includes routine post-delivery care and adjustments and soft liners for six months.
    4. Proper patient education and orientation to the use of removable complete dentures should be part of the diagnosis and treatment plan. Educational materials regarding these prostheses are highly encouraged to avoid misunderstandings and grievances, and to manage patient expectations.

2. Immediate Complete Dentures (Code D5130 and D5140)
    1. These covered dentures are inserted immediately after a patient's remaining teeth are removed. While immediate dentures give the patient the benefit of never having to be without teeth, they must be relined (refitted on the inside) during the healing period after the extractions have been performed.
    2. An immediate complete denture includes routine post-delivery care, adjustments and soft liners for six months.
    3. An immediate complete denture is not a benefit as a temporary denture. Subsequent complete dentures are not a benefit within a five-year period of an immediate denture.
    4. If prior services are found to be clinically defective due to inadequate technical quality, the providers are expected to replace, or correct services rendered by them at no additional charge to the member.

3. Partial Dentures (Codes D5211 – D5281)
    1. A removable partial denture is normally not indicated for a single tooth replacement of non-functional second or third molars (i.e., no opposing occlusion).
    2. Removable partial dentures are generally indicated when posterior teeth (See MSM 1000 for specific coverage requirements) require replacement on both sides of the same arch or multiple edentulous areas are present (excluding third molars). Remaining teeth must have a good endodontic prognosis and a good periodontal prognosis.
    3. An interim partial denture may be needed when the remaining teeth have a good prognosis and the patient has an existing partial denture that is not serviceable or an initial partial denture is being performed and the patient has several missing teeth on both sides of the same arch.
    4. For a treatment plan that includes both a fixed bridge and a removable partial denture in the same arch, the removable partial denture is considered the covered service.
    5. A unilateral removable partial denture is rarely appropriate. Best practices include replacing unilateral missing teeth with a fixed bridge or implant.
    6. Endodontic, periodontal and restorative treatment should be completed before fabrication of a removable partial denture.

7. Abutment teeth should be restored before the fabrication of a removable partial denture and would be covered if the teeth meet the same standalone benefit requirements of a single crown.
8. Removable partial dentures should be designed so they do not harm the remaining teeth and/or periodontal tissues, and to facilitate oral hygiene.
9. Materials used for removable partial dentures must be strong enough to resist breakage during normal function, nonporous, color stable, esthetically pleasing, non-toxic and non-abrading to the opposing or supporting dentition.
10. Partial dentures with acrylic clasps (such as Valplast) are considered under the coverage for Codes D5225 and D5226.

11. 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 expectations.
12. Replacement of an existing complete or partial denture:
    a. Removable complete or partial dentures are not covered for replacement if an existing appliance can be made satisfactory by reline or repair.
    b. Complete or partial dentures are not 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.
13. Complete or partial denture adjustments (Codes D5410 – 5422):
    a. An immediate complete or removable partial denture includes routine post-delivery care, adjustments and soft liners for six months.
    b. A conventional complete or removable partial denture includes routine post-delivery care and adjustments for six months.
    c. A prospective or retrospective request for a complete or partial denture adjustment must include documentation that the appliance is ill fitting.
14. Repairs to complete and partial removable dentures (Codes D5511 – D5671) must include documentation that demonstrates the appliance is broken or in need of repair.
15. Relines for complete and partial removable dentures (Codes D5730 – D5761):

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

b. 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.

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

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

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

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

17. 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 before a new appliance is made or an existing one is rebased or relined.

18. 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.

Oral Surgery

1. Extractions (Codes D7111 – D7251)

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

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

3. Extractions may be indicated in the presence of non-restorable caries, untreatable periodontal disease, pulpal and periapical disease not amenable to endodontic therapy, to facilitate surgical removal of a cyst or neoplasm, or when overriding medical conditions exist, providing

compelling justification to eliminate existing or potential sources of oral infection.

a. Extractions of erupted teeth
    i. An uncomplicated extraction (Code D7140) of an erupted or exposed root includes removal of all tooth structure, minor smoothing of socket bone and closure, as necessary. Extraction of an erupted tooth may be needed when the tooth has significant decay, is causing irreversible pain and/or infection, or is impeding the eruption of another tooth.
    ii. A surgical extraction of an erupted tooth (Code D7210) requires removal of bone and/or sectioning the tooth, including elevation of a mucoperiosteal flap if indicated.

b. An impacted tooth is "An unerupted or partially erupted tooth that is positioned against another tooth, bone, or soft tissue so that complete eruption is unlikely." (CDT)
    i. Extraction of a soft tissue impaction (Code D7220) is a tooth with the occlusal surface covered by soft tissue, and extraction requires elevation of a mucoperiosteal flap.
    ii. Extraction of a partial bony impaction (Code D7230) is a tooth with part of the crown covered by bone and requires elevation of a mucoperiosteal flap and bone removal.
    iii. Extraction of a completely bony impaction (Code D7240) is a tooth with most or all of the crown covered with bone and requires elevation of a mucoperiosteal flap and bone removal.
    iv. Extraction of a complicated completely bony extraction (Code D7241) requires documentation of unusual surgical complications.

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

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

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

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

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

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

f. Orthodontic extractions / procedures (D7280, D7282, D7283) can only be performed when there is an approval for orthodontic treatment by Medicaid or Nevada Check Up

2. Other Surgical Procedures

1. Residual tooth roots (Code D7250) may need to be removed when the residual tooth root is pathological or is interfering with another procedure.
2. Sinus perforation or oroantral fistula closure (Code D7260) requires documentation that there is a pathological opening into the sinus.
3. Tooth re-implantation and/or stabilization of an accidentally evulsed or displaced tooth (Code D7270) requires documentation that a tooth or teeth has been accidentally evulsed or displaced.
4. Codes D7280-D7283 – Require documentation that demonstrates medical necessity to expose, aid and facilitate eruption of impacted tooth. These procedures may be approved when there is an approval for orthodontic treatment by Medicaid or Nevada Check Up.
5. A biopsy of oral tissue (Codes D7285 and D7286) requires documentation that there is a suspicious lesion in the mouth that needs evaluation and the harvesting of oral tissue.
6. A surgical procedure to facilitate tooth movement (Codes D7292 – D7295) requires documentation that demonstrates the medical necessity of a surgical procedure to facilitate appropriate tooth positioning.
3. Alveoloplasty-Preparation of Ridge (Codes D7310 – D7321) requires documentation that demonstrates the medical necessity for the surgical recontouring of the alveolus. This is only payable in preparation for a full denture.
4. 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.

5. 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.
6. Incision and drainage of an abscess (Codes D7510 - D7521) requires documentation that shows an oral infection requiring drainage.
7. Removal of a foreign body (Code D7530), non-vital bone or a tooth fragment requires documentation that it is medically necessary to remove it.
8. Open/closed reduction of a fracture (Codes D7610 – D7640) requires documentation that demonstrates evidence of a broken jaw.
9. 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.
10. 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.
11. A frenectomy requires documentation that demonstrates evidence that a muscle attachment is interfering with proper oral development or treatment.
12. Buccal (D7961) 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
13. Lingual Frenum (D7962) 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

14. 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.

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

Adjunctive Services

1. Unclassified Treatment
    1. Palliative Treatment (Code D9110)
        a. Typically reported on a "per visit" basis for emergency treatment of dental pain.
        b. The submitted documentation must show the presenting issue and/or the emergency treatment provided that was medically necessary for the procedure.
    2. Fixed Partial Denture Sectioning (Code D9120)
        a. This procedure involves separation of one or more connections between abutments and/or pontics when some portion of a fixed prosthesis is to remain intact and serviceable following sectioning and extraction or other treatment. It includes all recontouring and polishing of retained portions.
        b. The submitted documentation must show it is medically necessary to section and remove part of a fixed partial denture and that the remaining tooth or teeth has a good prognosis.
2. Anesthesia
    1. Local or regional block anesthesia in or not in conjunction with operative or surgical procedures (Code D9210):
        a. Local or regional block anesthesia is considered to be part of and included in conjunction with operative or surgical procedures.
        b. Submitted documentation must show that it is necessary to anesthetize part of the mouth when it is not in conjunction with operative or surgical procedures.
    2. Deep Sedation/General Anesthesia or Intravenous moderate sedation/analgesia (Codes D9239 and D9243). For dental codes related

to general or IV anesthesia, the provider must show the actual beginning and end times in the recipient's dental record

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

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

c. Liberty provides benefits for covered general Anesthesia ("GA") or Intravenous ("IV") sedation in a provider setting ONLY when medical necessity is demonstrated by the following requirements, conditions and guidelines:

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

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

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

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

   v. When a Medicaid or Nevada Check Up enrollee is identified as having special health care need (aka a Child With Special Health Care Needs or Individual With Intellectual Disabilities (IDD)) the provider is required to identify any ongoing special conditions of the enrollee that require a course of treatment or regular care monitoring. For patients that require in-office sedation, the vendor will assist the member's PDP in locating an available dental anesthesiologist.

3. Requirements for Documentation:

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

b. Prior authorization and submission requirements:

   i. Before GA or IV sedation is performed in a provider setting, all necessary medical and dental documentation, including the dental treatment plan, must be reviewed and approved by Liberty.

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

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

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

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

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

   a. Removal of impacted teeth;

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

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

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

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

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

   a. Processing Guideline: Nitrous Oxide is considered inclusive with Non-Intravenous Conscious Sedation (Code D9248).

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

a. This is a medically controlled state of depressed consciousness that still maintains the patient's airway, protective reflexes and ability to respond to stimulation or verbal commands. It includes Non-intravenous administration of sedative and/or analgesic agent(s) and appropriate monitoring.
    i. The submitted documentation must demonstrate the medical necessity of non-IV conscious sedation.
    ii. The level of anesthesia is determined by the anesthesia provider's documentation of the anesthetic's effect upon the central nervous system and does not depend on the route of administration.

1. Professional Consultation (Code D9310)
    a. This is a patient encounter with a practitioner whose opinion or advice is sought regarding evaluation and/or management of a specific problem. It may be requested by another practitioner or appropriate source and it includes an oral evaluation.
    b. The submitted documentation must demonstrate the medical necessity of assistance in determining the treatment required for a specific condition.
2. Professional Visits (Codes D9410 and D9420)

· Hospital, house, extended care or ambulatory surgical center call
    a. Includes nursing homes, long-term care facilities, hospice sites, institutions, hospitals or ambulatory surgical centers.
    b. Services delivered to the patient on the date of service are documented separately using the applicable procedure codes.
    c. The submitted documentation must demonstrate the medical necessity of treatment outside of the dental office.

· Office visit for observation or case presentation during or after regularly scheduled hours (Code D9440)
    a. This is for an established patient and is not performed on the same day as evaluation.
    b. The submitted documentation must demonstrate the medical necessity of an office visit or case presentation during or after regularly scheduled office hours.

- Drugs (Codes D9610 – D9630) Administration of one or more parenteral drugs or dispensing of drugs or medicaments for home use requires documentation demonstrating the medical necessity of the drugs or medicaments for treating a specific condition.

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

· Occlusal Guard (Code D9940)

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

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

Retrospective Review

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

Retrospective review of services that had been previously pre-authorized will require documentation confirming that the procedure(s) was (were) completed as authorized and within the standard of care as defined by Liberty's Criteria Guidelines and Practice Parameters. Liberty's Criteria Guidelines and Practice Parameters are available for download from Liberty's Provider Resource Library at Libertydentalplan.com/Providers/Provider-Resource-Library.aspx

Section 9. Specialty Care Referral Guidelines

Liberty does not discriminate for the participation, reimbursement, or indemnification of any provider who is active with the scope of his/her license or certification under applicable State law, solely on the basis of that license,

specialty or certification. Liberty does not discriminate against particular providers who serve high risk populations or treat special conditions that require costly treatment. The following guidelines outline the specialty care referral process. Failure to follow the referral process may cause delays in treatment. Reimbursement of specialty services is contingent upon the member's eligibility at the time of service.

Non-Emergency Specialty Referral Submission and Inquiries

Each Liberty member is assigned a Primary Dental Provider (PDP) who is responsible for referrals for specialty care and other covered medically necessary services included in the Nevada Medicaid and Nevada Check Up benefit package. The PDP must submit a specialty care referral to Liberty for prior approval, and there are three options for submitting that referral:

1. **Provider Portal:** https://providerportal.Libertydentalplan.com/
2. **Fax: 888-401-1129**
3. **Mail:**

ATTN: REFERRAL DEPARTMENT

Liberty Dental Plan
P.O. Box 401086
Las Vegas, NV 89140

If no contracted Liberty specialist is available within a reasonable distance of your office, Member Services will provide assistance in referring the member to a non-contracted specialist.
If a referral is made by the member's assigned PDP without prior approval, the referring office may be held financially responsible. Failure to use the proper referral request and submit accurate information may delay claim processing or payment.
The Liberty Specialty Care Referral Request must be completed and used when making a referral. Radiographs and other supporting documentation will not be returned. It is highly recommended not to submit original radiographs.
Radiograph copies of diagnostic quality, including paper copies of digitalized images, are acceptable.

Emergency Referral

Emergency referrals apply when members are experiencing pain, swelling, bleeding or trauma. If an emergency specialty care referral is needed, the Referral Unit can issue an emergency authorization number to the PDP by calling Liberty's Referral Unit at 888-700-0643 Option 4.

Referral Guidelines

Specialty care referrals for endodontic, periodontic and oral surgical procedures are required if services are beyond the scope of the PDP. The member's PDP must initiate the referral request. The specialty care referral request should be submitted to Liberty along with radiograph(s) and supporting documentation. Referrals to a pediatric provider are not required.
FQHCs and Indian Health Service facilities can directly refer members to a contracted specialist.
The general dentist should confirm the need for a referral and that the referral criteria are met. Complete a Liberty Specialty Care Referral Request and provide the following:

- Member's name, Liberty identification number, group name and group number
- Name, address and telephone number of the contracted Liberty network specialist
- Procedure code(s) and tooth number(s), which requires referral

Inform the member that:

- Only services approved by Liberty will be covered;
- The member will be financially responsible for non-covered services provided by the Specialist;
- Payment by the Plan is subject to eligibility at the time services are rendered.

Referral Guidelines for Specialists

The specialist should obtain the Liberty Specialty Care Authorization and pre-operative radiograph(s) from Liberty, the general dentist or the member.
For any services not listed on the original authorization form from Liberty, you must submit a prior authorization request to the Plan with a copy of pre-operative radiograph(s) and a copy of the member's Liberty Specialty Care Authorization.

If an emergency service is needed but has not been listed on the original

authorization form, contact Liberty's Referral Unit at 888-700-0643 for an emergency authorization number.

After completion of treatment, submit your claim for payment with pre-operative and post-operative radiographs. (To expedite claim payment, please always attach a copy of the member's Authorization Form). **Radiographs and other supporting documentation will not be returned. Please do not submit original radiographs. Radiograph copies of diagnostic quality or paper copies of digitized images are acceptable.**

Section 10. Quality Improvement and Oral Health Equity

Purpose, Goals, and Objectives

Liberty's Quality Improvement and Oral Health Equity Program is compliant with all Nevada state, and Federal laws and regulations, and applicable contract requirements.

Program Description

Liberty's Quality Improvement and Oral Health Equity Program (QIOHEP), also known as Quality Assurance and Performance Improvement (QAPI) in Nevada is designed to ensure that licensed providers 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 QIOHEP continuously and objectively assesses dental member care services and systems for all members, including members 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 QIOHEP 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 QIOHEP Plan. The Dental Director, or his/her designee, oversees the QIOHEP and ensures that day-to-day quality assurance functions are carried out in compliance with dental program contracts and applicable requirements.

QIOHEP Goals and Objectives

The goal of the QIOHEP is to comprehensively identify and address the quality of dental care and service to our members. The QIOHEP 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 member'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 members' dental health. Liberty also implements measures to prevent any further decline in condition or deterioration of dental health status when a member'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 PDPs and specialists and uses them to evaluate care provided to members.

Program Scope

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

- Providing immediate and responsive feedback to members, providers, and the public as appropriate
- Policy and procedure development
- Annual QIOHEP evaluation and report
- Annual QIOHEP 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
- Member health education

The QIOHEP'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 ease and timeliness with which patients can obtain the care they need when they need it by network providers.
- **Appropriateness of Care:** the degree to which the correct care is provided, given the current community standards.
- **Continuity of Care:** the degree to which the care patients need is coordinated among practitioners and is provided without unnecessary delay.
- **Effectiveness of Care:** the degree to which the dental care provided 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 patient.

Program Content and Committees

- **Quality Improvement and Oral Health Equity Committee (QIOHEC):** 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, Utilization Management.
- **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 are monitored and CAPs are developed if deficiencies occur. Activity is reviewed by the **QIOHEC** quarterly, or more frequently, if necessary.
- **Credentialing:** Liberty's Credentialing Program includes initial credentialing and re-credentialing at 36month intervals of all primary and specialty care providers 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 members, providers and associates. As part of the CLC Program, information about language (spoken and

written), race and ethnicity information is 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.

- **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 **QIOHEC.**
- **Peer Review Committee (PRC):** The Peer Review Committee is responsible for identification and resolution of quality-of-care issues. Potential quality issues 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 members 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 QIOHEP, 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, office onsite assessments with deficient critical or structural indicators, aberrant 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.
- **Focus Reviews:** The Dental Director or designee may determine the need for focus reviews triggered by various findings such as potential quality issues (PQIs), grievances, utilization outlier status, potential fraud, waste or abuse or other administrative reasons.
- **Dental Advisory Committee (DAC):** The DAC Committee purpose is to join forces with the dental network and involve them in the oversight of Liberty operations, programs, activities and to provide related activities and metrics as provided by Liberty. Liberty's network may provide input

regarding provider relations issues that will allow Liberty to identify areas for continuous improvement activities.

- **Population Health Management Committee (PHM):** Liberty's Population Health Management (PHM) strategy seeks to improve outcomes for all members, regardless of level of need, while promoting delivery of personalized, cost-effective, preventive dentistry. We work to reduce health disparities, address barriers to care such as the social determinants of health and ensure all members can access their benefits. Our PHM Committee oversees Liberty's activities and PHM strategy, ensuring alignment between the many departments involved, and partner with providers and stakeholders to improve access and oral health outcomes. Case Management and Care Coordination referrals are tracked and reported within the committee to ensure members with complex oral health and medical needs access oral health care. The Committee reviews statistics, trends, and key performance indicators related to our CM program and learn from CM activities across our programs to identify opportunities for improvement.

Grievance and Appeals (G&As System)

The G&A Department monitors and reports the summary of quarterly findings identified through the member grievance, complaint, and appeals processes, including but not limited to access issues and office transfers.

The PRC reviews member G&A related to Liberty, providers, or benefits. The PRC is responsible for hearing and resolving G&A by monitoring patterns or trends to formulate police changes and generate recommendations as needed.

Corrective Action Plans

Negative findings resulting from the above activities may trigger further investigation of the provider facility by the Dental Director or his/her designee.

If an access to care problem is identified, corrective action must be taken including, but not limited to, the following:

- Further education and assistance to the provider.
- Provider counseling.
- Closure to new membership enrollment.
- Transfer of patients to another provider.
- Contract termination.

- Investigation results from subcommittees must be reported to the QIOHE Committee.

Care Coordination and Case Management

The overall goal of Liberty's Care Management Program is to assist members in regaining the highest level of oral health in the right setting based on their specific needs, utilizing the right Providers, in the right time frame, and in a cost-effective manner. The Program involves comprehensive assessments of the member's condition, determination of available benefits and resources, and the development and implementation of a nursing place of care with performance goals, monitoring, and follow up. Liberty's goals for the Care Management Program is as follows:

1. To assess comprehensively each member identified by the Department of Health Care Financing and Policy (DHCFP) as having special health care needs, to identify any ongoing special conditions of the member that require a course of treatment of regular care monitoring;
2. To coordinate care for members with complex needs and/or those who need assistance to overcome barriers to quality dental care;
3. To effectuate Care Coordination in partnership with Primary Dental Providers (PDPs), Specialists, Medical MCOs, other Providers, members, and members' support systems; and
4. To address members' needs holistically, including their oral health, mental health, co-morbid conditions, and Social Determinants of Health (SDOH).

Our network Providers are essential to the success of our Care Management Program from helping us to identify members who would benefit from Care Coordination or Case Management, to working with our clinical staff to develop member-centric plans of care, to participating in our innovative Value Based Payment programs that offer enhanced care to qualifying members and reward Providers for improving Member outcomes.

Providers may identify and refer members for Care Coordination and Case Management in multiple ways, including:

- Through the results of an Oral Health Risk Assessment, Caries Risk Assessment, or Social Determinants of Health Assessment;
- Through assigned Member Rosters in the secure Provider Portal (including under and over utilizers and members living in racial disparity zip codes);

- Upload a NV Liberty Dental Plan Case Management Referral Request Form through the Provider Portal, email the form to casemanagernv@Libertydentalplan.com, fax the form to 949-825-8200, or contact your designated Network Manager;
- Refer the member to Liberty's Member Services Department.

Copies of Liberty's **2025 Care Management Program Description and 2025 Population Health** Strategy are available on the Provider Portal.

Utilization Management

Liberty's Utilization Management (UM) Program is designed to meet contractual requirements with DCHFP as well as applicable state and federal laws and regulations, by providing members 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 Medically Necessary consistent with the member'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 member partnership
- Facilitating communication and partnerships among members, families, Dental Providers, Medicaid health plans, other Medicaid dental plans and Liberty in an effort to enhance cooperation and appropriate utilization of dental care services
- Reviewing, revising, and developing dental services coverage policies to ensure members have appropriate access to new and emerging care and technology
- Enhancing the coordination and minimizing barriers in the delivery of dental care services

Liberty has a long-established and effective Utilization Management (UM) Program designed to ensure that dental services are delivered at the appropriate level of care and in a timely, cost-effective manner. The UM Program focuses on improving the quality of care and enhancing the evaluation of practice patterns of oral health care delivery. Our UM program analyzes provider utilization data in the context of grievances and appeals, access and availability, and member satisfaction data for different categories of service and member demographics.

Liberty's Provider Performance Management (PPM) program reviews claims and utilization information on a continuous basis, comparing provider offices in many categories including utilization, access to care, grievances and appeals, among others. When Liberty identifies an issue, Liberty dentists provide peer-to-peer counseling and support to resolve the issue and answer any questions providers may have. This process fosters meaningful conversations to reinforce best practices, achieve better outcomes and improve patient experiences for our mutual members.

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 Providers and Dental Consultants, none of which are compensated or incentivized on clinical review decision making.

Liberty identifies which dental services require prior authorization based on:

- Clinical Standards of practice: Liberty's Clinical Criteria Guidelines are key components to the medical necessity decision-making process and ensure that decisions are based on sound clinical evidence. The CCG's are developed, updated, and reviewed by clinicians through our Peer Review Committee, which consists of both Liberty and network providers, and reports directly to the Liberty Quality Improvement and Oral Health Equity Committee. The QIOHEC has direct oversight by the Dental Director, who also chairs the Peer Review Committee.
- The Clinical Criteria Guidelines are updated annually for formal adoption and adhere to all state and federal regulations and guidelines. The CCG's are developed with guidance from the American Dental Association, American Academy of Periodontology, American Association of Oral and Maxillofacial Surgeons, American Academy of Pediatric Dentistry, American Association of Endodontics, American Association of Orthodontics, and the American College of Prosthodontists. In addition, our Peer Review Committee utilizes contemporary research, practice trends, and literature reviews to help inform any updates or necessary edits, changes, or additions.

- Utilization Review: We include ongoing results of our Utilization management and review processes to determine which services should be reconsidered for prior authorization. In situations where particular services might seem to be excessive or abused without prior authorization occurring, we will consider changing the requirements for that procedure for the following plan year. When doing so, provider notification would occur prior to the effective date of the new plan year. We re-evaluate this annually upon the release of the Code on Dental Procedures and Nomenclature (CDT) code updates. In reviewing utilization patterns, Liberty also adjusts our claim system to identify and control Potential Fraud Waste and Abuse (PFW&A) billing patterns. The claims system is flexible and PFW&A controls are able to customize at the provider, office, group, plan, and code levels. These types of system rules include but are not limited to considering members claims history especially for procedures that do not have frequency limitations.

Medical Necessity Determination

Liberty identifies which procedures require medical necessity determination. Liberty's definition of medical necessity aligns with all federal and state requirements, and nationally accepted clinical criteria and practices.

We approve care that is "medically necessary" and "appropriate," meaning:

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

- Services are provided in a manner that is no more restrictive than that used/indicated in State statutes and regulations.
- In making decisions of medical necessity, Liberty Staff Providers and Dental Consultants actively work with the treating provider to ensure a clear understanding of the member's unique needs, review our written guidelines, and review criteria to ensure members obtain appropriate and necessary dental services:
- In a manner that considers the timeliness of care that meets their dental needs;
- That are within professionally recognized standards of dental care; and
- At a location appropriate for their condition.

Process to Ensure Consistent Application of Review Criteria

State and or/plan specific requirements are built into our UM system to ensure all applicable procedures receive review and that procedures that should bypass this process are not subject to review. Procedures that require clinical review are systematically routed to the appropriate state-licensed staff provider for review. All authorization requests received are scanned and included in Liberty's electronic prior authorization process within our MIS. The Staff Provider reviews each procedure for evidence of need and prognosis electronically through our HSP system.

We ensure consistent application of our review criteria for authorization through a variety of strategies including:

- Documentation: Written policies and procedures and Provider and Member Handbooks clearly identify the procedures subject to prior authorization and how to process initial and continuing authorizations of services.
- Staff Provider/ Dental Consultant Training: Receive ongoing and continuous training on state and plan specific medical necessity and prior authorization requirements, including our written policies and procedures. All Staff Providers and Dental Consultants have extensive experience in both clinical practice and Utilization Review and receive continuing education and calibration to ensure that Liberty is current on all new and emerging trends in clinical dentistry.
- Monthly Quality Assurance reviews completed by the State Dental Director to ensure all UM decisions align with Liberty Clinical Criteria Guidelines.
- Semi Annual Inter-Rater Reliability calibration exercises reviewing real authorizations. Internal goals/requirements require 90% agreement by all clinicians. Any clinician who performs UM review and fails to meet this goal is

required to undergo one on one training with the Liberty National Director of Clinical Oversight and the State Dental Director until competency is achieved.

Member Grievances and Appeals (G&A)

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

- **All contracted provider offices are required to provide members with a copy of the Liberty grievance form, upon request**.

All members, authorized representatives, and/or the representative of a deceased member's estate can submit grievances and appeals verbally, in writing, online, or in person. No aspect of the member G&A process is delegated to an outside entity. Liberty does not take punitive action against any Provider who requests a standard or expedited resolution or supports a member's grievance and/or appeal.

G&A Definitions

- **Acknowledgement:** A written notice issued by Liberty confirming the receipt of the G&A to the member and provider.
- **Appeal:** A formal request from a member, or authorized representative, to reconsider and review the initial decision to deny, modify, or pend (delay) services or payment.
- Providers submitting a standard or expedited appeal on behalf of a member must obtain and supply Liberty with a copy of a signed document from the member indicating consent for the appeal to be filed on his/her behalf. If Liberty does not receive such documentation, the appeal cannot be processed.
- **Continuation of Benefits:** A formal written request from a member, or authorized representative, asking to maintain treatment or reinstate benefits scheduled to be reduced or terminated during the appeal and/or state fair hearing processes.
- **Expedited/Fast Track Review:** A formal request for an urgent review because the member's health or dental function is in immediate danger. Urgent review can be applied to member appeals, state fair hearing requests, and external review requests.
- **Extension:** A request from a member, authorized representative, or Liberty, if

in the member's best interest, requesting additional time for resolution of a standard or expedited appeal.

  - Appeal extension requests by Liberty include verbal and written notification of the extension to the member along with their right to file a grievance if the member or authorized representative is not in agreement with the Plan's extension.
  - If Liberty does not make a decision within the extension time period, the internal appeal process will be considered completed and the member will qualify for the next level in the appeal process.

- **External Review:** A formal written request for a review by an independent review organization from a member, or authorized representative, contesting an adverse benefit determination pertaining to a medical necessity determination or that the services are experiment or investigational in nature.
- **Grievance:** Any expression of dissatisfaction by a member, or authorized representative, that is not associated with a request for a review of an adverse benefit determination.
- Providers submitting a grievance on behalf of a member must obtain and supply Liberty with a copy of a signed document from the member indicating consent for the grievance to be filed on his/her behalf. If Liberty does not receive such documentation, the grievance cannot be processed.
- **State Fair Hearing:** A formal written request from a member, or authorized representative, seeking second level of appeal review with an impartial administrative law judge.
  - State fair hearings are only available once the member has completed the internal appeal process with Liberty, except for situations where the standard hearing timeframe could jeopardize the life, health, or ability to attain, maintain, or regain maximum function.

G&A Records Requests

Providers are **contractually required** to provide Liberty with copies of all member records requested as a part of a member G&A within **three (3) business days** of the request from the Plan.

- All providers are **required** to respond to Liberty with a written response to the members' concerns and include supporting documentation (-clinical

notes, treatment plans, financial ledgers, x-ray(s) etc.). Failure to cooperate/comply with the G&A process, request for records, or resolution 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.

G&A Cultural and Linguistics

Liberty's G&A system also addresses the cultural and linguistic needs as well as the needs of our members with disabilities. The process is designed to ensure that all Liberty members have access to and can fully participate in the G&A system.

- Liberty's members' participation in the G&A system, for those with linguistic, cultural, or communicative impairments, is facilitated through the coordination of translation, interpretation, and other communication services to assist in communicating the procedures, process, and findings of the G&A system.

Liberty makes available translation services for members whose primary language is not English. We currently provide translation services in one hundred and fifty (150) languages. G&A forms can be obtained from Liberty's Member Services Department, from a dental provider office/facility, or the Liberty website.

- To provide excellent service to our members, Liberty maintains a process by which members can obtain timely resolution to their inquiries, complaints, and appeals. This process allows for:
- The receipt of correspondence from members, in writing, by telephone, or in person.
- Thorough research
- Member education on plan provisions
- Timely resolution

Member Grievances, Appeals, and State Fair Hearing Processing Timeframes			
Topic	**Member Grievances**	**Member Standard Appeal**	**Member Expedited Appeals**
Filing Limitation	No filing limitation; can be filed at any time	No later than 60 calendar days from the date of the Notice of Adverse Benefit	No later than60 calendar days from the date of the Notice of Adverse Benefit

		Determination (NABD)	Determination (NABD)
Acknowledgement	Within 5 calendar days of receipt	Within 5 calendar days of receipt	Within 24 hours, verbally
Resolution	Within 30 calendar days of receipt	Within 30 calendar days of receipt	As expeditiously as the member's health condition requires not to exceed 72 hours
Extension	Up to 14 calendar days upon request of the member or upon Liberty's request as it would be in the member's best interest for additional information to be provided.	Up to 14 calendar days upon request of the member or upon Liberty's request as it would be in the member's best interest for additional information to be provided.	Up to 14 calendar days upon request of the member or upon Liberty's request as it would be in the member's best interest for additional information to be provided.
Continuation of Benefits Requests	Not Applicable	Within 10 calendar days of the notice or before the date the Plan state treatment or benefits will stop.	Within 10 calendar days of the notice or before the date the Plan state treatment or benefits will stop.
State Fair Hearing Timely Filing	Not Applicable	Within 90 calendar days of the appeal resolution that is not fully in favor of the member.	Within 90 calendar days of the appeal resolution that is not fully in favor of the member.
State Fair Hearing Review	Not Applicable	Within 90 calendar days of the request, unless extenuating circumstances warrant an extension.	Within 3 working days of the request – qualifying cases only.
Effectuation	Within 72 hours of the decision to overturn the initial decision fully or in part.	Within 72 hours of the decision to overturn the initial decision fully or in part.	Within 72 hours of the decision to overturn the initial decision fully or in part.

Continuation of Benefits

Liberty abides by all state and federal regulations with respect to continuation of benefits throughout the appeal and Fair Hearing process. Liberty will continue member benefits when all the following have been met:

- The request for continuation of benefits is submitted to Liberty as outlined

below.

- The member files the request for an Appeal within the filing limitation outlined above following the date on the Adverse Benefit Determination.
- The appeal involves the termination, suspension or reduction of a previously authorized course of treatment.
- The services were ordered by an authorized Liberty dental provider.
- The original period covered by the initial authorization has not expired.
- The member requests an extension of benefits.

If a member's benefits are continued pending the outcome of an Appeal or Fair Hearing, Liberty will notify the provider. If the final resolution of the appeal or the State Fair Hearing upholds the Plan's initial adverse benefit determination, the member may be held financially responsible for the cost of the services furnished during the appeal and/or state fair hearing processes.

G&A Resolution

Liberty resolves all member G&A within the timeframes demonstrated below.

Important Notes:

- There is no filing limitation for Grievances, and they can be submitted at any time. Liberty accepts member G&A in all manners of communication verbally, in writing, online, or in person.
- Members and providers are not required to use the Liberty G&A form. Liberty will process all member G&A in accordance with state and federal regulations and the timeframes outlined below.

G&A SUBMISSION

Members, authorized representatives, and/or the representative of a deceased member's estate, can submit a G&A to Liberty through any of the methods listed below:

Mail: Liberty Dental Plan of Nevada
Attn: Grievances and Appeals Department
P.O. Box 401086
Las Vegas, NV 89140

Fax: 833-250-1814
Online: Libertydentalplan.com/Members/File-a-Grievance-or-Appeal.aspx
Phone: 888-700-0643
TTY/TDD: 877-855-8039

STATE FAIR HEARING

A member, representative, or the representative of a deceased member's estate has a right to request a standard or expedited Fair Hearing from the state when they have completed Liberty's internal appeal system without receiving a resolution that is fully in his or her favor or in cases that Liberty fails to provide a resolution within the timeframes outlined above.

Expedited state fair hearings may be available when an urgent review is needed because the member's health or dental function is in immediate danger. Expedited state fair hearing requests must be submitted with pertinent medical information that supports the urgent reason for the expedited review.

- Requests for expedited state fair hearings can be made in writing, by telephone, online, in person, or other commonly available electronic means.
- Providers may file a request for an expedited state fair hearing on behalf of a member only in cases where the member is unable to act on their own behalf, either because of a physical or mental incapacity. Additional documentation may be required to demonstrate the members' incapacity on a case-by-case basis.

All requests, standard and expedited, for a Fair Hearing must be submitted in writing within the timeframes listed above.
Appeals with one or more of the following will be eligible for the State Fair Hearing process:

- Denial or limited authorization of requested services
- Reduction, suspension or termination of a service previously authorized
- Denial, in whole, of in part, of payment for a service

- Failure on Liberty's behalf to meet specified time frames
- Denial of disenrollment for good cause

Members who have questions about state fair hearing process or members who are not satisfied with Liberty's decision on the appeal, can contact the Nevada Division of Health Care Financing and Policy by telephone or in writing at the following:

Call:

Las Vegas: 702-668-4200 or 800-992-0900
Carson City: 775-684-3651 or 800-992-0900

Write:
Nevada Division of Health Care Financing and Policy
Hearings Unit
4070 Silver Sage Drive
Carson City, NV 89701

If Liberty or the administrative law judge decides to overturn a denied authorization of services and the member receives the disputed services while the appeal is pending, Liberty will issue payment for those services promptly and expeditiously as possible but no later than the effectuation timeframe outlined above.

If you need information or help, call us at:
Toll-Free: 888-700-0643
TTY/TTD: 877-855-8039

Provider Grievances and Payment Disputes (Appeals)

As a Liberty contracted, or non-contracted provider, you have the right to challenge, appeal, dispute or request reconsideration of a claim (or a bundled group of substantially similar multiple claims that are individually numbered), a prior authorization, or other decision made by Liberty. You can also submit disputes verbally or in writing seeking resolution of a billing determination, other contract dispute or a request for reimbursement of an overpayment of a claim.

- **Providers may not file a G&A on behalf of a member without appropriate written consent from the member. A copy of a signed document from the**

member indicating consent for the G&A to be filed on his or her behalf is required. If Liberty does not receive such a document, the G&A cannot be processed.

Providers have the right to submit a grievance (complaint) about any concerns, including but not limited to Liberty's quality of services, policy and procedure issues or any other concerns that do not involve claim disputes.

Provider G&A can be submitted verbally, in writing, by fax, or online, including cases from DHCFP and other sources.

- **Informal provider complaints may be resolved informally via phone by calling Liberty's Member Services at 888-700-0643 or by contacting your Network Manager.**

Liberty accepts provider grievances and provider payment disputes verbally, in writing, by fax or online in accordance with state and federal regulations. Please reference the Provider Dispute Resolution timeframes outlined in the chart below.

Pre-Service Provider Disputes (Appeals)

Pre-service appeals submitted on behalf of members, with appropriate written consent, will be processed in accordance with the member appeal process. For more information on the member process please reference the section above for Member G&A.

Providers may submit requests for expedited pre-service appeals on behalf of a member, with appropriate written consent, in the event there is an imminent and serious threat to the member'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 member's ability to attain, maintain or regain maximum function.

Cases that qualify for expedited will be resolved within the member expedited appeal timeframes referenced in the section above. The timeframe for expedited appeal review may be extended at the member's request or if Liberty needs additional information that would be in the best interest of the member.

Provider Dispute Resolution (PDR)

PDRs can be filed verbally, in writing, by fax, or online to Liberty's Grievances and Appeals Department in accordance with the timeframes listed below.

All PDRs, including those filed on behalf of a member, must contain, at minimum, the following information:

- The provider's name and license number
- The provider's contact information, i.e. telephone number
- The member's name and identification number
- A clear identification of the issue that is subject of the grievance or appeal, i.e. claim number, date of service, procedure, 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
- A signed authorized representative form or notice from the member in support of G&A submitted on his or her behalf, if applicable.

All PDRs not associated with a claim must distinctly explain the issue and the provider's position. PDRs not including all the required information may be returned to the submitter for completion. An amended PDR, including any missing or additional information required by the Plan, may be submitted within the timeframes outlined below. PDRs submitted to Liberty must include the information listed below for each contracted provider dispute and/or concern.

Provider Dispute Resolution (PDR) Timeframes		
Topic	**Provider Grievances (Non-Claim Related)**	**Provider Appeals (Claims Related)**
Filing Limitation	No later than 60 calendar days from the date of the issue and/or denial issued by Liberty	
Acknowledgement	Within 5 business days of receipt	
Amended Disputes	Within 30 business days of receipt of a returned PDR that is missing information	
Resolution	Within 30 calendar days of receipt	
Effectuation of payment	Within 5 business days from the date of the resolution letter	

Sending a PDR to Liberty must include the information listed above for each case/concern in question. All PDRs can be submitted to any of the following:

Mail: Liberty Dental Plan
Attn: Grievances and Appeals Department
P.O. Box 401086

Las Vegas, NV 89140

Fax: 833-250-1814
Online: https://www.Libertydentalplan.com/Members/File-a-Grievance-or-Appeal.aspx
Phone: 888-700-0643

All inquiries regarding the status of a PDR or about filing a PDR must be directed to Liberty's Grievances and Appeals Department at any of the contact methods listed above.

Section 11. Fraud, Waste and Abuse; and Overpayment

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

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

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

- Conspires to violate the FCA

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

As a provider, you are responsible to:

- Comply with all federal and state laws and Liberty requirements regarding fraud, waste, abuse and overpayment.
- Ensure the claims that you (or your staff or agent) submit and the services you provide do not amount to fraud, waste or abuse, and do not violate any federal or state law relating to fraud, waste or abuse.
- Ensure you provide and bill only for services to members that are medically necessary and consistent with all applicable requirements, regulations, policies and procedures.
- Ensure all claims submissions are accurate.
- Notify Liberty immediately of any suspension, revocation, condition, limitation, qualification, or other restriction on your license, or upon initiation of any investigation or action that could reasonably lead to a restriction on your license, or the loss of any certification or permit by any federal authority, or by any state in which you are authorized to provide healthcare services.
- Notify Liberty immediately when you receive information about changes in a Liberty member's circumstances that may affect the member's eligibility including the following:
    - Changes in the member's residence
    - A member’s death

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

Fraud means knowing or intentional or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to him/her or some other person. Fraud includes any act that constitutes fraud under applicable federal or state law.

Waste means over-utilization of services or other practices that result in unnecessary costs.

Abuse means provider practices that are inconsistent with sound fiscal, business, or medical practices, and result in an unnecessary cost to government-sponsored programs, and other healthcare programs/plans; or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for healthcare. Abuse also includes recipient practices that result in unnecessary cost to federally and/or state-funded healthcare programs, and other payers.

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

- Billing for services or procedures that have not been performed or have been performed by others.
- Submitting false or misleading information about services performed.
- Misrepresenting the services performed (e.g., up-coding to increase reimbursement).
- Not complying with regulatory documentation requirements.
- Lack of documentation to support services performed.
- Retaining and failing to refund and report overpayments (e.g., if your claim was overpaid, you are required to report and refund the overpayment, and unpaid overpayments also are grounds for program exclusion).
- A claim that includes items or services resulting from a violation of the Anti-Kickback Statute.
- Routinely waiving patient deductibles or co-payments.
- An individual provider billing multiple codes on the same day where the procedure being billed is a component of another code billed on the same day .

- Routinely maxing out members' benefits or authorizations regardless of whether the services are medically necessary.

Reporting Suspected Fraud, Waste, and Abuse: And Overpayment

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

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

All suspected cases of fraud, waste or abuse related to Liberty, including Medicare, Medicaid, and Nevada Check Up must be reported to Liberty's Special Investigation Unit (SIU). The caller will have the option of remaining anonymous.

Reports may be made to Liberty via one of the following methods:

- **Corporate Compliance Hotline**: **888-704-9833**
- **Compliance Unit email**: compliancehotline@Libertydentalplan.com
- **Special Investigations Unit Hotline**: **888-704-9833**
- **Special Investigations Unit email**: SIU@Libertydentalplan.com

Reports to the Corporate Compliance Hotline may be made 24 hours a day/7 days a week. Callers may choose to remain anonymous. All calls will be investigated and remain confidential.

U.S. Mail:

ATTN: SPECIAL INVESTIGATIONS UNIT

Liberty Dental Plan
PO Box 401086
Las Vegas, NV 89140

and/or

State of Nevada Office of the Attorney General

- **Fraud Hotline**: **702-486-3420**
- **Email: AgInfo@ag.nv.gov**
- **On-Line Complaint Form**

and/or

U.S. Government Recovery Board

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

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

Cooperate with Liberty's Audits and Investigations

Liberty's expectation is that you will fully cooperate and participate with its fraud, waste, abuse and overpayment audits and investigations. This includes, but is not limited to, permitting Liberty and/or the State of Nevada access to

member treatment records and allowing Liberty and/or the State of Nevada to conduct onsite audits or reviews.

What to Expect During a Fraud, Waste, Abuse or Overpayment Audit or Investigation

Liberty's Special Investigation Unit (SIU) investigates all reports of fraud, waste, abuse and overpayment. Allegations can come from various internal and external sources. SIU takes every allegation of fraud, waste, abuse and overpayment seriously and is required to investigate every allegation. The investigative process varies depending on the allegation.
SIU may choose to conduct a desk or onsite audit during the course of an audit or investigation.

During a desk audit, you will receive a request for member treatment records and other relevant documentation via certified mail, fax and/or email. You are expected to respond promptly information requests. Details on how to transmit the documentation will be provided to you in the initial record request letter.

An onsite audit can be announced or unannounced and can occur at any of your contracted service locations. Before an announced onsite audit, you will receive notice of audit via fax, e-mail or mail. The notice will provide details and instructions about the audit. You will not receive advance notice of an unannounced audit. SIU staff will provide you with proper identification as well as a written audit notice providing further details and instructions.

During onsite audits, you will be expected to provide treatment records, personnel files, scheduling documentation, and policies and procedures to SIU staff for review. If any of the information is maintained electronically, you will be expected to provide SIU staff with electronic access.
SIU may also take the following steps during an audit or investigation:

- Review your submitted claims for red flags
- Interview you and/or staff
- Review supporting documentation and conduct relevant background checks
- Interview members without provider interference

At the conclusion of an audit or investigation, SIU will report results to you in the form of a findings letter. SIU may also be required to report the findings to a

customer oversight agency or place you on a pre-payment review and/or a corrective action plan where permitted. Any overpayment identified will be referred to Liberty's claims department for recovery by refund check or future claims retractions in compliance with contractual and regulatory requirements. Liberty's responsibility is to:

- Advise you in writing if a site visit or audit is required
- Advise you of what you need to do to prepare for the site visit or audit
- Notify you of the results of the site visit or audit in a timely manner
- Work with you to develop a corrective action plan, if required
- Perform a follow-up review of treatment records to assure corrective action has been effective in improving your record documentation, if required

Your responsibility is to:

- Comply with Liberty's requests for site visits or audits
- Provide information in a timely manner, including files as requested by the site visit reviewer
- Be available to answer questions from the reviewer
- Participate in developing and implementing a corrective action plan if required
- Cooperate with Liberty in developing and carrying out a quality improvement corrective action plan should opportunities for improvement in documentation be identified

Conduct Routine Self-Audits

Providers are encouraged to conduct routine self-audits to measure and ensure internal compliance. During an investigation, a provider may also be asked to complete a self-audit.

Liberty's responsibility is to implement and regularly conduct fraud, waste, abuse and overpayment prevention activities that include:

- Extensively monitor and audit provider utilization and claims to detect fraud, waste, abuse and overpayment
- Actively investigate and pursue fraud, waste, abuse, overpayment and other alleged illegal, unethical or unprofessional conduct
- Report suspected fraud, waste, abuse, overpayment and related data to federal and state agencies, in compliance with applicable federal and state regulations and contractual obligations

- Cooperate with law enforcement authorities in the prosecution of healthcare and insurance fraud cases
- Conduct routine data mining activities to identify suspicious patterns in claims data
- Verify eligibility for members and providers
- Utilize internal controls to help ensure payments are not issued to providers who are excluded or sanctioned under Medicare/Medicaid and other federally funded healthcare programs
- Train all Liberty employees annually on Liberty's Corporate Code of Conduct and Compliance Program including, but not limited to fraud, waste, abuse and overpayment prevention, detection and reporting
- Make the Liberty Provider Handbook available to our providers

Fraud Waste and Abuse Training and Education

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

As a provider in our Medicaid and/or Medicare network, and to treat Medicare and/or Medicaid and Nevada Check Up members, you agree to:

- Comply with any CMS, Liberty or Medicaid/Medicare Advantage health plan training requirements including annual completion of Medicaid/Medicare Fraud, Waste and Abuse training, and review of Liberty's Code of Conduct.
- It is the owning providers responsibility to ensure that all staff and providers complete Medicaid/Medicare Fraud, Waste and Abuse training, and review Liberty's Code of Conduct within 90 calendar days of hire and annually thereafter.

Liberty provides, free of charge, Fraud, Waste and Abuse Prevention Training for all contracted providers and any other downstream entity that you contract with to provide health, and/or administrative services on behalf of Liberty. You may access Liberty's training and complete the mandatory attestations of your completion online at: Libertydentalplan.com/Providers/Provider-Training-1.aspx

Organizations must retain a copy of all documentation related to this training for at least 10 years – including methods of training, dates, materials, sign-in sheets, etc.

Section 12. Forms and Resources

Electronic forms are available for download including, but not limited to the following from the NV Medicaid webpage on Liberty 's website under Provider Forms at:
https://client.Libertydentalplan.com/NVMedicaid/Provider/DocumentsAndResources

- ADA.org: Caries Risk Assessment 0-6
- ADA Dental Claim Form
- Consent for Non-Covered Treatment
- EFT (Electronic Funds Transfer) and ERA (Electronic Remittance Advice) Enrollment Form
- Medicaid Service Manual (Chapter 1000 Dental)
- Member Grievance and Appeal Form - Nevada
- Online Provider Portal User Guide
- Provider Grievance and Appeal Form - Nevada
- Specialty Care Referral Form

From the Provider Forms section of the webpage, you may also access additional forms:

client.Libertydentalplan.com/NVMedicaid/Provider/DocumentsAndResources. CLICK on *Access Liberty's Provider Resource Library site*

Section 13. Nevada Medicaid Schedule of Benefits

The Adult and Child dental benefits schedule include diagnostic, preventive, restorative, endodontic, periodontal, prosthetic, oral and maxillofacial surgical, other adjunctive general services, coverage, limitations and prior authorization requirements.
The Nevada Medicaid Benefits Schedule is available by contacting Provider Relations or within Liberty's secure site at:

Site: Libertydentalplan.com/Secured-Documents.aspx

Password: 2020NVMedicaid

-END-