2025 Liberty Dental Plan National Provider Reference Guide

LIBERTY DENTAL PLAN®

Section 1. Liberty Dental Plan Information

Getting Started

We are excited to welcome you as a valued provider in Liberty Dental Plan's network. Liberty Dental Plan (Liberty) was founded in 2002 by Amir Neshat, DDS, with a simple but powerful goal to make care more personal, accessible, and compassionate. What began as a small, care-focused effort has grown into a trusted partner serving millions of members nationwide.

By joining our Liberty family, you have become part of a national network comprised of individual and group practices, hospitals, dental schools, FQHCs, and community-based clinics.

Welcome to the Liberty team!

Purpose

The intent of this Provider Reference Guide is to aid each participating provider and their staff members in becoming familiar with the enrollment in, and administration of, Liberty's dental plans. Please note this Provider Reference Guide serves only as an addendum to the terms of the Provider Agreement between you (or the contracting dental office/facility) and Liberty, and that additional terms and conditions of the Provider Agreement apply. In the event of a conflict between this Provider Reference Guide and the Provider Agreement, the Provider Agreement shall prevail, unless the applicable statement in this Provider Reference Guide specifically indicates that it prevails over the Provider Agreement. You received a copy of the fully executed Provider Agreement at the time of your activation on Liberty's network or your Liberty orientation; however, you may also access your Provider Agreement at any time by logging into our **Provider Portal** or by submitting a request to **provider@libertydentalplan.com** or by contacting the Provider Relations Department at **888.352.7924**.

Updates to the Provider Reference Guide will be available by logging in to the **Provider Portal** and/or going to the Provider Resource Library on our website.

Our Mission

We deliver quality, innovative, and affordable dental benefits that support health, strengthen communities, and enhance lives.

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, members, and Liberty staff.

Why Join Liberty?

Ease of Enrollment – Liberty's online contracting and credentialing platform makes it easy to enroll as a Liberty provider and we make credentialing decisions within **three (3) weeks** on average.

Dedicated Support – We use a dedicated Provider Relations Team and pair each provider office with an experienced Network Representative to provide one-on-one support.

Access to Provider Services – When members face challenges contacting their dental office, our dedicated Member Services and Provider Relations Team is prepared to assist in securing emergency or urgent care appointments within **24 to 72 hours**, as appropriate.

Resources and Training – We are a trusted resource to our provider network on the latest industry trends and regulatory actions. We offer providers the opportunity to earn continuing education credits and access to our library of online training, quarterly provider newsletters, and videos, among other resources.

Liberty's Concierge-Style Customer Service – We answer the phone! Our call center provides live first call resolution using qualified staff with dental backgrounds. Our experienced team is trained in first-call resolution to address issues in real time. We took over **550,000 provider calls** last year, answering **95%** of them in **under 20 seconds** with a **91%** first call resolution rate. That means less time on the phone and more time serving patients!

Provider-friendly Tools – Our state-of-the-art provider portal includes real-time eligibility, benefits, and improved history search for claims and prior authorizations.

Provider Recognition – Our programs identify providers whose performance meets our quality-of-care expectations so we can recognize and reward these offices with reduced administrative requirements, among other benefits.

Data Exchange and Interoperability – We provide real-time information with a seamless, coordinated healthcare experience to reduce administrative burden. This environment creates higher operational efficiency, thereby increasing provider capacity and output.

Increased Opportunity – We currently administer dental plans from all lines of business, including Commercial, Healthcare Exchange, Medicare Advantage, and Medicaid. Additionally, the Medicare Advantage population is one of the fastest growing market segments in the country. Many of our Plans function similarly to PPO Plans with quarterly and annual maximums that allow more flexibility in the types of treatment you can render to your patients. Becoming a Liberty Medicare Advantage provider will open your office up to a new segment of the population with great dental benefits who are looking for a dental home.

Provider Enrollment Assistance

Liberty provides local and regional network managers to assist with the enrollment process and provide guidance on contracting and credentialing with Liberty. There are several ways to access a Network Manager in your service area.

Phone: **888.352.7924**,
Press star (*) to speak to a Provider Service Representative about joining the Liberty network.

Email **provider@libertydentalplan.com**, enter "**Enrollment Assistance**", the state abbreviation, and the county for the location you want to contract in the subject line of the email. For example: "**Enrollment Assistance, TX, Harris**."

The appropriate Network Manager will respond within **one to two (1-2)** business days.

Provider Enrollment Overview

Liberty has a simple 5-step process for enrolling in our networks:

- Contact your local/regional Network Manager for contracting information, fee schedules, and guidance on how to streamline the enrollment process to start your Liberty network participation off on the right foot.
- Gather key documents needed for completion and submission of your contracting and credentialing package. Key Documents are listed below in the "**Required Documents List**" section.
- Submit your Contract and Credentialing Application(s) along with all required documents (See Provider Online Enrollment Instructions below).
- Stay in communication with your Network Manager to ensure all required documents are kept up to date until credentialing is complete.
- Work with your dedicated Network Manager to schedule an orientation once you receive your Welcome Letter.

Required Documents List

There are two categories of required documents when enrolling with Liberty.

Contracting Documents – These documents are required for each location.

- Facility Application: Provides relevant location and payee data to set up an in-network location.
- Provider Agreement: An agreement to accept payment on behalf of Liberty Dental Plan's contracted members.
- Medicaid and/or Medicare Addenda: Contains the required regulatory language for the applicable government programs.
- Fee Addendum: Represents the agreement to accept specific compensation arrangements (i.e., Fee for Service, Value Based, Capitation, etc.)
- W-9: Required to generate a 1099 for tax purposes and must have the address registered with the IRS listed as your corporate billing address for multiple locations with the same tax ID.
- Provider Compliance Attestation: Indicates that your office and all relevant staff have completed the required annual compliance training to participate in our networks.
- Payment Options Form: Used to select from available options regarding how payments will be processed. Payment options vary depending on state and appropriate state forms should be included in the package that is sent by your Network Manager or viewable on the Provider Online Enrollment site.
- Authorized Signatory form: Optional form signed by the CEO/owner delegating another employee (i.e., Office Manager, Management Company Contact, etc.) to sign enrollment documents on their behalf.
- State Required Documents: Some states have specific contracting requirements. Additional state requirements will be included on the checklist contained in your state's Contracting & Credentialing package.

Credentialing Documents – These are required for each Dentist/Hygienist/Denturist.

- Provider Credentialing Application: Allows each participating provider to provide the required credentialing information for third party verification. CAQH applications are allowed in most states but may require additional information or completion of a state-mandated application.
- Current Dental License: Successful credentialing requires a non-expired dental license. If your license expires prior to the completion of credentialing, an updated copy of your dental license will be required prior to credentialing approval.
- Current Federal DEA Certificate or waiver: Waivers are mandatory if you do not have a DEA Certificate and expire after 65 days from the signature date.
- Current Malpractice insurance certificate declaration page showing professional liability
    - Proves the dentist has the required liability insurance in place prior to enrollment. If certificate expires prior to the completion of credentialing, an updated copy of your declaration page will be required prior to credentialing approval. (Please note: Liability limits may vary per state and line of business)
- State Required Documents: Some states have specific credentialing requirements. Additional state requirements will be included on the checklist contained in your state's Contracting and Credentialing package.
- Copy of Specialty Certificate or Board Certification (if applicable)
- Copy of Internship/Residency/Fellowship Certificate (if applicable)
- Work History and Educational: Gaps may require explanations (vary by state)

Provider Online Enrollment (POE)

Liberty's Provider Online Enrollment allows providers, or their delegates, to complete enrollment and re-enrollment, using an online application. The website is accessed from Liberty's website at **www.libertydentalplan.com** or click this link to **join our network**.

Prior to starting the application, download the **Provider Online Enrollment User Guide** and gather all pertinent information, including applicable ownership, agent and managing employee information for your provider type.

It's important to keep your enrollment information up to date. To avoid any delays in payment of your claims, be sure to report any change within **thirty (30) days**. Changes include, but are not limited to:

- A change in ownership
- An adverse legal action
- A change in practice location

If you have any questions about enrollment or need assistance, please contact your assigned Provider Relations Network Manager.

Required Annual Compliance Training

Liberty monitors and ensures all participating offices, and their staff operate in compliance with applicable laws and regulations. Contracted and leased network offices have the option to complete Liberty's required training courses located on the Liberty website or other comparable trainings on the required topics within **thirty (30) days** of initial hiring, contracting, and annually thereafter.

Providers can access all compliance training modules on the Liberty website. Training modules, the attestation form, and access to a completion certificate are available at **www.libertydentalplan.com** or via the QR code. Paper or PDF versions of the attestation may be submitted to Liberty at **provider@libertydentalplan.com**.

Liberty is required to communicate, through dissemination of Liberty's Code of Conduct and Compliance Plan, its commitment to conducting business in an ethical manner, and consistent with governing law and program requirements. Liberty will also accept the dissemination of the provider's comparable Code of Conduct and Compliance Plan to fulfill this requirement.

Record Retention
Provider(s)/Office(s) must maintain supporting documentation for a period of **ten (10) years** after training completion.

Attestations are required annually and may be submitted via one of the following means:

Mail
Liberty Dental Plan
ATTN: Provider Relations
P.O. Box 26110
Santa Ana, CA 92799-6110

Email
provider@libertydentalplan.com

Fax
800.268.0154

Web
CMS Website Link

Credentialing/Recredentialing

Prior to acceptance into the Liberty provider network, dentists must submit a copy of the following information for verification:

- State Mandated Credentialing Application, if applicable.
- Current state dental license for each participating dentist.
- Current DEA license and/or State Drug Cert (If no DEA or SDC, must submit a DEA Waiver).
- Current evidence of malpractice insurance for at least one million ($1,000,000) per incident, and three million ($3,000,000) annual aggregate for each participating dentist.
- Current certificate of a recognized training internship and/or residency program with completion (for specialists).
- Current permit of general anesthesia or conscious oral sedation, if administered, for the appropriate dentist (as applicable).
- Immediate notification of any professional liability claims, suits, or disciplinary actions.
- Verification is made by referencing the State Dental Board and National Practitioner Data Bank.
- All provider credentials are continually monitored and updated on an ongoing basis. Providers will receive notification of license/credential expiration from Liberty's delegated Certified Verification Organization (CVO), **sixty (60) days** prior to expiration to allow time to submit current copies.

For all accepted providers, your assigned Network Manager will conduct an orientation within thirty (30) days of activation (upon receipt of your welcome letter). All providers receive a copy of Liberty's Provider Reference Guide. The Provider Reference Guide requires all providers to abide by Liberty's QMOHATP Program Policies and Procedures. The Reference Guide is considered an addendum to the Provider Agreement. To resolve any issues for the new provider, and following orientation, a representative will make a follow-up service call within **sixty (60) days** either in person or by telephone.

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

Enrollment FAQs

For answers to the most frequently asked questions, please visit our **Enrollment FAQs** located on our website.

Getting Started as a Liberty Contracted Provider

Getting started on the right foot in a new network is critical to maintaining a solid relationship with any payor. This section is dedicated to ensuring you have all the tools and support you need to succeed in your relationship with Liberty.

Liberty is dedicated to meeting the needs of our providers by utilizing leading-edge technology to increase your office's efficiency. Online tools are available for billing, eligibility, claim inquiries, referrals, and other transactions related to the operation of your dental practice. We offer **24/7 real-time access** to important information and tools through our secure online **Provider Portal**.

Registered users will be able to:

- Submit electronic claims
- Request for prior authorizations
- Verify member eligibility and benefits
- Verify provider eligibility status
- View office and contract information
- Submit referrals and check status
- Access benefit plans
- Print monthly eligibility rosters
- Perform a provider search
- Check the status of a claim

Adverse Incidents

Providers are responsible for reporting adverse incidents to Liberty within **forty-eight (48) hours** of the incident. Adverse incidents include members who show self-harm, threat to another person, threat to Liberty and those listed below.

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

<table>
<tr><th colspan="2">Contact Information</th></tr>
<tr><td>Phone
888.352.7924 or 877.855.8039 (TDD/TTY)
Monday-Friday 8:00 a.m.- 5:00 p.m. PST
• Eligibility & benefits
• Claims
• Prior authorizations
• Referrals
• Request materials
• General information

Email
provider@libertydentalplan.com</td><td>Website
www.libertydentalplan.com

Mailing Address
Liberty Dental Plan
P.O. Box 15149
Tampa, FL 33684-5149

Fax
800.268.0154</td></tr>
<tr><th>Provider Portal (iTransact)</th><th>Eligibility & Benefits</th></tr>
<tr><td>Go to the Liberty Provider Portal to create an account.

iTransact allows you:
• Electronic Claims Submission
• Claim Status & Inquiries
• Real-time Eligibility Verification
• Member Benefits
• Referral Submission & Status</td><td>Use iTransact for real-time status at the Liberty Provider Portal.</td></tr>
<tr><th>Referral Submissions & Inquiries</th><th>Claim Submissions & Inquiries</th></tr>
<tr><td>Use iTransact for submissions & to check the status at the Liberty Provider Portal.

Mail
Use our mailing address, ATTN: Referrals Department</td><td>Use iTransact for submissions & to check the status on the Liberty Provider Portal.

EDI Payor ID#
CX083

Mail
Use our mailing address ATTN: Claims Department</td></tr>
<tr><th>Provider Dispute Resolution (PDR)</th><th>Member Grievances & Appeals (G&A)</th></tr>
<tr><td>Use iTransact for PDR submissions at www.libertydentalplan.com.

PDR Forms are available online through the Provider Resource Library.

Mail
Use our mailing address, ATTN:
Grievance & Appeals Department</td><td>Member G&A form and online submission are available at www.libertydentalplan.com.

Fax
833.250.1814

Email
GandA@Libertydentalplan.com

Mail
Use our mailing address, ATTN:
Grievance & Appeals Department</td></tr>
</table>

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 for assistance with the following:

- Plan contracting
- Escalated claim payment issues
- Education on Liberty Policies and member benefits
- Provider training and orientations
- Directory validation
- Changes in office demographics
- Opening, changing, selling, or closing a location
- Adding or terminating associates
- Credentialing and recredentialing of owner and associate dentist inquiries
- Change in name or ownership
- Taxpayer Identification Number (TIN) change
- Changes in office hours

You may contact a member of the Provider Relations Team in one of the following ways:

Phone
888.352.7924
Monday – Friday
8am – 5pm PST

Mail
Liberty Dental Plan
ATTN: Provider Relations
P.O. Box 26110
Santa Ana, CA 92799-6110

Email
provider@libertydentalplan.com

Section 3. Online Self-Service Tools

Online Account Access

Register and obtain immediate access to your office's account by visiting the **Provider Portal**.

All contracted network dental offices are issued a unique office number and access code. These numbers can be found on your Liberty Dental Plan Welcome Letter and are required to register your office on Liberty's Provider Portal.

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

If you are unable to locate your office number and/or access code, please contact the Provider Relations Department at **888.352.7924**, or email **provider@libertydentalplan.com**. For technical assistance, email **portalsupport@libertydentalplan.com**.

Short tutorial videos are available in the Library on the Provider Portal. These detail how to use the portal, accomplish specific tasks, and provide best practices. Detailed instructions on how to utilize the Provider Portal can be found in the Online Provider Portal user Guide.

System Requirements

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

Directory Information Verification (DIV) Online

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

Anytime you have changes, including, but not limited to, appointment times, office hours, address, phone number, fax number, associate dentists, etc., you will be able to update or attest that no changes were made no less than once per quarter by going online. We also highly recommend you set a calendar reminder in your system to go to the website every **three (3) months** and validate the information. To ensure that your information is displayed accurately, and claims are processed efficiently, please submit all changes **thirty (30) days** in advance. The easiest way to update your office information is through our Provider Directory Information Verification (DIV) website at **Provider DIV**. You may also contact Provider Relations for further instructions on updating your provider demographics and associate dentists that are available to Liberty members.

The benefits of online DIV updates:

- Fix what's wrong with the click of a button.
- No filling out paper forms and faxing or emailing.
- Provide the most up-to-date information to existing and new members so they can make educational decisions about their provider office choices.

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 the Provider Relations Department at **888.352.7924** for assistance.

Provider Resource Library

Looking for training materials and up-to-date information regarding Liberty? We have state-specific educational and reference materials available for download on our website in the **Provider Resource Library**.

Section 4. Eligibility

How To Verify Eligibility

Providers are responsible for verifying member and provider eligibility before each visit. The member ID card does not guarantee eligibility. Checking member eligibility at the time of service will allow you access to the most up to date eligibility information and reduce the risk of denied claims. Verifying provider eligibility will ensure the provider is eligible to receive payments for the specific plan the member is enrolled in.

There are several options available to verify eligibility:

- Provider Portal - We recommend using the member's last name, first name, and date of birth for best results when checking member eligibility. Provider eligibility can be checked at the member level. Please see Liberty's **Provider Portal User Guide** for more details.
- Telephone - Speak with a live representative from 8am to 5pm PST, Monday – Friday by contacting **888.352.7924**.

Primary Care Dental Home Assignment (DHMO Programs Only)

Dental home is the ongoing relationship between the dentist and the member, inclusive of all aspects of oral health care delivered in a comprehensive, continuously accessible, coordinated, and family-centered way. A dental home addresses anticipatory guidance and preventive, acute, and comprehensive oral health care and includes referral to dental specialists when appropriate.

Members can choose a Primary Care Dentist (PCD) at any time. Upon initial enrollment, Liberty will assign members to the nearest PCD based on such factors as language, cultural preference, previous history of the member or another family member, within a specified distance of member's home. Members can change PCDs at any time by either calling Liberty, going onto the Liberty website, or by being seen by an in-network PCD of their choice.

All members must be assigned to their primary care dental home prior to treatment. Dental homes may include offices that offer the full scope of general dentistry services, also known as PCD.

Providers are responsible for verifying member and provider eligibility prior to providing dental services. In addition, your office should ensure the members are listed in the "**My Members**" section of the **Provider Portal** to ensure the members is assigned to your office. Checking eligibility will allow providers to complete medically necessary procedures and reduce the risk of denied claims.

Eligibility Rosters (Capitation Programs Only)

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
- Dependent(s) name(s) or number of dependents covered
- Member identification number
- Member date of birth
- Group name (if through employer group, name of employer)
- Type of coverage (plan number/name)
- Effective date of coverage

Dependents may include spouses and eligible children. In most cases, eligible children are those who are unmarried and financially dependent upon the member for full support. Dependents include natural children, stepchildren, and foster children under the age of **nineteen (19)**. Children may continue to be eligible up to the age of **twenty-six (26)** if they are full-time students.

In the event a member does not appear on the monthly roster, please contact Liberty's Member Services Department at **888.352.7924**.

Member Identification Cards

Members should present their ID card at each appointment. Providers are encouraged to confirm 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 Liberty's payment of benefits. Not all Liberty plans provide printed ID cards. In such cases, providers should check a photo ID and check against an eligibility list, contact the Member Services Department, or login to the **Provider Portal** for verification of both the ember and provider's eligibility. Please note that due to possible eligibility status changes, this information does not guarantee payment and is subject to change without notice.

Section 5. Claims and Billing

All claims billed to Liberty must be submitted with the appropriate procedure code and the correct date of service. The False Claims Act (FCA), 31 U.S.C. §§ 3729 – 3733 is a federal law that prohibits a person or entity, from "knowingly" presenting or causing to be presented a false or fraudulent claim for payment or approval to the Federal government, and from "knowingly" making, using, or causing to be made a false record or statement to get a false or fraudulent claim paid or approved by the Federal government. The Act also prohibits a person or entity from conspiring to defraud the government by getting a false or fraudulent claim allowed or paid. These prohibitions extend to claims submitted to Federal health care programs, such as Medicare or Medicaid.

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 efficient and accurate claims processing. It is imperative that all submitted information be accurate and in the correct format. As a rule, network dentists are encouraged to submit clean claims within **forty-five (45) calendar days** of treatment completion. Timely claim filing may vary based on the plan in accordance with your Provider Agreement and applicable laws, and as indicated on your Explanation of Payment (EOP).

Liberty may require prior authorization for certain dental benefit programs. When prior authorization is not required, you may still request prior authorization for extensive treatment plans to help clarify any member financial obligations before treatment is rendered.

Liberty receives dental claims in four possible formats:

- HPAA compliant "837D" file
- Electronic submissions via clearinghouse
- Electronic submissions via Liberty's **Provider Portal**
- Paper claims

HIPAA Compliant 837D File

Liberty currently accepts HIPAA Compliant 837D files. If you would like to set up or inquire about this option, please contact our IT Department at **888.352.7924**.

Electronic Submission – Claims, Prior Authorizations and Referrals

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

- **Provider Portal**
- Third party clearinghouse

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

Liberty EDI Vendor	Phone Number	Website	Payer ID
DentalXchange	**800.576.6412**	**www.dentalxchange.com**	CX083
Vyne Dental	**463.218.6519**	**www.vynedental.com**	CX083

All electronic submissions must follow state and federal laws, and Liberty's policies and procedures. National Electronic Attachment, Inc. (NEA) is recommended for electronic attachment submission. For additional information regarding NEA and to register your office, please visit **www.nea-fast.com**, select FASTATTACH™, then select Providers.

Paper Claims

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

Products	Liberty Dental Plan P.O. Box 26110 Santa Ana, CA 92799-6110	Liberty Dental Plan P.O. Box 15149 Tampa, FL 33684	Liberty Dental Plan P.O. Box 401086 Las Vegas, NV89140
Commercial	All states except FL & NV	FL	NV
Medicare	All other Medicare plans	Devoted and MMM	N/A
Exchange	All Exchange	N/A	N/A
Medicaid	CA	FL and OK	NV, NJ, NY, and TX

"Clean" Claims

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

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

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

- 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 documentation required by Liberty:

- All claims must be submitted to Liberty for payment of services with the member ID number, first and last name, and pre-or post-treatment documentation, if required.
- Your National Provider Identifier (NPI) number and tax ID are required on all claims. Claims submitted without these NPIs will be rejected. All health care providers, health plans, and clearinghouses are required to use the NPI number as the only identifier in electronic health care claims and other transactions.
- All claims must include the name of the program under which the member is covered and all the information and documentation necessary to adjudicate the claims.

For emergency services, please submit a standard claim form which must include all the appropriate information, including pre-operative radiographs and a detailed explanation of the emergency circumstances. If applicable, the Liberty **Specialty Care Referral Request Form** should be completed and submitted with the Emergency box checked.

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.

Claims Status Inquiry

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

Phone
888.352.7924

Online
Provider Portal

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 and is being reviewed for benefit determination

Claims Resubmission

Providers have **three hundred sixty-five (365) calendar days** from the original request a resubmission or reconsideration of a claim that was previously denied for:

- Missing documentation
- Incorrect coding
- Processing errors

Claims Overpayment

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

Notice Of Overpayment of a Claim

If Liberty determines that a claim has been overpaid, Liberty will notify the provider in writing through a separate notice clearly identifying the claim, the name of the member, the date of service and a clear explanation of the basis upon which Liberty believes the amount paid on the claim was more than the amount due, including interest and penalties on the claim.

Contested Notice

If the provider contests Liberty's notice of a claim overpayment, the provider, within thirty (30) business days of the receipt of Liberty's notice of claim overpayment, must send written notice to Liberty stating the basis upon which the provider believes the claim was not overpaid. Liberty will follow the contracted provider dispute resolution process described in the Section 13 (Quality Management) titled "**Provider Dispute Resolution Process**."

No Contest

If the provider does not contest Liberty's notice of a claim overpayment, the provider must reimburse Liberty **within thirty (30) working days** of the provider's receipt of Liberty's notice of claim overpayment. If the provider does not contest the overpayment notice and fails to reimburse Liberty **within thirty (30) working days** of the receipt of Liberty's notice of claim overpayment, Liberty may offset the amount of the overpayment from any amounts due to the provider for current and/or future claim submissions as described below.

Offset To Payments – Uncontested Notice of Overpayment

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

Prompt Payment of Claims

Liberty's processing policies, payments, procedures, and guidelines follow applicable state and federal requirements.

Electronic Funds Transfer (EFT) And Optum Echo Platform

For accurate and timely reimbursements, Liberty offers direct deposit services. Our Electronic Fund Transfer (EFT) platform enables providers to receive payments faster and access funds quicker than traditional paper check reimbursements. This provides levels of security that are not possible with paper checks as items cannot be lost or stolen out of the mail, misused, misplaced, or incorrectly deposited into wrong accounts. To utilize our EFT services, complete the **EFT form** located on our website.

Liberty uses the Optum ECHO platform in several states for payment processing. To enroll in ECHO please complete the **ECHO Electronic Fund Transfer and Remittance Advice Form** located on our website. For more information, please reference the **ECHO EFT-ERA Reference Guide**.

Your state's **Provider Resource Library** houses the applicable forms and guides for your office needs.

Paper Checks

If you do not elect EFT, we ask that your office deposit all issued paper checks **within fourteen (14) business days**.

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 the number listed on the Explanation of Payment.

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%** of the cost of covered services. COB also ensures that providers do not collect more than the actual cost of the member's dental expenses.

- Primary Carrier: the benefit plan that takes precedence in the order of making payment.
- Secondary Carrier: the benefit plan 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 Liberty actively covers a member.

When there is a break in coverage Liberty will be primary based on Liberty's effective date versus the new group effective date. The table below can assist your office in determining the primary carrier.

Patient is the Enrollee	**Primary**
Enrollee has dental coverage through employee	Enrollee coverage is always primary
Enrollee has dental coverage as an active employee and coverage through the spouse	Enrollee coverage is primary
Enrollee has two active insurance carriers; both provide dental coverage	The carrier with the earliest effective date is primary
Enrollee has dental coverage through a group plan and COBRA coverage	Group plan is primary
Enrollee has dental coverage as an active employee of one plan and as a retired employee of another plan	The active coverage is primary
Enrollee has two retiree plans	The carrier with the earliest effective date is primary
Enrollee has a retiree plan, and spouse holds a group plan	Spouse's group plan is primary
Enrollee has dental coverage through a group plan and individual or supplemental coverage through another carrier Examples: • Student Accident Plans • Supplemental Plans (Western Dental) • Prepaid Trust Plans • Individual Plan (AFLAC) • Reimbursement Plans	Group plan is primary
Enrollee has a Discount/Reduced Fee Plan	Liberty does not coordinate discount/reduced fee plans.
Enrollee has a government funded plan and individual or supplemental coverage through another carrier	Government funded plan is primary
Enrollee has two government funded plans. One is Federal (Medicare), and the other is State (Medicaid, Medi-Cal or Value Add)	Federal coverage is primary
Enrollee has dental coverage through a group plan and a government (Medicaid/Medicare) funded plan	Group plan is primary

Enrollee has dental coverage through a retiree plan and a government funded plan	Government funded plan is primary
Enrollee has COBRA coverage and a Medicare plan	Medicare plan is primary
Enrollee has two Medicare plans	The Plan with the earliest effective date is considered primary
Enrollee has a government funded plan and spouse holds a group plan	Spouse's group plan is primary
Enrollee is a Medicare beneficiary aged 65 or older and has Group Health Plan	Individual is age **65 or older**, is covered by a group plan through current employment or spouse's current employment and the employer has less than **20 employees**: Medicare pays primary

Figure 6.1

Coordination of Benefits Scenarios

When Liberty is Primary Carrier

When Liberty is the primary carrier, payment is made for covered services without regard to what the other plan might pay. The secondary carrier, depending upon its provisions and limitations, may pay the amounts not covered by Liberty.

Because Liberty's participating dentists have agreed to accept Liberty's allowance as payment in full for covered services, they should bill the secondary carrier for the member's coinsurance, any amounts exceeding the annual or lifetime maximums and/or any amounts applied towards the member's deductible or non-covered services.

When Liberty is Secondary Carrier

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

When Liberty is secondary, payment is based on the lesser of either:

- the amount that Liberty would have paid in the absence of any other dental benefit coverage, or
- the member's total out-of-pocket cost payable under the primary carrier for benefits covered under Liberty. (That means whatever amount remains on the member's bill that was not paid by the member's primary carrier is now the responsibility of Liberty to pay as long as the remaining amount is for procedures that are covered benefits of Liberty.)

When the Member has Two Managed Care Plans (DHMO-CAP Program)

When the member is eligible under two managed care programs and assigned to the same contracted dentists, the member would be responsible for the copayment of the plan with the lesser copayment (Plan #2 fig 6.2) for the covered benefit. The member can be charged for copayment under one program only. If the treatment is a benefit under one program only, the applicable copay for that program applies (Plan #1 fig 6.3).

Examples:

CDT Code	Carrier	Copayment	Member's Portion	Determination
D7240	Plan #1 Plan #2	$150 $125	$125	The plan with the lesser copayment

Figure 6.2

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

Figure 6.3

Section 7. Professional Guidelines and Standards of Care

Primary Care Dentist (PCD) Responsibilities

All dental services, including those proposed, recommended and/or performed, must be documented and/or provided consistently with professionally recognized standards of dental practice.

- Provide and/or coordinate all dental care for the member
- Follow CMS "Plan Directed Care" requirements
- Ensure the services you are furnishing are covered by the member's plan. For services not covered by the member's plan, the provider must obtain pre-approval and wait for determination prior to services being rendered.
- Verify provider eligibility to provide covered services for the member's plan and ensure members have access to an in-network dentist.

Section 8. Specialty Care Referral Guidelines

The following guidelines outline the specialty care referral process. Failure to follow these guidelines may result in financial penalties against provider's office such as through capitation adjustment or financial recoupment processes from future claims or other means.

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

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

Non-Emergency Specialty Referral Submission and Inquiries

General dentists may need to submit a referral request to Liberty for prior approval before members can seek services at a specialist. There are three options to submit a specialty care referral:

Mail
Liberty Dental Plan
ATTN: Referral Department
P.O. Box 26110
Santa Ana, CA 92799-6110

Phone
888.352.7924

Web
Provider Portal

If there is no in-network specialist available within the general dentist's office or within reasonable proximity to the general dentist's office, the provider's office staff may contact Liberty's Member Services Department who will provide assistance to refer the member to a non-contracted specialist.

If a referral is made to an out-of-network specialist by the member's assigned general dentist without prior approval, the referring office may be held financially responsible for any additional costs. Failure to use the proper forms and submit accurate information may cause delays in processing or claim payment.

The Liberty Specialty Care Referral Request Form or an Attending Dentist Statement must be completed and used when requesting a referral. The form may be photocopied and duplicated in the provider's office as needed.

Radiographs and other supporting documentation with referral submission will not be returned. Please do not submit original radiographs. Radiograph copies of diagnostic quality, including paper copies of digitalized images, are acceptable.

The provider must include a narrative statement as to the reasons for the specialty referral. These narratives assist Liberty in processing the specialty referral in a timely manner.

Emergency Referral Guidelines

Emergency referrals can be obtained when a member is experiencing pain, swelling, bleeding or trauma. The fastest method for PCDs and oral surgeons to obtain an emergency referral is through our **Provider Portal**.

Additionally, emergency referrals can be requested in one of the following ways:

- Referral Unit: **888.352.7924**, Option 4.
- The Emergency Referral Unit is staffed with Dental Consultants who can review and approve immediate referral requests and any treatment plan during normal business hours Monday through Friday, 5am – 5pm PST.
- Emergency referrals are valid for **thirty (30 days)**. Extensions can be requested by a member or provider.

General Dentist Referral Guidelines

Confirm the need for a referral and that the Referral Criteria listed below are met.

For all specialty care referrals, the following must be included:

- Complete a Liberty Specialty Care Authorization form and provide:
    - Member's name, subscriber identification number, group name
      Name, address, and telephone number of the contracted Liberty network specialists.
      If the provider and provider's staff are unfamiliar with the network specialist, contact Liberty's Member Services for specialty referral assistance
    - Procedure code(s), tooth number(s), and member copayments for the covered treatment which requires referral
    - ORTHO: Add comments concerning the member's malocclusion
- Inform the member that:
    - Referrals are only approved for services listed on the request from the referring general dentist
    - The member will be financially responsible for non-covered services provided by the specialist, as well as the copayment for the covered services

- Payment by Liberty is subject to both member and provider eligibility at the time services are rendered
- Submit referral to Liberty with appropriate documentation/radiographs through the **Provider Portal** or via standard mail service
- Liberty's Dental Consultant (a licensed dentist) will review the referral to ensure requested procedures meet referral guidelines and plan benefits.

For non-emergency referrals, submit referral to Liberty with appropriate documentation/radiographs through the **Provider Portal** or via standard mail service.

Liberty's dental consultant (a licensed dentist) will review the referral to ensure requested procedures meet referral guidelines and plan benefits.

Endodontist Referral Guidelines

Obtain the Liberty Specialty Care Authorization and pre-operative periapical radiograph(s) from Liberty, the general dentist, or the member.

For any services, other than those listed on the original authorization form from Liberty, you must submit a preauthorization request to Liberty with a copy of pre-operative periapical radiograph(s) and justifying narrative, as well as the member's Liberty Specialty Care Authorization.

If an emergency endodontic service is needed but has not been listed on the original authorization form, the endodontist should contact Liberty's Referral Unit for an emergency authorization number. This will provide tentative authorization. However, any such service added to an existing prior authorization by virtue of phoning the Referral Unit, will require pre-operative radiograph and narrative when Specialist submit for payment. Any emergency service must qualify for authorization and will receive clinical review by a Liberty Dental Consultant at the time it is reviewed for payment.

After completion of treatment, submit claim for payment with post-operative periapical radiographs. (To avoid delays in 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.

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

Oral Surgeon Referral Guidelines

Obtain the Liberty Specialty Care Authorization and appropriate radiograph(s) from Liberty, the general dentist, or the member.

For any services, other than those listed on the referral from the member's general dentist, you must submit a preauthorization request to Liberty with a copy of pre-operative periapical radiograph(s) or panoramic radiograph, and any justifying narrative, as well as the member's Liberty Specialty Care Authorization.

If an emergency oral surgery service is needed but has not been listed by the general dentist on the Liberty Specialty Care Authorization, the oral surgeon should contact Liberty's Referral Unit for an emergency authorization number. Any such services added to the referral via telephone will be subject to clinical review at the time of submission for payment. Enclose any narrative and supportive pre-operative radiographs for these services on the claim form.

After completion of treatment, submit your claim for payment. To avoid delays in claim payment, please attach a copy of the member's Liberty Specialty Care Authorization form. If emergency care was provided after obtaining a Liberty emergency authorization number, print that number on the claim form and attach the radiograph(s). For a biopsy, also attach a copy of the laboratory's report. 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.

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

Orthodontist Referral Guidelines

Obtain the Liberty Specialty Care Authorization from Liberty, the general dentist, or the member. Contact Liberty's Membership Services Department to obtain the member's copayments and plan-specific benefits, limitations and exclusions for:

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

After the pre-treatment visit, arrangements for initial records should be made. If the member requires further general dentistry prior to banding, refer them back to the assigned general dentist.

After the member is banded, submit your claim to Liberty for payment. Net payable claim amounts in excess of $300.00 will be paid over the period of active orthodontic treatment.

Pediatric Dentist Referral Guidelines

Obtain the Liberty Specialty Care Authorization and appropriate radiograph(s) from Liberty, the general dentist, or the member.

For any services, other than those listed on the referral from the member's assigned general dentist, you must submit a prior authorization request to Liberty with a copy of pre-operative periapical radiograph(s) and any justifying narrative and of the member's Liberty Specialty Care Authorization.

If an emergency pediatric service is needed but has not been listed by the general dentist on the Liberty Specialty Care Authorization, the pediatric dentist should contact the Liberty's Referral Unit for an emergency authorization number. Any such services added to the referral via telephone will be subject to clinical review at the time of submission for payment. Enclose any narrative and supportive pre-operative radiographs for these services on the claim form.

After completion of treatment, submit your claim for payment with justifying narrative and radiographs for any treatment that has not been prior authorized. To avoid delays in claim payment, please always attach a copy of the Liberty Specialty Care Authorization for treatment when applicable. Radiographs and other supporting documentation will not be returned. Please do not submit original radiographs. Radiograph copies of diagnostic quality, including paper copies of digitized images, are acceptable.

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

Periodontist Referral Guidelines

Obtain the Liberty Specialty Care Authorization and appropriate radiograph(s) from Liberty, the general dentist, or the member.

For any services, other than those listed on the referral from the member's assigned general dentist, submit a preauthorization request to Liberty with copies of:

- Pre-operative radiographs
- Complete periodontal charting showing six-point probing of each natural tooth and any furcation involvements, abnormal mobility, areas of little-to-no attached gingiva or areas of recession. Submit radiographs that were enclosed with original authorization form (or copies) and any justifying narrative
- The member's Liberty Specialty Care Authorization.

If an unforeseen periodontic service is needed but has not been listed by the general dentist on the Liberty Specialty Care Authorization, the periodontist should contact the Liberty's Referral Unit for an emergency authorization number. Any such services added to the referral via telephone will be subject to clinical review at the time of submission for payment. Enclose any narrative and supportive pre-operative radiographs for these services on the claim form.

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

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

Referral Coverage Based on Gingivitis Diagnosis

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

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

Slight Chronic/Aggressive Periodontitis (Localized or Generalized)

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

Moderate Chronic/Aggressive Periodontitis (Localized or Generalized)

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

Severe Chronic/Aggressive Periodontitis (Localized or Generalized)

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

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

Refractory Chronic/Aggressive Periodontitis

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

Prosthodontist

Referrals for this type of specialist are not covered under Liberty Dental Capitation, DHMO-EPO, and Discount Programs. Consult individual Benefits Schedules for Evidence of Coverage to determine if prosthodontic referrals are available.

Section 9. Clinical Dentistry Guidelines

Liberty's Clinical Criteria, Guidelines and Practice Parameters (CCGs) are developed by Liberty's Dental Directors with input from participating panel general dentists and specialists. Liberty utilizes the American Dental Association's (ADA) "Dental Practice Parameters", American Academy of Pediatrics (AAP), American Association of Oral and Maxillofacial Surgeons (AAOMS), American Association of Endodontics (AAE), clinical principals within community dental standards.

Disclaimer
Please note specific plan/program guidelines supersede the information contained in these Clinical Dentistry Practice Parameters. The practice parameters are the default set of practice parameters when plan documentation is silent on a particular topic.

The Clinical Criteria Guidelines are available on Liberty's website at the **following link** or by scanning the QR code.

Participating general dentists and specialists agree to comply with these Clinical Criteria, Guidelines and Practice Parameters by virtue of their signed Liberty Provider Agreement or by reference to this document in their applicable provider manual, if participating through a leased network.

Section 10. Quality Management

Purpose, Goals, And Objectives

Liberty's Quality Management Program is compliant with all state, and federal laws and regulations, and applicable contract requirements.

Program Description

Liberty's Quality Improvement and Oral Health Access Transformation (QIOHATP) Program is designed to ensure that licensed dentists are reviewing the quality of dental care provided, that quality of care problems are identified and corrected, and follow-up is planned when indicated. The Quality Improvement and Oral Health Access Transformation Program 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 QIOHATP 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 QIOHATP Plan. The Dental Director, or his/her designee, oversees the QIOHATP and ensures that day-to-day quality assurance functions are carried out in compliance with dental program contracts and applicable requirements.

Quality Improvement and Oral Health Access Transformation Program Goals and Objectives

The goal of the QIOHATP is to comprehensively identify and address the quality of dental care and service to our members. The QIOHATP 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 PCDs and specialists and uses them to evaluate the care provided to members.

Program Scope

Liberty's QIOHATP Program 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 QMI document describes the programs, 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 QIOHATP evaluation and report
- Annual QIOHATP 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 QIOHATP Program's activities focus on the following components of quality, which are included in established definitions of high-quality dental care services:

- Accessibility of Care: the 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 Access Committee (QIOHAC): 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.
- 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 of outlier status, potential fraud, waste or abuse or other administrative reasons.
- Access and Availability (AA): 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 QIOHAC Committee quarterly, or more frequently, if necessary.

- Credentialing: Liberty's Credentialing Program includes initial credentialing and re-credentialing at 36-month intervals of all primary and specialty care dentists listed in the Provider Directories. Pertinent findings are reviewed quarterly or more frequently if deemed necessary during Credentialing Committee meetings. Quality-of-care issues are then referred to the Peer Review Committee for recommendations and further action.
- Cultural and Linguistic Competency (CLC): Liberty establishes processes and procedures for providing support, maintaining compliance and creating cultural awareness for all 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 QIOHAC.
- 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 on improving care for 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 QIOHATP, 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.
- Grievances and Appeals (G&A) System: The G&A Department monitors and reports quarterly summaries related to member grievances, complaints, and appeals tracking and trending. The PRC reviews member G&A issues related to Liberty, providers, or benefits. The PRC is responsible for hearing and resolving member G&A by monitoring patterns or trends to formulate policy changes and generate recommendations as needed
- 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.

Utilization Management

Liberty's Utilization Management (UM) Program is designed to meet contractual requirements and federal regulations, while 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
- Medical necessity 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 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 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 does not delegate any UM responsibility to a third party. We conduct all reviews in-house by our state dental directors and our appropriately licensed, experienced Staff Dentists and Dental Consultants, none of which are compensated for or incentivized on clinical review decision making.

Liberty determines 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 CCGs are developed, updated, and reviewed by clinicians through our Peer Review Committee, which consists of both Liberty and network dentists, and reports directly to the Liberty Quality Improvement and Oral Health Access Committee. The QIOHATP 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 CCGs 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 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 can 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 meet accepted standards of dentistry
- Will prevent the onset of an illness, condition, or disability
- Will prevent the deterioration of a condition
- Will prevent or treat a condition that endangers life or causes suffering, pain, or results in illness or infirmity
- Will follow accepted medical practices
- Services are member-centered and consider 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 Dentists 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.

Processes 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 dentist for review. All authorization requests received are scanned and included in Liberty's electronic prior authorization process within our MIS. The Staff Dentist 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 Dentist/ 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 Dentists 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.
- Quarterly Inter-Rater Reliability calibration exercises reviewing real authorizations. Internal goals/requirements require 89% 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.

Program Standards and Guidelines

Liberty understands and supports that high quality dental care is dependent, in part, on the ability of both the PCD (provider) and specialty care providers to see members promptly when they need care, and to spend a sufficient amount of time with each of their members.

Provider Access Surveys
For all provider offices, Liberty conducts quarterly random office contacts to assess availability of appointments.

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

Corrective Action

Negative findings resulting from the above activities may trigger further investigation of the provider's 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 members to another provider
- Contract termination
- Investigation results from subcommittees must be reported to QIOHAC

Provider Quality Improvement and Oral Health Access Program Responsibilities

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

Records Review

Liberty has established guidelines for the delivery of dental care to plan members. In summary, all providers are expected to render dental care in accordance with community standards. The guidelines begin below and conclude with the form that our dental consultants use to evaluate member records.

Chart selection: A minimum of ten (10) randomly selected member charts shall be reviewed.

Grievances & Appeals (G&A) and Provider Claim Disputes

As part of our commitment, Liberty ensures that all members and providers have every opportunity to exercise their right to a fair and timely resolution to any grievance and/or appeals. All contracted provider offices are required to provide members with a copy of the Liberty G&A form, upon request.

G&A Records Requests

Providers are contractually required to provide Liberty with copies of all member records requested because of a grievance and/or appeal filed by a member within three (3) business days of a request from Liberty.

All providers are obligated to respond to Liberty with a written response/narrative to the member's concerns and include supporting documentation, (i.e., clinical notes, treatment plans, financial ledgers, radiographs, etc.).

Failure to cooperate/comply with the G&A system may lead to disciplinary actions, including but not limited to, referral to the PQI unit, or terminations from the Liberty network.

G&A Cultural and Linguistics

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

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

Liberty provides members whose primary language is not English with translation services in over 150 languages. The G&A form can be obtained from Liberty's Member Services Department, from a dental provider facility, or from the Liberty website. All contracted provider facilities are required to display member grievances and appeals forms. All member quality of care grievances, benefit complaints, and appeals are received and processed by Liberty.

Members and providers can submit G&A by telephone by calling Liberty's Member Services Department at 888.352.7924, or by fax, online through Liberty's website, letter, G&A form, or in person.

G&A Process

The timeframe for members and provider to submit G&A varies by the line of business and/or program. Members can locate information on grievance and appeals filing and resolution timeframes outlined in their Member Handbooks/Evidence of Coverage/Certificate of Coverage.

Liberty's G&A process encompasses investigation, review, and resolution of member issues submitted to Liberty and/or contracted providers, Health Plan partners and regulatory entities. Liberty accepts member G&A in all manner of communication, both verbally and in writing. Members and providers do not have to use the Liberty G&A form. Liberty will process all members' G&A in accordance with contractual obligations, state, and federal regulations.

To provide excellent service to our members, Liberty maintains a G&A system by which members can obtain timely resolution to their inquiries, grievances, and appeals. This process allows for:

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

Providers can file a G&A on behalf of the member with appropriate written consent. An expedited appeal filed by a provider on behalf of a member also requires the provider to first obtain the member's written consent. If Liberty does not receive such a document, the G&A cannot be processed and will be dismissed.

An expedited appeal is appropriate when the provider indicates that taking the time for a standard resolution could seriously jeopardize the member's life, health, or ability to maintain, or regain maximum function.

Liberty does not take punitive action against any member, or provider who files a G&A on behalf of a member, or persons who request an expedited resolution or supports a member's request for an expedited resolution.

The Liberty G&A system includes the compilation of all the information necessary to coordinate fair and timely review and resolution of all member and provider G&A. All clinical G&A aspects are reviewed by a Liberty Dental Director or Clinical Dental Designee, licensed dentists, who were not a part of the initial decision, are not a subordinate of the original decision maker, have the appropriate clinical expertise, and consider all new and existing documentation. Liberty personnel involved in determining a member and provider appeals must have had no prior involvement in the initial decision. This rule extends to both the G&A Analyst coordinating the appeal.

G&A Resolution Definitions

- Acknowledgement: Liberty mails written notification of the receipt of the G&A to the member and provider.
- Appeal: A request for Liberty to review and change a decision made about coverage for a requested or completed service(s).
- Expedited/Fast Track: Cases in which a member or provider on behalf of a member feels their health would be harmed by waiting for the standard resolution timeframe, can request an "expedited/fast track review". Qualifying cases are resolved within **seventy-two (72) hours**.
    - For a member to qualify for an expedited review, the criteria must first be met. The expedited criteria include but are not limited to severe pain, bleeding, swelling, and/or loss of bodily function.
- Extensions: Members, providers on behalf of a member, or Liberty, if in the best interest, may request a **fourteen (14) calendar day** extension on a Grievance, Expedited or Standard appeal request.
    - G&A extension notices by Liberty will include verbal and written notification of the extension to the member along with their right to file a grievance if the member is not in agreement with the Plan's extension.
- Grievance: Any expression of dissatisfaction with Liberty, a provider, or with the dental care or treatment received from a provider.
- Standard: Cases are resolved as expeditiously as the member's condition requires. If Liberty does not decide within the additional **fourteen (14) calendar days**, the internal appeal process will be considered completed, and the member will qualify for the next level in the appeal process.
- Independent Review Entity (IRE): An independent entity contracted by CMS to review adverse level one (1) appeal decision made by Liberty, including the review of Plan dismissals, when appropriate.

Member Grievances

Members may file a grievance following any incident or action that is the subject of their dissatisfaction. All members have the option to submit a grievance in writing; either by composing a letter or completing a G&A form. Liberty will accept member grievance in any format both verbally and in writing.

- **Commercial and Exchange Plan Members** - Commercial business members have the right to file a grievance within a specific timeframe, in accordance with specific state regulations, following any incident or action that is the subject of their dissatisfaction. Members can submit a grievance by telephone by calling Liberty's Member Services Department at **888.352.7924**, or by fax, online through Liberty's website, letter, or G&A form.
- **Medicaid Members** - Medicaid members do not have a filing limitation and have the right to file a grievance at any time, in accordance with federal regulations set forth by the Centers for Medicare and Medicaid Services (CMS). Please reference the state specific Medicaid Provider Reference Guide for more details on the member grievance process.
- **Medicare Members** - Medicare members have **sixty (60) calendar days** from the event that lead to his/her dissatisfaction, in accordance with federal regulations set forth by the Centers for Medicare and Medicaid Services (CMS).

Member Appeals

Members may file an appeal following the issuance of a Notice of Adverse Benefit Determination for services, procedures, or payment that were not fully approved or paid in his or her favor. All members have the option to submit an appeal in writing either by composing a letter or completing a G&A form. Liberty will accept member appeals both verbally and in writing.

Expedited member appeals may be available if the member's life, health, or ability to maintain maximum function would be in jeopardy by waiting the standard turnaround time for resolution. Expedited appeals are resolved within **seventy-two (72) hours**. Expedited appeal requests that do not meet the criteria will automatically be processed as a standard/non-urgent appeal.

Commercial and Exchange Plan Member Appeals

- Commercial/Exchange business members have the right to file an appeal within a specific timeframe, in accordance with specific state regulations, following an adverse determination issued by Liberty. Based on the state and/or line of business, Commercial/Exchange members may have two levels of internal appeals with Liberty.
- In certain types of cases, Commercial/Exchange members can request an external review with an Independent Review Organization (IRO), but only after they have exhausted Liberty's internal appeal processes. The completion of Liberty's internal appeal process is not required if a) we fail to meet our internal appeal process timelines, b) the member has a life-threatening situation files an external review before exhausting our internal appeal process, or c) Liberty decides to waive the appeal process requirements.

Medicaid Members

- Medicaid members have **sixty (60) calendar days** from the date of the adverse determination issued by Liberty to file an appeal, in accordance with federal regulations set forth by the Centers for Medicare and Medicaid Services (CMS). Please reference the state specific Medicaid Provider Reference Guide for more details on the member appeal process.

Medicare Members

- Medicare members have **sixty-five (65) calendar days** from the date of the adverse determination issued by Liberty to file an appeal, in accordance with federal regulations set forth by the Centers for Medicare and Medicaid Services (CMS).
- Medicare members have multiple levels of appeal. Once Liberty's internal appeal process has been exhausted, Medicare members have **one hundred twenty (120) calendar days** from the date of Liberty's adverse determination that is not fully in their favor to request a review with an external Independent Review Entity (IRE). Members may represent themselves, or be represented by a friend, lawyer, or any other person. If they want someone else to represent them, they are responsible for making the arrangements.

Continuation Of Benefits

Liberty abides by all state and federal regulations with respect to continuation of benefits throughout the member appeal process. The member must state in the appeal that he/she wants to continue receiving treatment during the appeal process. Liberty will continue member benefits when the following have been met:

- The request for continuation of benefits is submitted to Liberty on or before the later of the following: within **ten (10) calendar days** of Liberty mailing the Notice of Adverse Benefit Determination; or the intended effective date of Liberty's proposed Adverse Benefit Determination
- The member files the request for an appeal within **sixty (60) calendar days** 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 time 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, Liberty will notify the provider.

When a member has requested and received continuation of benefits during an appeal, Liberty will ensure that the member benefits are continued until one of the following occurs:

- The member withdraws the appeal
- The member failed to meet the requirements outlined above for the continuation of benefits.
- The appeal decision to uphold, partially or fully, the Plan's original decision to terminate or reduce services.

Medicaid Member State Fair Hearings

Liberty Members who are eligible for both Medicare and Medicaid (duals) who do not receive a written resolution to their appeal within the required timeframes, or are dissatisfied with the resolution of their appeal, may request a State Fair Hearing from his/her appropriate state agency but only after they have exhausted Liberty's appeal process.

Medicaid members have one level of appeal, once Liberty's internal appeal process has been exhausted, Medicaid members have **one hundred twenty (120) calendar days** from the date of Liberty's adverse determination that is not fully in their favor to request a State Fair Hearing.

Members may represent themselves at the State Fair Hearing, or be represented by a friend, lawyer, or any other person. If they want someone else to represent them, they are responsible for making the arrangements. Members are informed that they are eligible for free legal assistance by contracting the appropriate state agencies.

Requesting a State Fair Hearing will not affect a member's eligibility for coverage, and members will not be penalized for seeking a State Fair Hearing. Members may request benefit continuation during a State Fair Hearing.

Please reference the state specific Provider Reference Guide for more details on the Medicaid State Fair Hearing process.

Independent Review Entity/Organizations

Independent Review Entities (IREs) are not associated with Liberty, Health Plan Partners, dental providers, or members and are utilized to determine if Liberty's adverse determination was correct for cases that involve medical judgement (including, but not limited to, those based on medical necessity, appropriateness, health care setting, level of care, effectiveness of a covered benefits or experimental/investigational treatment, dismissals, and rescissions of coverage.

Liberty Medicare members who do not receive a written resolution to their appeal within the required timeframes, or are dissatisfied with the resolution of their appeal, can request a review by an IRE. Members may represent themselves, or be represented by a friend, lawyer, or any other person. If they want someone else to represent them, they are responsible for making the arrangements and ensuring appropriate written consent is obtained.

Expedited external appeals may be available if a member feels his/her health is in danger and will be harmed by waiting. A Physician Certification from the members doctor is required for all requests for an expedited external review.

Liberty automatically forwards all Medicare member adverse benefit determinations to an IRE, when the resolution of the appeal is not fully in favor of the member.

Provider Grievances and Payment Disputes (Appeals)

Contracted or non-contracted providers have the right to participate in Liberty's provider grievances and payment appeals process, collectively known as the Provider Dispute Resolution (PDR) process.

Providers may not file a G&A on behalf of the member without appropriate written consent; this includes expedited appeals. If Liberty does not receive such a document, the G&A cannot be processed and will be dismissed.

Non-contracted providers have the right request reconsideration of denied payments only with a signed waiver of liability form, holding the member harmless regardless of the appeal outcome.

Provider Dispute Resolution (PDR) Definitions

- Provider Grievance: A formal expression of dissatisfaction from a provider regarding issues unrelated to payment or claim adjustments, such as customer service, operations, or network-related matters.
- Provider Payment Dispute (Appeal): A written request from a provider to review a denied claim, partial payment, or overpayment determination for services rendered to a Medicare enrollee.

Provider Grievances

Providers can submit any concerns, including but not limited to Liberty's quality of services, policy and procedure issues or any other concern that does not involve a claim dispute with Liberty's G&A Department.

Contracted and non-contracted providers can submit a grievance verbally or in writing by contacting Liberty's Member Services. Informal provider complaints may be resolved informally via phone by calling Liberty's Member Services.

Provider Payment Disputes (Appeals)

Providers may also submit written appeals of a claim that has been denied, adjusted, contested, or of a request for reimbursement of an overpayment of a claim, such as disagreement with an adjudicated amount or reason code, or situations where the provider believes the denial was made in error.

PDR Submission Requirements

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

- A summary of the grievance or appeal
- The providers name and NPI/API
- The claim number, if applicable
- The impacted member's name and ID number, if applicable
- The date of service, if applicable
- The reason why the initial determination should be reversed, if applicable
- The name and phone number of the person to be contacted regarding the request
- Copies of all related documentation and/or applicable medical records to support the appropriateness of the services rendered, if applicable.
- A copy of the Explanation of Payment (EOP) under dispute, if applicable
- An original signed paper claim that may be used for processing in the event of a Plan overturn and approval, if applicable.

Provider disputes that are not associated with a claim require a clear explanation of the issue and the provider's position on the issue. Provider disputes that do not include all required information may be returned to the submitted for completion.

An amended provider dispute, which includes the missing information, may be submitted. In the event an amended provider dispute with the missing information is not received, Liberty will uphold the initial decision and consider the provider dispute process completed.

Liberty will acknowledge and respond to all provider disputes within the applicable statutory guidelines. All inquiries regarding the status of a contracted provider dispute or about filing a contracted provider dispute must be directed to the G&A Department at **888.352.7924**.

Liberty acknowledges and resolves Medicare PDRs, when appropriate, as outlined below:

Medicare	Provider Grievances	Provider Appeal
Filing Limitation	Within **60 calendar days** from the event that lead to the provider's dissatisfaction	Within **65 calendar days** from the date of the Notice of Adverse Benefit Determination (NABD)
Acknowledgement	Within **15 calendar days** from receipt. *Grievances received and resolved verbally do not require an acknowledgement notice.	Within **15 calendar days** from receipt.
Resolution	Within **30 calendar days** of receipt	Within **30 calendar days** of receipt

Commercial and Exchange Plan PDRS - Commercial and Exchange PDRs will be processed in accordance with specific state regulations, following any incident or action that is the subject of their dissatisfaction.

Medicaid PDRS - Please reference the state specific Medicaid Provider Reference Guide for more details on the PDR process and timeframes.

Members and providers can submit G&A and PDRs to the attention of the G&A Department at the following:

Mail
Liberty Dental Plan
Attn: Grievances and Appeals Department
PO Box 26110
Santa Ana, CA 92799-6110

Email
GandA@libertydentalplan.com

Web
File a Grievance or Appeal

Fax
833.250.1814

Section 11. Fraud, Waste, And Abuse

Fraud, Waste, And Abuse Program Description

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

Liberty promotes provider practices that are compliant with all federal and state laws on fraud, waste, abuse, and overpayment. Our expectation is that providers will submit accurate claims, not abuse processes or allowable benefits, and exercise their best independent judgment when deciding which services to order for their members. 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 the Federal False Claims Act, state false claims laws, and makes a person liable to pay damages to the government if he or she knowingly:

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

As a provider, you are responsible to:

- Comply with all federal and state laws and Liberty requirements regarding fraud waste and abuse and overpayment
- Ensure that the claims that you (or your staff or agent) submit and the services you provide do not amount to fraud, waste, or abuse, and do not violate any federal or state law relating to fraud, waste or abuse
- Ensure that you provide and bill only for services to members that are medically necessary for services that were rendered, and consistent with all applicable requirements, regulations, policies, and procedures
- Ensure that all claim 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

Provider Self-Disclosure

The provider has an obligation to ensure that claims are submitted accurately. Section 1128J(d) of the Social Security Act requires providers to report and return overpayments to Liberty Dental Plan within

sixty (60) days from the date the overpayment is identified. Examples of appropriate self-disclosure may include, but are not limited to:

- Billing errors
- Systemic errors
- Any self-audit which identifies an overpayment was made to the dental office by Liberty Dental Plan.

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

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

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

- Over-utilization of services
- Misuse of resources

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

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

Section 12. Alternative Treatment

When a member has more than one dental treatment option, it is the responsibility of the provider to advise the member of treatment alternatives that are within professionally accepted standards of care, including procedures that are and are not covered by the member's dental benefits plan. By thoroughly explaining the treatment options to the member, he/she can select the treatment that is most appropriate for him/her. The provider can make professional recommendations as to the treatment option; however, the decision remains that of the member.

Liberty requires that any alternative, upgraded and/or elective treatment(s) be presented to the member in writing during the informed consent process, with the statement of fact that the service is not covered. In addition, the member's signature of approval should be documented prior to initiating treatment. This process will alleviate potential member disputes. Any member covered by a Medicare or Medicaid plan must have a clear statement that the service is not covered. Statements to the effect that "any service not covered by your plan is your responsibility" are not adequate for benefit plans that are part of Medicare or Medicaid plans.

Definition Of Alternative Treatment

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

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

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

*This does not include any upgraded treatment.

Upgraded Treatment

Liberty considers treatment to be an upgrade when similar, more expensive procedures or materials are recommended.

When a member selects an upgraded treatment or material, they are responsible for the cost of the upgrades. The cost of upgraded materials should be based on the actual lab or material costs of such materials. For example:

Provider's usual fee for the alternative treatment (i.e., fixed bridge)	$2,100.00
Provider's usual fee for the covered treatment (i.e., partial denture)	$975.00
Difference between alternative treatment and covered treatment ($2,100.00-$975.00)	$1,125.00
Copayment for the covered treatment	$125.00
Upgraded material (Total cost of material)	$500.00
Total member's responsibility* ($1,125.00+$125.00+$500)	$1,625.00

*Please refer to specific benefit plan designs for additional information

Section 13. Forms and Resources

Electronic forms are available for download including, but not limited to the following from the Provider Forms tab at Liberty 's website at:

1. Provider Resource Library
2. Select your state from the drop-down menu
3. Click "**Continue**" and then click on the document

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

- Provider Portal (iTransact) registration
- Secure email portal access
- Mandatory Annual Provider Compliance Training
- Liberty's Clinical Criteria and Guidelines
- Teledentistry Resources
- Value-based Program information
- Directory Information Validation (DIV)
- Americans with Disabilities Act (ADA) Survey
- Opioid Risk Tool

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

- ADA Claim Form
- CMS Appointment of Representative Form
- Electronic Fund Transfer (EFT) Form
- ECHO Electronic Fund Transfer (EFT) and Electronic Remittance Advice (ERA) Form
- Grievance Form - English
- Grievance Form - Spanish
- Informed Consent for Alternative Treatment Form - English
- Informed Consent for Alternative Treatment Form - Spanish
- Informed Consent for Alternative Treatment Form - Chinese
- Justification of Need for Prosthodontics
- Provider Complaint and Dispute Form (fillable)
- Provider Compliance Training & Attestation
- Specialty Care Referral Form

Section 14. Benefit Plans and Fee Addenda

Benefit Plans

Benefit Plans allow providers to evaluate member coverage and are available by logging into the Provider Portal and navigating to "**My Members**" or by contacting the Provider Relations Department at **888.352.7924**. Please refer to the Online Provider Portal User Guide for more information.

Benefit Schedules also include a listing of CDET code descriptions, exclusions, benefit limitations, prior authorization requirements as well as the member's applicable co-payment or co-insurance.

Accessing My Contract Fees

Liberty

- Liberty's secure Provider Portal under "**My Resources**"
- Call Provider Services at **888.352.7924**
- Contact your assigned Provider Relations Network Manager
- Request via email at **provider@libertydentalplan.com**

Leased Network Partners

- Liberty is not able to fulfill requests for fee schedules from our leased network participating providers.
- Please contact the payor your provider/practice is directly contracted with to obtain copies of fee schedules.

Plan Offerings

The following defined plans represent programs Liberty is contracted to administer.

Preferred Provider Organization (PPO) - A type of health plan where you pay less if you use providers in the plan's network. You can use doctors, hospitals, and providers outside of the network without a referral for an additional cost.

Exclusive Provider Organization (EPO) - A managed care plan where services are covered only if you use doctors, specialists, or hospitals in the plan's network (except in an emergency).

Health Maintenance Organization Network (HMO) - A type of health insurance plan that usually limits coverage to care from doctors who work for or contract with the HMO. It generally won't cover out-of-network care except in an emergency. An HMO may require you to live or work in its service area to be eligible for coverage. HMOs often provide integrated care and focus on prevention and wellness. **Please note HMO health plans Liberty administers offer PPO/EPO dental benefits**.

Dental Health Maintenance Organization (DHMO) - A legal entity that accepts the responsibility of providing services at a fixed price. The enrollees in these plans must have dental care provided through designated doctors.

Section 15. Medicare Dental Program

Providers and their staff members must coordinate care with an in-network associate within the member's primary care office. If an in-network associate is not available, the office must work with Liberty to obtain permission for the out-of-network associate to provide treatment as an in-network dentist.

Contact Liberty's Member Services Department to identify a contracted provider prior to referring a member to an out-of-network provider to ensure that members are receiving medically necessary services that are covered by the Plan.

If a referral is made to an out-of-network specialist by the member's in-network Dentist without prior approval, the referring office may be held financially responsible for any additional costs.

Guidelines

- Perform an oral evaluation
- Provide a written treatment plan to members that identifies covered services, non-covered services, and clearly identifies any costs associated with each treatment plan that is understandable by a prudent layperson with general knowledge of oral health issues
- Provide supporting materials for dental services and procedures which document their medical necessity
- 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 demonstrating an understanding of the treatment plan and an agreement with a treatment plan and the associated financial terms
- A financial agreement for any non-covered service to be documented separately from any treatment plan or informed consent
- Work closely with specialty care provider to promote continuity of care
- Cooperate with, and adhere to Liberty's Quality Improvement and Oral Health Access
- Transformation Program
- Identify dependent children with special health care needs and notify Liberty of these needs
- The provider has the right to dismiss a member in writing to Liberty stating the reasons for dismissal.
- Dismissal may not include the following reasons:
    - Because the member's attempt to exercise his or her rights under the grievance system
    - Adverse change in the member's health status
    - Member's utilization of services, diminished mental capacity, or uncooperative or disruptive behavior resulting from his/her special needs
- Notify Liberty of a member death
- Arrange coverage by another provider when away from the dental facility
- Ensure that emergency dental services and/or information are available and accessible for members of record 24 hours a day, 7 days a week
- Maintain scheduled office hours
- Maintain dental records for a period of **ten (10) years**
- Post the availability of language assistance services signage in provider office

- Coordinate and provide language assistance services, which include telephonic and onsite interpretation services for members, when necessary
- Document member's preferred language and request/refusal of interpreting services in dental chart
- Provide Liberty with updated credentialing information upon request
- Provide requested information upon receipt of member grievance/complaint/appeal within **three (3) business days** of receiving the notice letter from Liberty
- Provide claim or encounter data on standard ADA claim form within timely filing requirements
- Capitation plans require disclosure of services rendered
- Notify Liberty of any changes regarding his or her practice, including location name, telephone number, address, associate additions/terminations, change of ownership, plan terminations, etc.
- If a member chooses to transfer to another participating dental office, there will be no charge to the member for copies of records maintained in their chart. All copies of records must be provided to the member within **fifteen (15) calendar days** of the request
- Provide dental services in accordance with peer-reviewed clinical principles, criteria, guidelines and any evidence-based parameters of care
- Providers may not close, or otherwise limit, their acceptability of members unless the same limitations apply to all commercially insured members
- Providers understand and agree that assignment of delegation by provider of services under its agreement with Liberty is null and void unless prior written approval is obtained from Liberty and, to the extent required, by Liberty from relevant Health Plan Partners

Specialty Care Dentist (SCD) Responsibilities

- All the responsibilities of the SCD listed above
- Provide specialty care to members
- Work closely with PCDs to ensure continuity of care
- Submit claims to Liberty for all dental services that were authorized
- Dentists with certification in the following specialties: Endodontics, Oral Surgery/OMFS, Periodontics, and Prosthodontics must have, or have confirmation of application submission, of valid DEA or waiver and CDS certificates
- Provide credentialing information upon renewal dates.

Member Rights and Responsibilities

Liberty members have specific rights and responsibilities when it comes to their care. The member's rights and responsibilities are provided to each member in the member's Evidence of Coverage booklet and are outlined below.

As a member of Liberty, everyone is entitled to the following rights:

- To be treated with courtesy and respect, with appreciation of his/her individual dignity, and with protection of his/her need for privacy.
- To a prompt and reasonable response to questions and requests

- To know who is providing dental services and who is responsible for his/her care
- To know what rules and regulations apply to his/her conduct
- To know what member support services are available, including whether an interpreter is available if he or she does not speak English
- To refuse any treatment, except as otherwise provided by law
- To be given, upon request, full information, and necessary counseling on the availability of known financial resources for his/her care.
- To receive, upon request prior to treatment, a reasonable estimate of charges for dental care.
- Medicare eligible members have the right to know, upon request and in advance of treatment, whether the health care provider or facility accepts the Medicare assignment rate.
- To receive a copy of a reasonably clear and understandable, itemized bill and, upon request, to have the charges explained.
- To impartial access to treatment or accommodations, regardless of race, national origin, religion, handicap, or source of payment
- Treatment for any emergency dental condition that will deteriorate from failure to provide treatment
- To know if treatment is for the purpose of experimental research and to give his/her consent or refusal to participate in such experimental research
- Know their treatment choices and participate in decisions about their health care
- Use Advance Directives (such as a living will or a durable health care power of attorney)
- To express grievances/complaints regarding any violation of his/her right, as state in applicable state law, through the grievance procedure of the heath care provider or facility which service his/her to the appropriate state licensing agency.
- To request an appeal of an adverse benefit determination to deny, defer, or limit services or benefits either verbally or in writing.
- To request a grievance about Liberty or the care provided and feel confident it will not affect the way they are treated
- Make recommendations about Liberty's policies regarding member rights and responsibilities; and
- Talk openly about the care needed for their health, regardless of cost or benefit coverage, as well as the choices and risks involved. The provider must provide the information to members in a way they understand

As a member of a liberty affiliated health plan, everyone has the responsibility to behave according to the following standards:

- Become familiar with their coverage and the rules they must follow to get care as a member
- Tell Liberty and dental providers if they have any additional health insurance coverage or prescription drug coverage
- Tell their dentists and other health care providers that they are enrolled in Liberty Dental Plan
- Give their dentist and other providers complete and accurate information to care for them, and to follow the treatment plans and instructions that they and their providers agree upon

- Provide their dentist or other health care providers, to the best of his/her knowledge, accurate and complete information about present complaints, past illnesses, hospitalizations, medications, and other matters relating to his/her health
- Reporting to their dentist or other health care provider any unexcepted changes in his/her health conditions
- Understand their dental health problems and help set treatment goals that they and their dentist agree to
- Ask their dentist and other providers questions about treatment if they do not understand
- Following the recommended treatment plan from their dentist or other health care provider
- Tell their dentist that they understand the treatment plan, the course of treatment and what is expected from him/her
- Make sure their doctors know all the drugs they are taking, including over-the-counter drugs, vitamins, and supplements
- Act in a way that supports the care given to other members and helps ensure the smooth running of their doctor's office, hospitals, and other offices
- Pay their plan premiums and any co-payments or coinsurance they owe for the covered services they receive. Members must also meet their other financial responsibilities as described in the Evidence of Coverage booklet
- Keeping scheduled appointments, and when he/she is unable to do so for any reason, notifying the dentist or other health care provider/facility at least **24 hours** in advance
- Inform Liberty Dental Plan if they move
- Inform Liberty Dental Plan of any questions, concerns, problems, or suggestions by calling the Member Services Department listed in their Evidence of Coverage booklet

Voluntary Termination of the Provider Contract

Providers are required to provide Liberty at least **ninety (90) days** advance written notice of their intent to terminate a provider contract. Providers must continue to treat members until the last day of the month following the date of termination. Impacted members are given advance written notification informing them of their transitional rights. Certain contractual rights survive termination, such as the agreement to furnish member records in response to a grievance or claims review. Please consult your provider contract for your responsibilities after the date of termination.

National Provider Identifier (NPI)

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

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

How to Apply for an NPI

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

- **CMS Website**
- Dental providers can agree to have an Electronic File Interchange (EFI) Organization submit the application data on their behalf
- The provider can obtain a copy of the paper NPI application/update form (CMS-10114) by visiting **www.cms.gov** and mail the completed, signed application to the NPI Enumerator.

Standards of Accessibility and Availability

Liberty is committed to ensuring our members receive timely access to care. Providers are required to schedule appointments for eligible members in compliance with standards of accessibility and availability as defined below.

Availability Standards	
Non-urgent Appointments (exams, x-rays, restorative	Not to exceed **thirty (30) business days**
Emergency Appointments (acute pain/swelling/bleeding)	24 hours a day, 7 days a week
Preventive Care (prophys or periodontal care)	Not to exceed **thirty (30) business days**
Lobby Waiting Time (for scheduled appointments)	Not to exceed **thirty (30) minutes**

After Hours and Emergency Services Availability

The provider's after-hours response system must enable members to reach an on-call dentist **twenty-four (24) hours a day, seven days a week**. In the event the primary care provider is not available to see an emergency for a member of record within **twenty-four (24) hours**, it is his/her responsibility to ensure that emergency services are available. Members requiring after-hours emergency dental services must receive an assessment by telephone from the provider within one hour of the time the member contacts the provider's "**after hours**" telephone service. Members must be scheduled within **twenty-four (24) hours** and should be informed that only the emergency treatment will be provided at that time. If the member is unable to access emergency care within these guidelines and must seek services outside of your facility, provider may be held financially responsible for the total costs of such services. Additionally, if your office is unable to meet Liberty guidelines, Liberty has the right to transfer some or all capitation programs enrollment to another provider or close your office to new enrollment.

Recall, Failed, or Cancelled Appointments

Contracted dentists are expected to have an active recall system for established members who fail to keep or who cancel scheduled appointments. Failed appointment charges may apply. Copayments will vary based on the members' plan benefits. Refer to the members' benefits schedule or contact the Member Services Department for more information. Missed or cancelled appointments should be noted in the member's record.

Please note that members who are eligible for both Medicare and Medicaid (duals) cannot be charged for a no show or missed appointment.

Appointment Rescheduling

When it is necessary for a provider or member to reschedule an appointment, the appointment shall be promptly rescheduled in a manner that is appropriate for the member's health care needs and ensures continuity of care consistent with good professional practice. Appointments for follow-up care are required to be scheduled according to the same standards as initial appointments.

Compliance With the Standards of Accessibility and Availability

Liberty monitors compliance with the standards set forth in this manual through dental facility site assessments, provider/member surveys and other Quality Management processes. Liberty may require corrective action from providers that are not meeting accessibility standards.

Facility Physical Access for the Disabled – Americans with Disabilities Act

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

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

The Americans with Disabilities Act sets requirements for new construction of and alterations to buildings and facilities, including health care facilities. In addition, all buildings, including those built before the ADA went into effect, are subject to accessibility requirements for existing facilities. Detailed service and facility requirements for disabled individuals can be found by visiting www.ada.gov.

Treatment Plan Guidelines

All members must be presented with an appropriate, written treatment plan including an explanation of the benefits, alternatives, recommendations, and financial implications of the treatment recommended and/or proposed. If there are alternate treatments available, the treating dentist must also present those options and the related costs for both covered and/or non-covered services.

Alternate and/or Elective/Non-Covered Procedures and Treatment Plans: Liberty members cannot be denied appropriate plan benefits if they do not choose "alternative or elective/non-covered" procedures. All accepted or declined treatment plans must be signed and dated by the member or his/her guardian and the treating dentist. Refer to the Members' benefit plans to determine covered, alternate, and elective procedures.

Non-Covered Services

Non-covered services can be discussed with the member.

Important Notice: Any non-covered services selected by a member must be clearly presented on a separate treatment plan clearly stating that the service is not covered, and that the member has been

informed of covered services and elects the non-covered service and understands and accepts the financial responsibility. Liberty recommends that payment agreements with members be recorded in writing and agreed to by the member before any treatment is rendered. The member is responsible for **100% of the entire fee**.

In instances where dental services are not covered by Liberty, a dentist may charge a member for non-covered services after following certain protocols:

- Liberty must issue a denial of the prior-authorization request, and the member must exhaust their appeal rights.
- The provider must enter into a private-pay financial agreement with the member prior to rendering the service.
- The agreement should be a mutual and voluntary decision, and the member must consent in writing.
- The consent should include the specific codes, description, and dollar amount that the member is agreeing to pay the provider.
- The provider must maintain a record of the member's signed consent (for example, in the member's medical record). You may access the Consent for Non-Treatment Services in the **Provider Resource Library**.
- Treatment plans and **informed consent documents** must be signed by the member or responsible party demonstrating an understanding of the treatment plan and an agreement with a treatment plan and the associated financial terms.

Please note most Liberty commercial (non-governmental) plans allow for an upgrade in materials to noble or high noble metal and for porcelain on molar teeth with a signed treatment plan and informed consent by the member.

Second Opinions

Members may request a consultation with another network dentist for a second opinion to confirm a diagnosis and/or treatment plan at no cost. Providers should refer these members to the Member Services Department at **888.352.7924**, Monday through Friday, 8 a.m. to 5 p.m. PST.

Continuity And Coordination of Care

Liberty ensures appropriate and timely continuity and coordination of care for all plan members.

All care rendered to Liberty members must be properly documented in the member's dental charts according to established documentation standards. Communication between the PCDs and dental specialists shall occur when members are referred for specialty dental care. Liberty expects general dentistry providers to follow up with the member and with the specialist to ensure that referrals are occurring consistent with the best interests of the member. Specialist providers are encouraged to send treatment reports back to the referring general dentist providers to ensure that continuity of care occurs consistent with generally accepted standards of practice.

Liberty enforces Quality Improvement and Oral health Access Transformation (QIOHATP) Program policies and procedures that will ensure:

- An enrollment packet contains a list of providers that shall be given to all members upon enrollment

- A current list of providers is maintained on Liberty's web site at Find a Dentist
- Members who do not select a provider shall be assigned one, based on the member's geographic location (for capitation plans)
- Dental chart audits will verify compliance with documentation standards
- Guidelines for adequate communication between the referring and receiving providers when members are referred for specialty dental care are included in this provider guide
- During facility on-site audits, Liberty monitors compliance with continuity and coordination of care standards
- When a referral to a specialist is authorized, the general dentist provider is responsible for evaluating the need for follow-up care after specialty care services have been rendered and schedule the member for any appropriate follow-up care
- When a specialty care referral is denied, the general dentist provider is responsible for the evaluation of the need to perform the services directly, and schedule the member for appropriate treatment
- The results of site audits shall be reported to the Peer Review and Quality Improvement and Oral health Access Transformation Committees, and corrective action shall be ordered when deficiencies are identified

Infection Control

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

The Member's Dental Record

Dental records are the complete, comprehensive records of dental services, to include chief complaint, treatment needed, and treatment planned to include charting of hard and soft tissue findings, diagnostic images to include radiographs and digital views and to be accessible on site of members participating dentist and in the records of a facility for members in a facility.

Member dental records must be kept and maintained in compliance with applicable state and federal regulations. Complete dental records of active or inactive members must be accessible for at least **ten (10) years**, per the State Board of Dentistry Regulations.

Dental records must be comprehensive, organized, and legible. All entries should be in ink, signed and dated by the treating dentist or other licensed health care professional who performed services. Electronic dental records must capture the dentist's identification (signature, initials, or other indication showing that the dentist has approved the chart entry in the electronic dental record).

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

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 Improvement and Oral health Access 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 with 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 and continued, or egregious non-compliance will lead to contract termination.

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

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

- Use of PHI (including 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 the top of the page
    - Select "**Secure Email Portal**"

Use physical and technical safeguards to ensure monitors cannot be viewed by unauthorized individuals, and screen automatically lock on devices, after a reasonable period of inactivity.

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

Review and adhere to Liberty's Secure Use and Transmission of e-PHI policy, located online in the Provider Resource Library.

**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.*

Verbal PHI - Do not discuss patient information 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 discussion occurs 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. Use 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 information to accomplish the required purpose. Also, please avoid using speaker phones

Tangible PHI - Do not display or store paper or other tangible PHI in common areas. Do not leave such PHI unattended on desks or in exam rooms or operatories. Never dispose of paper or other tangible PHI in the trash. Use secure methods to destroy and dispose of such PHI (for example, cross-cut shredder).

- 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 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

Anti-Discrimination

Discrimination is against the law. Liberty complies with all applicable federal civil rights laws and does not discriminate, exclude people, or treat them differently based on race, color, national origin, age, disability, gender affirming care, patient care decisions support tools (AI), telehealth, or sex. Liberty provides free aids and services to people with disabilities, and free language services to people whose primary language is not English, such as:

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

If you need these services, please contact us at **1.888.844.3344**. If you believe Liberty has failed to provide these services or has discriminated based on race, color, national origin, age, disability, or sex, you can file a grievance with Liberty's Civil Rights Coordinator:

Phone
888.704.9833 or **888.735.2929** (TTY)

Fax
714.389.3529

Email
compliancehotline@libertydentalplan.com

Web
Compliance

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

U.S. Department of Health and Human Services
200 Independence Avenue
SW Room 509F,
HHH Building Washington, D.C. 20201
1.800.368.1019, **800.537.7697** (TDD)

Web Resources

- File a grievance online
- Access grievance forms online

Culturally Competent Care

In accordance with state and federal regulations, Liberty provides culturally competent care and services in a nondiscriminatory manner that ensures all members including those with Limited English

Proficiency (LEP) and members with disabilities, receive effective and respectful care in a timely manner compatible with their culture, health beliefs, practices and preferred language. Liberty collaborates and participates with applicable state and regulatory agencies to promote the delivery of care in a culturally competent manner.

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

Language Assistance Services

- Language Assistance services are available to ensure Limited English Proficient (LEP) members have appropriate access to language assistance including special format for hearing and visually impaired members, while accessing dental care.
- Interpretation services for Limited English Proficient members (when and where required by state law or group/client arrangement):
- Interpretation services, including American Sign Language, are available at no cost to members, 24 hours a day, 7 days a week by contacting Liberty's Member Services Department at **888.352.7924**. When and where required by law or client group requirement, Liberty offers free telephonic interpretation through our language service vendor. When required, this service is available to the member at no cost.
- To engage an interpreter once the member is ready to receive services, please call Liberty's Member Services Department. You will need the member's Liberty Dental ID number, date of birth, and the member's full name to confirm eligibility and access interpretation services. It is not necessary to arrange for these services in advance. Liberty discourages the use of family or friends as interpreters. Family members, especially children, should not be used as interpreters in assessments, therapy, and other situations where impartiality is critical.
- Providers must also fully inform the member that he or she has the right not to use family, friends, or minors as interpreters.
- If a member prefers not to use the interpretation services after she/he has been told that a trained interpreter is available free of charge, the member's refusal to use the trained interpreter shall be documented in the member's dental record, when in a provider setting, or the member's administrative file (call tracking record) in the Member Services setting.
- Language preferences of members will be available to directly contracted dentists upon request through telephone inquiries, and only for those members entitled to receive such services by virtue of state requirement or client group requirement.
- Written Member Informing Materials in threshold languages and alternative formats (including braille and large font) are available to members at no cost and can be requested by contacting Liberty's Member Services Department.
- Assistance in working effectively with members using in-person, telephonic interpreters, other media such as TTY/TDD and remote interpreting services can be obtained by contacting Liberty's Member Services Department.