PROVIDER REFERENCE GUIDE

CALIFORNIA

LIBERTY DENTAL PLAN®

Making members shine, one smile at a time™

APRIL 2026

Table of Contents

SECTION 1. LIBERTY DENTAL PLAN INFORMATION

INTRODUCTION

Welcome to LIBERTY Dental Plan's (LIBERTY's) network of Participating Providers. We are proud to maintain a broad network of qualified dental providers who offer both general and specialized treatment, guaranteeing widespread access to our members.

This Provider Reference Guide intends to aid each Participating Provider and their staff members in becoming familiar with the administration of LIBERTY. Please note that this Provider Reference Guide serves only as a summary of certain terms of the Provider Agreement between you (or the contracting dental office/facility) and LIBERTY and that additional terms and conditions of the Provider Agreement apply. In the event of a conflict between a term in this Provider Reference Guide and a term of the Provider Agreement, the term of the Provider Agreement shall control. You will receive a copy of the fully executed Provider Agreement at the time of your activation on LIBERTY's network; however, you may also obtain a copy of the Provider Agreement at any time by submitting a request to prinquiries@libertydentalplan.com or by contacting Professional Relations at 800-268-9012.

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

To provide the most current information, updates to the Provider Reference Guide will be available by logging in to the Provider Portal at www.libertydentalplan.com

OUR MISSION

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

CALIFORNIA PROVIDER CONTACT AND INFORMATION GUIDE

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

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

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

EMERGENCY REFERRALS: 800-268-9012 Option 4

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

EDI PAYOR ID#: CX083

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

PROVIDER DISPUTE RESOLUTION (PDR)	MEMBER GRIEVANCES & APPEALS (G&A)
Use i-transact for PDR submissions at www.libertydentalplan.com PDR Forms available online through Provider Resource Library at www.libertydentalplan.com Mail PDR forms to our mailing address Attention: Grievances & Appeals Department Fax PDR forms to 833-250-1814	LIBERTY Dental Plan Member G&A form and online submission are available at www.libertydentalplan.com Fax: 833-250-1814 Phone: 800-268-9012 Option 6 Mail member G&A forms to our mailing address Attention: Grievances & Appeals Department

This Reference Guide is considered an addendum to the Provider Agreement. For all accepted providers, the local Network Manager presents a provider orientation at which time the provider receives a copy of LIBERTY's Provider Reference Guide. The Provider Reference Guide obligates all providers to abide by LIBERTY's Quality Improvement Oral Health Access (QIOHA) Program Policies and Procedures. To resolve any issues for a 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 which is maintained by the Professional Relations Department and also includes audit results. The latter contains copies of signed agreements, addenda, and related business correspondence.

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

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

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

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

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

PROVIDER TRAINING

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

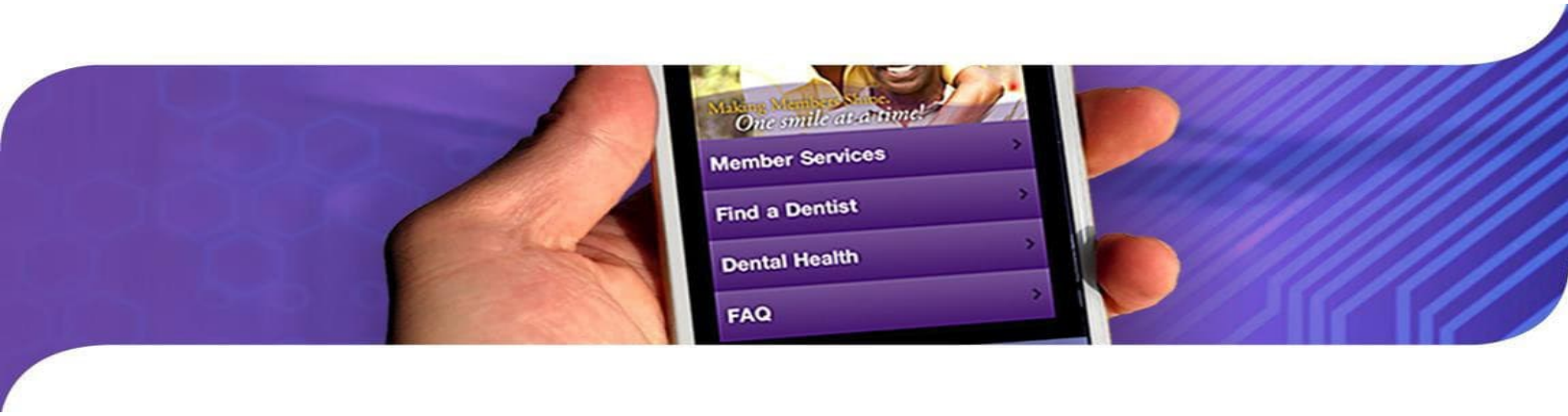
Providers and supporting dental office staff are required to complete annual compliance training modules. All training regarding the requirements, including any contract amendments and special needs of members are available to providers and their staff. Providers are also trained in identifying adverse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

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

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

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

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



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

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

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

ONLINE ACCOUNT ACCESS

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

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

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

If you are unable to locate your Office Number and/or Access Code, please contact our Member Services Department at 800-268-9012 for assistance. For technical assistance, email portalsupport@libertydentalplan.com.

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

iTRANSACT Provider Portal

DIRECTORY INFORMATION VERIFICATION (DIV) ONLINE

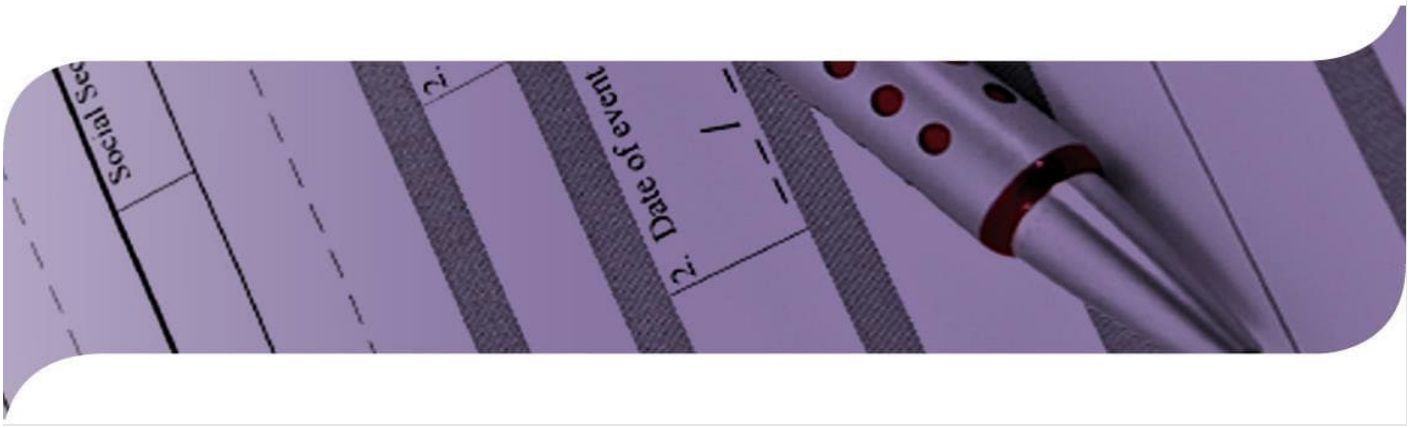
LIBERTY actively works to verify and maintain the accuracy of our provider directories which are available to members and the public. It is required that we maintain current office information to ensure the information provided to our members reflects both your current office demographic information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

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

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

Your office must go online at least every ninety (90) days to confirm and attest that no changes have occurred with your office information. We also highly recommend that you set a calendar reminder in your system to go to the website every eighty-five (85) days and validate the information.

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



HOW TO VERIFY ELIGIBILITY

There are several options available to verify eligibility:

- Provider Portal: https://www.libertydentalplan.com- The Member's Last Name, First Name, and any combination of Member Number, Policy Number, or Date of Birth will be required (DOB is recommended for best results).
- Telephone: Speak with a live Representative from 8:00 a.m. to 5:00 p.m. PST, Monday through Friday by contacting our Provider Service Line at 800-268-9012, Option 1 (TTY 877-855-8039).

Member Identification Cards

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

SECTION 5. CALIFORNIA MEDI-CAL DENTAL PROGRAM

LIBERTY is a dental benefits administrator for the Sacramento Geographic Managed Care (GMC) and Los Angeles Pre-Paid Health Plan (PHP) Medi-Cal Dental Programs. Your office can obtain immediate access to the Department of Health Care Services (DHCS) Medi-Cal Dental Program Provider Handbook, Section 5 – Manual of Criteria (MOC) at:
https://www.dental.dhcs.ca.gov/MCD_documents/providers/provider_handbook/PHB_section_05_MOC_SMA.pdf

PROVIDER TRAINING

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

MONTHLY ELIGIBILITY ROSTERS

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

ANESTHESIA PERMITS

California law requires all general dentists, specialists, and anesthesiologists to be contracted as Medi-Cal providers and have active permits and endorsements for the type of sedation being administered on file with the Dental Board of California.

General Anesthesia/Deep Sedation:

1. General Anesthesia permit for dental patients aged seven (7) years and older.
2. General Anesthesia permit, Pediatric Endorsement, and Documentation of Deep Sedation and General Anesthesia or Moderate Sedation Cases for Pediatric Endorsement form for pediatric patients under the age of seven (7).

Moderate Sedation (Replaced "Conscious Sedation")

1. Oral Conscious Sedation permit for adult dental patients.
2. Oral Conscious Sedation Permit and Pediatric Endorsement for dental patients under thirteen (13).

Pediatric Minimal Sedation (Replaced "Oral Conscious Sedation")

1. Pediatric Minimal Sedation permit for dental patients under the age of thirteen (13).

Requests for pre-estimates and requests for claims payment submitted without active sedation permits on file will be denied until the rendering provider submits the required sedation permits and supporting documentation through the PAVE Portal.

To update your permit information, submit a Supplemental Change Form in the PAVE Portal or contact Medi-Cal Dental at 800-423-0507 Monday through Friday 8:00 a.m. to 5:00 p.m. PST.

MEDICAID DENTAL BENEFITS

Please reference the sections below for additional guidance on Provider Billing Practice and Non-Covered Services.

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

An adequate informed consent form must state that specific services are not covered, it must include the procedure code and description as well as the cost of the services, and the member's signature, indicating the member understands which specific services are not covered by the plan and that the member agrees to be financially responsible for these specific costs.

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

PROVIDER BILLING PRACTICE

Medi-Cal dental providers and dental offices are required to verify Medi-Cal eligibility before the completion of any covered or non-covered service.

California laws prohibit dental providers and dental offices from billing Medi-Cal members as private pay patients to avoid claim submissions, obtaining prior authorization, or complying with any other program requirement once Medi-Cal eligibility has been verified.

Once a member's Medi-Cal eligibility has been verified, a member cannot be billed or charged for any part of a Medi-Cal covered service. Dental providers and dental offices cannot bill members for private insurance cost-sharing amounts such as deductibles, coinsurance, or copayments.

Medi-Cal dental providers and dental offices may only enter into a private payment agreement with a member under the following circumstances:

1. The provider and the member have agreed that the specific dental treatment is outside of the benefits allowed by the Medi-Cal Dental Program. The provider has not verified the member's eligibility or submitted any requests for a pre-estimate or request for claim payment for this current phase of treatment.
2. The provider has submitted a request for a pre-estimate or request for claim payment for a specific dental procedure that was subsequently denied because it was either not a benefit under the Medi-Cal Dental Program or it was denied because it did not meet the medical necessity criteria of the program or the time or frequency limitations for the procedure.

NON-COVERED SERVICES

Before recommending or completing any non-covered service, members must first receive a full explanation of the treatment plan options available as covered benefits under the Medi-Cal Dental Program.

Dental providers and offices cannot use administrative or quality-of-care denials as a reason to decide that a procedure is not a covered benefit or service. Any services denied due to technical or administrative reasons cannot be billed, or charged to Medi-Cal members under any circumstances.

Dental providers and offices cannot require Medi-Cal members to pay out-of-pocket for non-covered benefits or services as a condition for providing covered benefits or services.

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

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

Your office can obtain immediate access to the MOC through the following link https://www.dental.dhcs.ca.gov/MCD_documents/providers/provider_handbook/PHB_section_05_MOC_SMA.pdf

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

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

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

1. Pay-for-Performance (P4P): To improve oral health through increasing the utilization of preventive dental care services. Under this initiative, Medi-Cal providers will continue to qualify for bonuses as a P4P initiative and be able to offer additional covered services. Under this initiative, Medi-Cal providers will continue to qualify for bonuses as a P4P initiative and be able to offer additional covered services to their patients. Select eligible preventive procedure codes for P4P payments at an enhanced rate can be found on the DHCS bulletin. DHCS Bulletin – Volume 37, Number 24: Special Provider Bulletin November 2021 (ca.gov)
2. Additional Benefits: The initiative adds two statewide oral health benefits. The Caries Risk Assessment (CRA) bundle (D0601/D0602/D0603 with D1310) and Silver Diamine Fluoride (SDF) (D1354) are two benefits added to promote a risk-based utilization of preventive services. Provider training is a mandatory requirement to receive payment for the Caries Risk Assessment (CRA) bundle benefit.
    - Required Provider Trainings for CRA bundle:
        - TYKE - Treating Young Kids Everyday training: https://www.cda.org/Home/Education/Learning/TYKE-Program.
        - SMYLE - Strengthening Many Young Lives Everyday training: Medi-Cal Dental LMS
        - All rendering dental providers must complete one of the above one-time mandatory trainings to be eligible for reimbursement for the CRA Bundle. To complete the trainings, use the links above.

- Upon completion of the training, please submit the certificate of completion to the email address: professionalservices@libertydentalplan.com.
- All rendering dental providers who have previously taken the TYKE or SMYLE training must submit certificates issued to the following email address: professionalservices@libertydentalplan.com.

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

Proposition 56: Tabacco Tax Funds Supplemental Payments.

The CA Healthcare, research, and Prevention Tabacco Act of 2016, or Proposition 56, was approved on November 8th, 2016.
Effective January 1, 2022, pursuant to the 2021 Budget Act, the department of Health Care Services (DHCS) is authorized to continue Prop 56 supplemental payments for specific dental codes.
https://www.dhcs.ca.gov/provgovpart/Prop-56/Pages/Prop56-Provider-Dental.aspx
Proposition 56 funds will be utilized for supplemental payments for dental services under the Medi-Cal program for providers who bill the Dental Fiscal Intermediary or Dental Manage Care Plans.

- As part of the enactment of Assembly Bill 227 (2025-2026 Budget Act), DHCS is discontinuing Prop 56 supplemental payments to Medi-Cal Dental providers for dates of service, July 1, 2026, and later. Prop 56 claims are subject to a one (1) year claims runout period. Claims for services provided on or before June 30, 2026, must be submitted within one (1) year of the date of service, and no later than June 30, 2027, to be eligible for reimbursement.

COORDINATION OF BENEFITS

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

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

As required by federal law, LIBERTY provides comprehensive, diagnostic, and preventive dental services to eligible recipients under the age of twenty-one (21) years, if such services are medically necessary to correct or ameliorate a defect, condition, or physical or mental illness that exceeds the state's Medicaid benefit.

This includes emergency, preventive, diagnostic, and therapeutic services for dental disease that, if left untreated, may become acute dental problems, or cause irreversible damage to the teeth or supporting structures.

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

American Academy of Pediatrics Periodicity Schedule
https://downloads.aap.org/AAP/PDF/periodicity_schedule.pdf

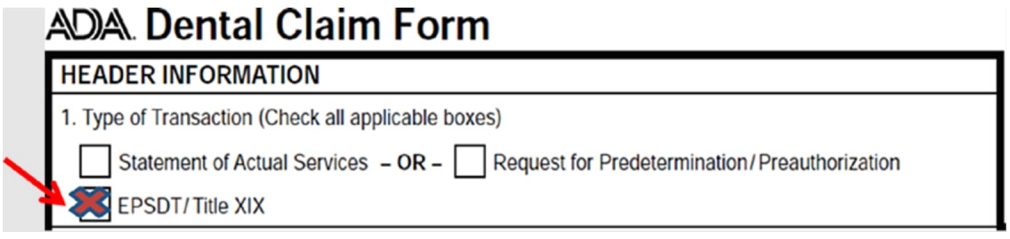
PRE-ESTIMATE OF EPSDT Dental Services

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

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

Providers requesting a pre-estimate of billing for EPSDT services should select the "EPSDT" box in section 1 of the American Dental Association (ADA) dental claim form, image below.

- Pre-estimate requests will be clinically reviewed for medical necessity; and
- Approved pre-estimates will be reimbursed based on your current fee schedule.



CASE/CARE MANAGEMENT

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

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

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

MEMBER TRANSITION OF CARE NOTIFICATION TO LIBERTY PROVIDERS

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

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

- Begin the process within five (5) business days following the receipt of the request. Authenticate member's patient of record status at an out-of-network dental office (if necessary).
- Develop a treatment plan with the treating provider and negotiate fees (if LIBERTY and an out-of-network provider cannot agree on fees, LIBERTY may recommend an in-network provider option).
- Complete non-urgent requests within thirty (30) calendar days, fifteen(15) calendar days for more serious dental conditions, and three (3) calendar days for members with imminent risk of harm.
- Upon completion, notify the member and provider of the determination, and for approvals, provide the timeframe (no longer than twelve (12) months from

the date of LIBERTY enrollment) for the transition of care.

- Notify the member thirty (30) calendar days before the end of the Transition of Care period.
- Retroactive requests for Transition of Care benefits may also be made through Member Services so long as treatment occurred after February 1, 2017, and the request is made within thirty (30) days from the first date of service.

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

COVERED CALIFORNIA TO MEDI-CAL TRANSITION

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

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

MEDICAID AND MEDICARE (DUALS) PRIOR-ESTIMATE OUTREACH

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

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

When LIBERTY receives a Medicaid or Duals member pre-estimate request, which lacks the information necessaryto make a medical necessity determination, LIBERTY will make reasonable provider outreach attempts to obtainthe information needed to decide as early in the decision-making process as possible. Examples of reasonable provider outreach attempts include attempts to contact a provider via

telephone, fax, email, and mail as appropriate, and within acceptable timelines determined by whether the initial pre-estimate request relates to a standard or expedited determination.

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

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

REQUESTS FOR PRE-ESTIMATE

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

Important note: *To promote timely access to care and minimize the risk of treatment delays, offices are encouraged to submit prior authorization requests within 5 business days.*

Pre-Estimates and Inquiries:

- Certain services may now require a pre-estimate, referrals, or supporting documentation
- For services that do not require a pre-estimate, providers are not required to submit a request before performing the service. If a provider chooses to submit a request for these services through the standard process (via ADA form or web portal), Liberty will process these requests as an inquiry. Providers will receive an explanation of available benefits and an estimated payment amount based on the information submitted.
- If provider requests review based upon EPSDT and Medical Necessity, it will not be considered an inquiry.

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

To confirm benefits and member copayments for LIBERTY programs, it is highly recommended that a pre-estimate be submitted for large or complex treatment

plans. The Following are some treatment examples where a pre-estimate would be highly recommended:

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

CLAIMS

California law requires Medi-Cal dental providers and dental offices to reimburse a member for a claim if the member provides proof of eligibility for the period during which medically necessary covered benefits or services were completed and paid for by the member.

Medicaid members cannot be charged for missed or canceled appointments. Missed or canceled appointments should be noted in the member's record and reported to LIBERTY through the claims submission process for any missed (D9986) and canceled (D9987) patient appointments.

Continue outreach to these members to educate them on the importance of keeping their appointments and rescheduling the appointments to avoid interruption in dental care. Please see Section 7. Claims and Billing for more information.

MEMBER RIGHTS AND RESPONSIBILITIES

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

APPOINTMENT ACCESSIBILITY STANDARDS

LIBERTY is committed to our members receiving timely access to care. Providers are required to schedule appointments for eligible members per the standards set by the state of California for the Medicaid programs.

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

California Medi-Cal Dental Appointment Accessibility Standards	
Type of Appointment	**Appointment Scheduling/Wait Time**
Initial (exams and x-rays)	Within 4 weeks
Routine Care, Non-Emergency (restorative care)	Within 4 weeks
Preventive Care (prophylaxis or periodontal care)	Within 4 weeks
Emergency (acute pain/swelling/bleeding)	As quickly as the member's condition requires but no later than 24 hours
Urgent Care (Lost crown, broken filling)	As quickly as the member's condition requires but no later than 72 hours
After-Hours/Emergency Availability All providers must have at least one of the following: • Answering service that will contact the provider on behalf of the member. • Call forwarding system that automatically directs member's calls to the Provider. • Answering system with explicit instructions on how to reach the provider and emergency instructions	Must be available 24 hours a day, 7 days a week.
Specialists	30 Business days- Adults 30 Calendar days- Children
In-Office Wait Time (scheduled appointments)	Not to exceed 30 minutes. Offices must maintain records indicating member appointment arrival time and the actual time the member was seen by a provider.
Telephone Wait Time to Answer	Within 30 seconds
Return Telephone Call	Within 30 minutes
Office Hours	Minimum of 3 days/30 hours per week

MEMBER GRIEVANCES AND APPEALS PROCESS

LIBERTY MEDI-CAL DENTAL

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

By Phone:

- Los Angeles County members call: 888-703-6999
- Sacramento County members call: 877-550-3875
- TTY/TDD: 877-855-8039

Online:

- https://www.libertydentalplan.com/Legal/Grievances.aspx

In Writing:

LIBERTY Dental Plan
Grievances & Appeals Department
PO Box 26110,
Santa Ana, CA 92799-6110

By Fax:

- 1-833-250-1814

IMPORTANT INFORMATION

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

- Grievances: Members can file a grievance at any time following any incident or action that is the subject of their dissatisfaction.
- Appeals: Members have the right to request an appeal of a decision made by LIBERTY to deny, modify, or pend (delay) a request for payment or treatment, within sixty (60) calendar days from the date of the Notice of Action (NOA) issued by the Plan.
    - Providers submitting an appeal on behalf of a member, must obtain and supply LIBERTY with a copy of a signed document from the member indicating consent for the appeal to be filed on his/her behalf. If LIBERTY does not receive such a document, the appeal cannot be processed.
- Continuation of Benefits: Members who are currently receiving treatment that they want to continue, must submit a request to the Plan within ten (10) calendar days from the date the letter was postmarked or delivered to them, or before the date the health plan states that services will stop.

- The member's appeal must state that they want to continue receiving treatment during the appeal process.
- If a member's benefits are continued pending the outcome of an Appeal or Fair Hearing, LIBERTY will notify the provider.
- If the final resolution of the appeal or the State Fair Hearing upholds the Plan's initial adverse benefit determination, the member may be held financially responsible for the cost of the services furnished during the appeal and/or state fair hearing processes.

- Independent Medical Review (IMR): Members who receive a Notice of Appeal Resolution (NAR) from LIBERTY that was denied due to medical necessity, or experimental/investigational may request IMR within one-hundred-eighty (180) calendar days from the date of the NAR letter.
- State Fair Hearings: Medicaid members who receive a NAR from LIBERTY, that is not fully in their favor, may request a State Fair Hearing no later than one-hundred-twenty (120) calendar days from the date on the NAR letter.
  - Members may represent themselves at the State Fair Hearing, or be represented by a friend, lawyer, or any other person. If they want someone else to represent them, they are responsible for making the arrangements. Members are informed that to get free legal assistance, they may call the Public Inquiry and Response Unit of the Department of Social Services at their toll-free number, 1-800-952-5253.
  - Requesting a State Fair Hearing will not affect a member's eligibility for coverage, and members will not be penalized for seeking a hearing. Members may request benefit continuation during an appeal, IMR, or State Fair Hearing by contacting LIBERTY's Member Services Department toll-free for GMC at 877-550-3875 and for PHP at (888) 703-6999 (TTY/TDD 877-855-8039).
- Expedited/Fast Track Review: In cases in which a member's health or dental function is in immediate danger a request for an expedited grievance, appeal, State Fair Hearing, or IMR may be requested. All requests for expedited review, that meet the criteria, will be resolved within (72) hours from the time of receipt.
  - Please reference Section 12. Quality Management for more information on the member grievance and appeals process.

ANTI-DISCRIMINATION

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

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

TELE-DENTISTRY

Medi-Cal dental Providers have the flexibility to use tele-dentistry as a modality to render services based upon service categories and parameters, using designated CDT codes as is the current policy, when in compliance with ALL the following requirements:

- The procedure is a diagnostic (D0100-D0999) or preventive (D1000-D1999) service. Tele-dentistry is not allowable for all other service categories and CDT codes (D2000-D9999) except D9995 and D9996, which are the tele-dentistry modality codes; and D9430 office visit observation is billable with code D9995
- Dental provider billing for services delivered via tele-dentistry must be enrolled as Medi-Cal dental providers. The dental provider rendering Medi-Cal covered benefits or services via a tele-dentistry modality must be licensed in California, enrolled as a Medi-Cal Dental rendering provider, operate within their allowable scope of practice, and meet applicable standards of care.
- Providers must inform the patient before the initial delivery of tele-dental services about the use of tele-dentistry and obtain verbal or written consent from the patient for the use of tele-dentistry as an acceptable mode of delivering dental care services. Providers also need to document when a patient consents to receive services, and such documentation must be maintained in the patient's medical (dental) record.
- All services rendered through tele-dentistry must comply with the Manual of Criteria, including documentation requirements to substantiate the corresponding technical and professional components of billed CDT codes.
- A patient who receives tele-dentistry services under these provisions shall also have the ability to receive in-person services from the dentist or dental practice or assistance in arranging a referral for in-person services.

- The referral to the dentist or dental practice must be documented to use asynchronous tele-dentistry to establish a patient relationship.
- The procedure does not require an in-person presence of the patient in a dental facility, such as administration of anesthesia, direct visualization, or instrumentation of the mouth by a licensed dentist.
- Procedures do not involve the insertion/removal of dental devices or products – such as crowns, implants, removable partials or dentures, or orthodontic appliances.
- Tele-dentistry CDT codes
    - D0100-D0999
    - D1000-D1999D9430
    - D 9994 (Added 12/1/2024)

SECTION 6. SUMMARY OF PLAN OFFERINGS

DHMO – Select *Not applicable to Medi-Cal Dental
Dental Health Maintenance Organization Network (DHMO) – Dentist compensation consists of fixed monthly payments (capitation), member charges (copayments), and procedural guarantee payments for specific plans. Monthly capitation payments are issued on the twenty (20th) day of each month and will reflect the members listed on the monthly roster. Members can select any contracted participating provider in the DHMO network as their primary care dentist. A referral from the member's primary care dentist will be required to see a specialist unless specifically noted otherwise.

DHMO (Co-payment only) *Not applicable to Medi-Cal Dental
Dental Health Maintenance Organization Network (DHMO) – Dentist compensation consists of member charges (copayments). Depending on the member's plan benefits, additional reimbursement from LIBERTY may be available for specific services.

DHMO – Choice *Not applicable to Medi-Cal Dental
DHMO – Choice Network dentists are compensated on a contracted fee schedule, less applicable member's copayment. Offices are encouraged to submit claims each month to ensure timely payment.

DHMO Benefit Copayment Schedules *Not applicable to Medi-Cal Dental
Benefit Copayment Schedules are available by logging into the Provider Portal or by contacting the Provider Service Line at 800-268-9012 (TTY 877-855-8039).

MEMBER BENEFITS

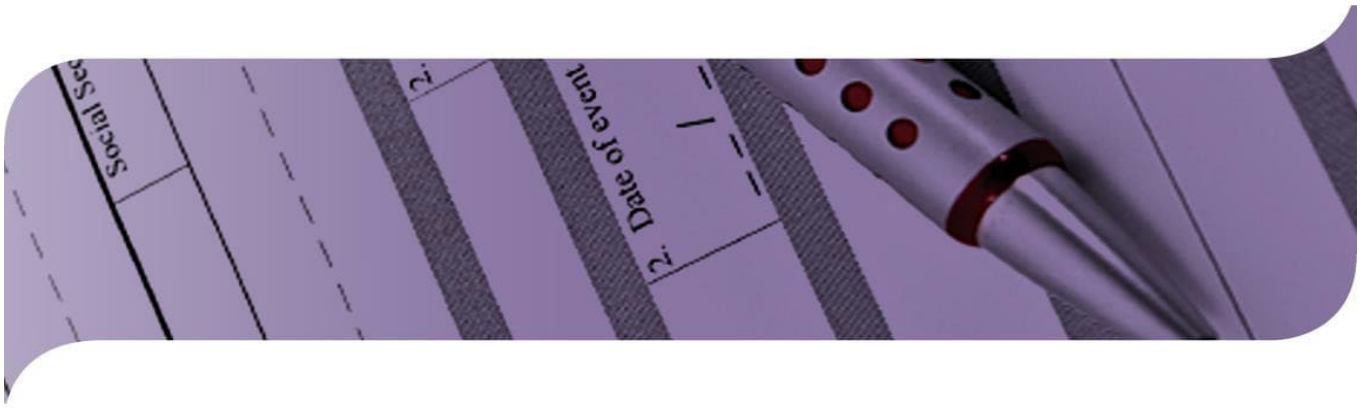
Members cannot be charged more than their allowable copayments and coinsurance amounts. Members cannot be charged for non-covered services, unless the member has been properly informed of all covered and non-covered services, and your office has obtained an adequate informed consent form signed

by the member consenting to treatment and accepting financial responsibility. Before recommending or completing any non-covered service, members must first receive a full explanation of the treatment plan options available as covered benefits under the member's dental plan.

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

Dental providers and offices that do not obtain adequate informed consent from members, as described above, may be required to provide full reimbursement to the member for any non-covered services completed.

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



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

ELECTRONIC SUBMISSION

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

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

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

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

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

PAPER CLAIMS

Paper claims must be submitted on ADA-approved claim forms. You can find the ADA claim forms on LIBERTY's website at https://www.libertydentalplan.com/Resources/Documents/ADA-Claim-Form.pdf.

Please mail all paper claim/encounter forms to:

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

CLAIMS SUBMISSION REQUIREMENTS

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

1. All claims must be submitted to LIBERTY for payment for services no later than six (6) months or one hundred and eighty (180) days after the date of service.
2. Your National Provider Identifier (NPI) number and tax ID are required on all claims. Claims submitted without these numbers will be rejected. All health care providers, health plans, and clearinghouses are required to use the National Provider Identifier number (NPI) as the ONLY identifier in electronic health care claims and other transactions.
3. All claims must include the name of the program under which the member is covered and all the information and documentation necessary to adjudicate the claim.

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

CLAIMS STATUS INQUIRY

There are two (2) options to check the status of a claim:

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

CLAIMS STATUS EXPLANATION

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

CLAIMS RESUBMISSION

Providers have three hundred and sixty-five (365) calendar days from the date of service to request a resubmission, reconsideration, or dispute of a claim that was previously denied for:

- Missing documentation
- Incorrect coding
- Processing errors

CLAIMS OVERPAYMENT

The following paragraphs describe the process that will be followed if LIBERTY determines that it has overpaid a claim. Claims submitted by any contracted provider who was not licensed when the services were rendered will be considered overpayments.

NOTICE OF OVERPAYMENT OF A CLAIM

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

CONTESTING A NOTICE OF OVERPAYMENT OF A CLAIM

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

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

NO CONTEST OF OVERPAYMENT OF A CLAIM

If the provider does not contest LIBERTY's notice of overpayment of a claim, the provider must reimburse LIBERTY within thirty (30) business days of the provider's receipt ofthe notice of overpayment of a claim. If the provider fails to reimburse LIBERTY within thirty (30) business days of receipt of an overpayment demand letter for a claim, LIBERTY is authorized to offset (recoup) the uncontested notice amount of the overpayment from the provider's current and future claim submissions.

OFFEST TO PAYMENTS

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

1. The provider fails to reimburse LIBERTY within the timeframe set forth above, and
2. LIBERTY's contract with the provider specifically authorizes LIBERTY to offset (recoup) 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 under 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. Becoming a non-contracted provider will not change any overpayments incurred during a provider's contracted period.

AB 3275: Health Care Coverage: Claims Reimbursement. Effective 01/01/2026

1. Liberty and any of Liberty's delegated entities will reimburse a complete claim, or portion of a claim, as soon as practicable, but no later than thirty (30) calendar days after receiving the claim. If a claim, or portion of a claim, does not meet the criteria for a complete claim or for coverage under Liberty's contract, the claimant will be notified in writing that the claim, or portion thereof, is contested or denied, as soon as practicable, but no later than thirty (30) calendar days after receipt.
2. Liberty will automatically pay interest on complete claims that are not reimbursed within thirty (30) calendar days, at a rate of 15 percent per year, beginning on the first calendar day after the thirty (30) calendar day period. If Liberty does not comply with this requirement for a claim, the claimant will also be paid a fee equal to the greater of an additional fifteen dollars ($15) or 10 percent of the accrued interest on the claim.
3. If a claim, or portion of a claim, is contested, Liberty will identify the contested claim or contested portion by procedure code and specify the information needed from the provider to reconsider the claim. The notice will include any defect, impropriety, or additional information required to adjudicate the claim.
4. Liberty will not contest a claim that is consistent with the procedure codes and services approved through prior authorization, when the appropriate documentation is included with the claim submission.
5. If a claim, or portion of a claim, is denied, Liberty will identify the denied claim or denied portion by procedure code and state the specific reasons for the denial, including any defect or impropriety.

6. If a claim, or portion of a claim, is contested because Liberty has not received the information reasonably necessary to determine payer liability, Liberty will complete reconsideration of the claim within thirty (30) calendar days after receiving the additional information.

SECTION 8. COORDINATION OF BENEFITS

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

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

IDENTIFY THE PRIMARY CARRIER

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

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

PATIENT IS THE MEMBER	PRIMARY
Member has dental coverage through an employer.	Member coverage is always primary.
Member has dental coverage as an active employee and through the spouse.	Member coverage is primary.
Member has two active insurance carriers; both provide dental coverage.	The carrier with the earliest effective date is the primary.

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

PATIENT IS THE MEMBER	PRIMARY
Member has dental coverage through a retiree plan and a government-funded plan.	The government-funded plan is the primary plan.
Dependent Child and the Birthday Rule.	1. The plan of the parent whose birthday falls earlier in the calendar year (month and day only) holds the primary coverage for dependent children. 2. If both parents have the same birthday, the plan that has covered either of the parents the longest is the primary plan. However, if the other plan follows the "gender rule" with male coverage always primary, LIBERTY will follow the rules of that plan. 3. These rules may be superseded by a court order that establishes the party responsible for the child's coverage. When determining the primary carrier for dependents with dual coverage, verify that both parents are the biological parents before applying the birthday rule. 4. Coverage through the biological parent is primary.
If coverage is through a biological parent and a stepparent residing in the same household.	The biological parent's plan is the primary plan.

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

SCENARIOS FOR COB:

When Member has two (2) Managed Care Plans (DHMO-CAP program)

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

Examples:

CDT Code	Carrier	Copayment	Member's Portion	Determination
D7240	Plan #1 Plan #2	$150.00 $125.00	$125.00	The plan with the lesser copayment
D7240	Plan #1 Plan #2	$100.00 Not Covered	$100.00	The plan with the covered benefit

WHEN LIBERTY IS PRIMARY CARRIER

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

WHEN LIBERTY IS SECONDARY CARRIER

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

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

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

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

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

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

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

Example #1:

Standard Calculation (before COB)				
Insurer	SubmittedFee	AllowedFee	Member'sPortion	Plan Pays Office
Primary Carrier	$325.00	$137.00	$67.40	$69.60 ($137 - $67.40)
LIBERTY	$325.00	$81.00	$55.00	$26.00 ($81 - $55.00)

After applying COB:

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

Example #2:

Standard Calculation (before COB)				
Insurer	SubmittedFee	AllowedFee	Member'sPortion	Plan Pays Office
Primary Carrier	$325.00	$137.00	$67.40	$69.60 ($137 - $67.40)
LIBERTY	$325.00	$150.00	$55.00	$95.00 ($150 - $55.00)

After applying COB:

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

SECTION 9. PROFESSIONAL GUIDELINES AND STANDARDS OF CARE

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

PROVIDER RESPONSIBILITIES AND RIGHTS

- Provide and/or coordinate all dental care for members.
- Perform an initial dental assessment.
- Work closely with specialty care providers to promote continuity of care.
- Maintain adherence to LIBERTY's Quality Management and Improvement Program.
- Identify dependent children with special health care needs and notify LIBERTY of these needs.
- Notify LIBERTY of a member's death.
- Arrange coverage by another provider when away from the dental facility.
- Ensure that emergency dental services are available and accessible 24 hours a day, 7 days a week through primary care dentists.
- Maintain scheduled office hours.
- Maintain dental records for no less than ten (10) years.
- Document the member's preferred language and request/refusal of interpreting services in the dental chart.
- Post the availability of language assistance services signage in the provider office.
- Provide language assistance services to members when requested.
- Provide updated credentialing information upon renewal dates.
- Provide requested information upon receipt of member grievance/complaint within three (3) business days of the notice letter from LIBERTY.

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

SPECIALTY CARE PROVIDERS RESPONSIBILITIES & RIGHTS

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

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

ANTI-DISCRIMINATION

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

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

ANTI-DISCRIMINATION AGAINST GENDER IDENTITY AND SEXUAL ORIENTATION

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

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

NATIONAL PROVIDER IDENTIFIER ("NPI")

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

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

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

HOW TO APPLY FOR AN NPI

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

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

VOLUNTARY PROVIDER CONTRACT TERMINATION

Providers must give LIBERTY at least ninety (90) days advance notice of intent to terminate a contract. Provider must continue to treat members until the last day of the month following the date of termination.

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

MATERIAL MODIFICATIONS

LIBERTY is committed to providing Providers with a forty-five (45) day written notification before any material modifications as required by applicable law.

STANDARDS OF ACCESSIBILITY

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

COMPLIANCE WITH THE STANDARDS OF ACCESSIBILITY AND AVAILABILITY

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

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

California Dental Appointment Accessibility Standards (Non Medi-Cal Dental)	
Type of Appointment	**Appointment Scheduling/Wait Time**
After-Hours/Emergency Availability All providers must have at least one (1) ofthe following: • Answering service that will contact the provider on behalf of the member. • Call forwarding system that automatically directs member's calls to the Provider. • Answering system with explicit instructions on how to reach the provider and emergency instructions.	24 hours a day, 7 days a week.
Emergency Care (acute pain/swelling/bleeding)	As soon as the member's condition requires, not later than 24 hours
Urgent Care (Lost crown, broken filling)	As soon as the member's condition requires, no later than 72 hours
Initial (exams, and x-rays)	36 business days
Routine Care, Non-Emergency (restorative care)	36 business days
Preventive Care (prophylaxis or periodontal care)	40 business days

California Dental Appointment Accessibility Standards (Non Medi-Cal Dental)	
Appointment Scheduling/Wait Time	
Specialty	Within 30 calendar days of the authorized request – child Within 30 business days of the authorized request – adult
In-Office Wait Time (Scheduled appointments)	For scheduled appointments. Not to exceed 30 minutes. Offices must maintain records indicating member appointment arrival time and the actual time the member was seen by the provider.
Telephone Wait Time to Answer	Within 30 seconds
Return Telephone Call	Within 30 minutes
Office Hours	Minimum of 3 days/30 hours per week

AFTER HOURS AND EMERGENCY SERVICES AVAILABILITY

The provider's after-hours response system must enable members to reach an on-call dentist 24 hours a day, 7 days a week. In the event the primary care provider is not available to see an emergency patient within twenty-four (24) hours, it is his/her responsibility to make arrangements to ensure that emergency services are available. Members requiring after-hours emergency dental services must receive an assessment by telephone from the provider within one (1) hour of the time the member contacts the provider's "after-hours" telephone service.

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

FACILITY PHYSICAL ACCESS FOR THE DISABLED – AMERICANS WITH DISABILITIES ACT

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

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

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

APPOINTMENT RESCHEDULING

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

RECALL, FAILED OR CANCELLED APPOINTMENTS

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

INTERPRETER SERVICES

Interpreter services should be coordinated with scheduled appointments for dental services in a manner that ensures the provision of interpreter services at the time of the appointment. See Page 49 for more information.

TREATMENT PLAN GUIDELINES

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

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

LIBERTY provides an alternative treatment plan form available on our website at: LDP_Informed_Consent_Treatment_Form_Updated_ENG.pdf (libertydentalplan.com)

Note: Most plans allow for an upgrade to noble and high noble metal and porcelain on molar teeth with informed consent by the Member. Please reference the members' dental benefits information for LIBERTY's clinical guidelines for inlay, onlay, and crown coverage. *Not applicable to Medi-Cal Dental

SECOND OPINIONS

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

CONTINUITY AND COORDINATION OF CARE

LIBERTY ensures appropriate and timely continuity and coordination of care for all plan members. A panel of network dentists shall be available in currently assigned counties from which members may select a provider to coordinate all their dental care. All care rendered to LIBERTY members must be properly documented in the patient's dental charts according to established documentation standards.

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

- An enrollment packet contains a list of Providers that is given to all members upon enrollment.
- A current list of Providers is maintained on LIBERTY's website at www.libertydentalplan.com.
- If a member has not selected Provider within thirty (30) days of enrollment, a reminder postcard notifying the member of their "automatic assignment" will be sent within ten (10) days after assignment of his/her Provider (for capitation plans).
- Members who do not select a Provider will be assigned one, based on the member's geographic location (for capitation plans).
- Dental chart documentation standards are included in this provider guide. Dental chart audits will verify compliance with documentation standards.
- Guidelines for adequate communications between the referring and receiving providers, when members are referred for specialty dental care, are

included in this provider guide.

- During facility on-site audits, LIBERTY monitors compliance with continuity and coordination of care standards.
- When a referral to a specialist is authorized, the Provider is responsible for evaluating the need for follow-up care after specialty care services have been rendered and scheduling the member for any appropriate follow-up care.
- When a specialty care referral is denied, the Provider is responsible for the evaluation of the need to perform the services directly and schedule the member for appropriate treatment.
- The results of site audits shall be reported to the Quality Management Committee, and corrective action shall beimplemented when deficiencies are identified.

COMMUNITY HEALTHCARE WORKER (CHW) DENTAL SERVICES

Effective December 1, 2024, CHWs, with appropriate training, may provide dental education to improve oral health. Supervising providers are responsible to verify and monitor CHW training and must ensure CHW services comply with all requirements listed in APL 25-012.

- Supervising providers must submit a signed Liberty Dental Plan "Attestation of Community Health Workers" form prior to rendering CHW services. (see forms listed on pg 97)
- Claims for CHW services must be submitted by a supervising enrolled dental provider using code D9994, and include:
    - CHW's name
    - Number of units
    - Training times (e.g., 11:00 AM – 12:00 PM)

- Documentation of CHW services must be maintained in the members' chart and submitted to Liberty as requested, including CHW name, number of units, training times and nature of services rendered to substantiate time spent with member.
- Coverage for in-person CHW services allows up to four, 30 minute units (two hours) per day per member.
- Coverage for CHW services via teledentistry allows up to three, 30 minute units (1.5 hours) per day, per member.
- If CHW is conducted via teledentistry, D9995 is not payable when billed with D9994.
- There is a maximum 12 units of D9994 allowed annually. Additional units require prior authorization from the plan.

CULTURALLY COMPETENT CARE

Per 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 promptly and compatible with their culture, health beliefs, practices, and preferred language. LIBERTY collaborates and participates with applicable state and regulatory agencies to promote the delivery of care in a culturally competent manner.

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

LANGUAGE ASSISTANCE SERVICES

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

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

- Interpretation services, including American Sign Language, are available at no cost to members, 24 hours a day, 7 days a week by contacting LIBERTY's Member Services Department at 800-268-9012 (TTY/TDD 877-855-8039).
- To engage an interpreter once the member is ready to receive services, please call 800-268-9012 (TTY/TDD 877-855-8039).
- You will need the member's LIBERTY Dental ID number, date of birth, and the member's full name to confirm eligibility and access to interpretation services. It is not necessary to arrange for these services in advance.
- A Provider covered by HIPAA, is not required to collect an individual's authorization to disclose PHI when using an interpreter to communicate with a member, as defined in federal regulation 45 CFR 160.103 and 164.506.
- LIBERTY discourages the use of family or friends as interpreters. Family members, especially children, should not be used as interpreters in assessments, therapy, and other situations where impartiality is critical.
- Providers must also fully inform the member that he or she has the right not to use family, friends, or minors as interpreters.
- Providers and dental office staff are required to coordinate language assistance services, upon request by the member.

- When in-person interpretation services is not available, provider must coordinate telephonic interpretation services for the member.
- If a member prefers not to use the interpretation services after s/he has been told that a trained interpreter is available free of charge, the member's refusal to use the trained interpreter shall be documented in the member's dental record, when in a provider setting, or the member's administrative file (call tracking record) in the Member Services setting.
- Language preferences of members will be available to directly contracted dentists upon request through telephone inquiries, and only for those members entitled to receive such services by virtue of state requirements or client group requirements.
- 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.

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA)

LIBERTY takes pride in the fact that we administer our dental plan effectively and innovatively 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) and all subsequent revisions. LIBERTY requires all dental providers to comply with HIPAA laws, rules, and regulations.

LIBERTY reminds network providers, that under the signed Provider Agreement (Contract), providers agree to abide by all HIPAA requirements and Quality Management Program requirements. Member-protected Personal Health Information (PHI) may be shared with LIBERTY as per the requirement in the HIPAA laws that enables the sharing of such information for Treatment, Payment, and Health Care Operations (TPO), as well as for peer review and quality management and improvement requirements of health plans. There is no need for special member authorizations when submitting member PHI for these purposes.

OUR COMMITMENT IS DEMONSTRATED THROUGH OUR ACTIONS

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 healthcare provider and covered entity, you and your staff must follow HIPAA guidelines regarding PHI.

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

PROTECTED HEALTH INFORMATION (PHI)

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

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

ELECTRONIC PHI

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

Note the following:

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

- Transmission of PHI via text is not permitted.

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

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

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

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

VERBAL PHI

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

BEST PRACTICES INCLUDE:

- Implementing appropriate physical safeguards such as closed doors and insulated walls for exam rooms and operatories.
- Implementing ambient music or white noise to cover conversations in common areas.
- Arranging waiting areas to minimize one member overhearing conversations with another.
- Posting a sign requesting that members who are waiting to sign in or be seen do not congregate in 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. Avoid the use of speaker phones.

TANGIBLE PHI

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

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

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

MEMBER RIGHTS AND RESPONSIBILITIES

LIBERTY California Medi-Cal members are entitled to the following rights:

- A member has the freedom to exercise these rights without adversely affecting how they are treated by LIBERTY, network providers, or the state.
- A member is free from any form of restraint or seclusion that is used as a means to coercion, discipline, convenience, or retaliation when making decisions about his or her care.
- A member has the right to be treated with courtesy and respect, with an appreciation of his or her dignity, consideration of the member's rights to privacy, and the need to maintain confidentiality of medical and dental information.
- A member has the right to receive pertinent written, and up-to-date information about LIBERTY, the managed care services LIBERTY provides, the network providers and dental office, as well as Member Rights and Responsibilities.
- A member has the right to be given information about the Plan and its services, including covered benefits.
- A member has the right to request care coordination, if necessary.
- A member has the right to a prompt and reasonable response to questions and requests, including information about the definition of emergency care.
- A member has the right to know who is providing medical services and who is responsible for his or her care.
- A member has the right to be provided with information on disenrollment requirements, limitation, and to disenroll upon request.
- A member has the right to know what member support services are available, including access to a no-cost interpreter if he or she does not speak English.
- A member has the right to know what rules and regulations apply to his or her conduct.
- A member has the right to choose his or her Primary Care Dentist in the Plan's network upon enrollment, including Federally Qualified Health Centers, Rural Health Clinics, or Indian Health Service Facilities that meets the cultural and racial needs of the member.
- A member has the right to access emergency dental services outside of the Plan's network.
- A member has the right to be given by the health care provider information concerning diagnosis, planned course of treatment, alternatives, risks, and prognosis.
- A member has the right to request information regarding the decision-making of their dental care.

- A member has the right to refuse any treatment, except as otherwise provided by law.
- Emancipated minors have the right to make decisions regarding their dental care, with the appropriate legal documentation.
- A member has the right to receive a copy of a reasonably clear and understandable, itemized bill and upon request to have the charges explained.
- A member has the right to be given, upon request, full information, and necessary counseling on the availability of known financial resources for his or her care.
- A member who is eligible for Medicare has the right to know, upon request and in advance of treatment, whether the health care provider or health care facility accepts the Medicare assignment rate.
- A member has the right to receive, upon request, before treatment, a reasonable estimate of charges for dental care.
- A member has the right to choose a PCD within LIBERTY's network, at any given time including upon enrollment, that meets the member's cultural, linguistic, and racial needs.
- A member has the freedom to change his or her PCD upon request for any reason and as frequently as needed.
- A member has the right to receive a copy of a reasonably clear and understandable, itemized bill and, upon request, to have the charges explained.
- A member has the right to impartial access to medical treatment or accommodations, regardless of race, national origin, sexual orientation, religion, handicap, or source of payment.
- A member has the right to treatment for any emergency medical condition that will deteriorate from failure to provide treatment, without prior authorization.
- A member has the right to know if medical treatment is for purposes of experimental research and to give his or her consent or refusal to participate in such experimental research.
- A member has the right to file a grievance and appeals system verbally, in writing, online, or in person.
- A member has the right to file a grievance verbally, in writing, online, or in person about LIBERTY, a network provider, dental office staff, any care received, or any other aspect s that are part of his or her dissatisfaction.
- A member has the right to express grievances regarding any violation of his or her rights, as stated in the applicable state law, through the grievance procedure of the health care provider or health care facility that served him or her and to the appropriate state licensing agency.

- A member has the right to request an appeal of any denial/adverse benefit determination, or notice of action, within the applicable timeframes as mandated by applicable state and federal laws, either verbally, in writing, online or in person.
- A member has the right to request an expedited review of a grievance or appeal for cases involving imminent and serious threats to his or her health.
- A member has the right to request a state fair hearing with an Administrative Law Judge, including information on the circumstances in which an expedited state fair hearing is possible.
- A member has the right to request a no-cost second opinion with a general dentist or specialist.
- A member has the right to get no-cost written member information in other formats (such as braille, large-size print, audio and accessible electronic formats) upon request and in a timely manner appropriate for the format being requested, including grievances and appeals notices.
- A member has the right to formulate an advance directive, living will, or another type of directive to provide to a medical professional.
- A member has the right to access the health information about them as provided by 45 CFR 164.524, including the right to inspect or obtain a copy, or both.
- A member has the right to request in writing the transmission of their PHI to another person or entity they designate as specified by 45 CFR 164.524(c)(3).
- A member has the right to amend their protected health information as provided by 45 CFR 164.526.
- A member has the right to receive an accounting of disclosures as provided by 45 CFR 164.528.
- A member has the right to request restriction of the uses and disclosures of their information, including the right to receive confidential communications as provided by 45 CFR 164.522.
- A member has the right to request a printed copy of the Member Handbook at least once per year or more frequently, if necessary.
- A member has the freedom from LIBERTY prohibiting or restricting a providers from advocating on behalf of a member.
- A member has the right to access LIBERTY's health education programs and outreach services in order to improve dental health.
- A member has the right to make recommendations regarding LIBERTY's Member Rights and Responsibilities polices.

LIBERTY California Medi-Cal member has the following responsibilities to behave according to the standards:

- A member is responsible for providing the health care provider, to the best of his or her knowledge, accurate and complete information about present complaints, past illnesses, hospitalizations, medications, and other matters relating to his or her health.
- A member is responsible for ensuring that another person does not use California Medi-Cal medical or dental identification cards.
- A member is responsible for communicating any changes in demographic or dependent information, or other changes that would affect eligibility to the Department of Health Care Services (DHCS.)
- A member is responsible for reporting unexpected changes in his or her condition to the health care provider.
- A Member is responsible for informing LIBERTY and the DHCS of any dual insurance coverage.
- A member is responsible for reporting to the health care provider whether he or she comprehends a contemplated course of action and what is expected of him or her.
- A member is responsible for routinely scheduling appointments for dental care and to be on time for all scheduled appointments.
- A member is responsible for keeping scheduled appointments and communicating at least twenty-four (24) in advance when he or she is unable to do so for any reason.
- A member is responsible for actively taking part in his or her treatment decisions, and actions if he or she refuses treatment or does not follow the healthcare provider's instructions.
- A member is responsible for cooperating with LIBERTY's network providers in following a prescribed course of treatment, including instructions and oral health care commendations and guidelines provided.
- A member is responsible for reporting to his or her dental provider whether he or she understands the recommended course of treatment, actions, and what is expected of him or her.
- A member is responsible for asking his or her dental provider or other provider about treatment if they do not understand.
- A member is responsible for communicating and providing feedback on their needs and expectations to LIBERTY and his or her dental provider.
- A member is responsible for assuring that the financial obligations of his or her health care are fulfilled as promptly as possible.
- A member is responsible for respecting and following the policies and guidelines given by LIBERTY's network providers, provider staff, and LIBERTY administrative staff with respect and courtesy.

- A member is responsible for knowing and following LIBERTY guidelines and healthcare facility rules and regulations affecting patient care and conduct when seeking dental care.
- A member is responsible for reporting any suspected fraud, waste, or abuse to LIBERTY and the DHCS.

CONFIDENTIAL COMMUNICATIONS FOR SENSITIVE SERVICES

California law states that members can request confidential communications regarding the receipt of sensitive services. These types of services can include:

- Bills and attempts to collect payment
- A Notice of Adverse Benefit Determination(s)
- An Explanation of Benefits notice(s)
- A Plan's request for additional information regarding a claim
- A notice of a contested claim
- The name and address of a provider, description of services received, and other information related to a visit.
- Any verbal, written, or electronic communications from the Plan that contain protected health information.

To request confidential communications from LIBERTY for any of the services listed above, please call Member Services or you can submit a request in writing by mail the following:

- By mail to: LIBERTY Dental Plan, P.O. Box 26110, Santa Ana, CA, 92799-6110
- By telephone to: LIBERTY's Member Services at (888) 703-6999 or TDD/TTY: (877) 855-8039

CLINICAL CRITERIA GUIDELINES (CCG)

A. Please refer to the MOC for criteria, process, and benefits for Medi-Cal Dental members: https://www.dental.dhcs.ca.gov/MCD_documents/providers/provider_handbook/PHB_section_05_MOC_SMA.pdf
B. For additional information please reference the CCG online at: https://www.libertydentalplan.com/Resources/Documents/National-Clinical-Criteria-Guidelines.pdf.

LIBERTY's Clinical Criteria, Guidelines and Practice Parameters (CCG) are developed by LIBERTY's Dental Directors with input from participating panel general dentist 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), and clinical principals within the dental community standards.

The Clinical Criteria Guidelines are available on LIBERTY's website at the following link or by scanning the QR code:

Link to PDF:
https://www.libertydentalplan.com/Resources/Documents/2023_Clinical_Criteria_Guidelines_Practice_Parameters.pdf

If you would like a copy of LIBERTY's CCG, please contact Member Services at 888-703-6999 (TTY/TDD 877-855-8039) or you can go online to https://www.libertydentalplan.com/Resources/Documents/National-Clinical-Criteria-Guidelines.pdf

The Medi-Cal Dental Manual of Criteria (MOC) is available online at https://www.dental.dhcs.ca.gov/MCD_documents/providers/provider_handbook/

PHB_section_05_MOC_SMA.pdf

DISCLAIMER: Please note that 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.

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

Outcomes

A. Please refer to the MOC for criteria, process, and benefits for Medi-Cal Dental members: https://www.dental.dhcs.ca.gov/MCD_documents/providers/provider_handbook/PHB_section_05_MOC_SMA.pdf
B. For additional information please reference the CCG online at: https://www.libertydentalplan.com/Resources/Documents/National-Clinical-Criteria-Guidelines.pdf
   - If you would like a copy of the CCG, please contact Member Services at 800-268-9012 (TTY/TDD 877-855-8039).

FIXED PROTHODONTICS

A. Please refer to the MOC for criteria, process, and benefits for Medi-Cal Dental members:

   https://dental.dhcs.ca.gov/MCD_documents/providers/MOC_CDT24_Feb_24.pdf
B. For additional information please reference the CCG online at: https://www.libertydentalplan.com/Resources/Documents/National-Clinical-Criteria-Guidelines.pdf
   a. If you would like a copy of the CCG, please contact Member Services at 800-268-9012 (TTY/TDD 877-855-8039).
C. When a single posterior tooth is missing on one side of an arch and there are clinically acceptable abutment teeth on each side of the missing tooth, the general choice to replace the missing tooth would be a fixed bridge or implant.
D. When it is necessary to replace teeth on the opposite side of the same arch, the benefit would generally be a removable partial denture instead of a fixed bridge.
E. When up to all four incisors are missing in an arch, the potential abutment

teeth are clinically adequate, and implants are not appropriate, possible benefits for a fixed bridge may be evaluated on a case-by-case basis.

1. Evaluation and diagnosis of any patient's periodontal status or active disease should be documented with recent full mouth periodontal probing and then submitted for any benefit determination request.

Outcomes

A. Please refer to the MOC for criteria, process, and benefits for Medi-Cal Dental members: https://www.dental.dhcs.ca.gov/MCD_documents/providers/provider_handbook/PHB_section_05_MOC_SMA.pdf

B. For additional information please reference the CCG online at: https://www.libertydentalplan.com/Resources/Documents/National-Clinical-Criteria-Guidelines.pdf

1. If you would like a copy of the CCG, please contact Member Services at 800-268-9012 (TTY/TDD 877-855-8039).

REMOVABLE PROSTHODONTICS

A. Please refer to the MOC for criteria, process, and benefits for Medi-Cal Dental members: https://www.dental.dhcs.ca.gov/MCD_documents/providers/provider_handbook/PHB_section_05_MOC_SMA.pdf

B. For additional information please reference the CCG online at: https://www.libertydentalplan.com/Resources/Documents/National-Clinical-Criteria-Guidelines.pdf

- If you would like a copy of the CCG, please contact Member Services at 800-268-9012 (TTY/TDD 877-855-8039).

C. Appliances should be designed to minimize any harm to abutment teeth and/or periodontal tissues and to facilitate oral hygiene.

Determination of Functional Occlusion:

A. To determine if a removable prosthetic is essential, eight posterior natural or prosthetic molars and/or bicuspids in occlusion will be considered adequate for functional purposes. Four (4) maxillary and four (4) mandibular teeth in functional contact are considered adequate. If it is determined that the member has eight posterior natural or prosthetic molars and/or bicuspids in occlusion, then the removable prosthetic may not be considered necessary.

B. Removable partial denture is normally not indicated for a single tooth replacement of non-functional second or third molars (i.e., no opposing occlusion), except when an anterior tooth is missing

C. Removable partial dentures are covered when posterior teeth require replacement on both sides of the same arch or multiple edentulous areas are present (excluding non-functional second or third molars). Remaining teeth must have a good endodontic prognosis, a good restorative prognosis, and a good periodontal prognosis
D. An interim partial denture may be needed when the remaining teeth have a good prognosis
E. A partial denture may be covered if the patient has an existing partial denture that is not serviceable, or an initial partial denture is being performed, and the patient has several missing teeth on both sides of the same arch
F. For a treatment plan that includes both a fixed bridge and a removable partial denture in the same arch, the removable partial denture is considered the covered service
G. A unilateral removable partial denture is rarely appropriate. Best practices include replacing unilateral missing teeth with a fixed bridge or implant
H. Endodontic, periodontal, and restorative treatment should be completed prior to fabrication of a removable partial denture
I. Abutment teeth should be restored prior to the fabrication of a removable partial denture and would be covered if the teeth meet the same standalone benefit requirements of a single crown
J. Removable partial dentures should be designed so that they do not harm the remaining teeth and/ or periodontal tissues, and to facilitate oral hygiene
K. Materials used for removable partial dentures must be strong enough to resist breakage during normal function, nonporous, color stable, esthetically pleasing, non-toxic, and non-abrading to the opposing or supporting dentition
L. Partial dentures with acrylic clasps (such as Valplast or others, also known as "Combo Partials") are considered under the coverage for Codes D5213 and D5214.
M. Proper patient education and orientation to the use of immediate complete or partial dentures should be part of the diagnosis and treatment plan. Educational materials regarding these prostheses are highly encouraged to avoid misunderstandings, and grievances, and to manage patient expectation

Complete Dentures (Codes D5110 / D5120)

A. Please refer to the MOC for criteria, process, and benefits for Medi-Cal Dental members: https://www.dental.dhcs.ca.gov/MCD_documents/providers/provider_handbook/PHB_section_05_MOC_SMA.pdf
B. For additional information please reference the CCG online at:

https://www.libertydentalplan.com/Resources/Documents/National-Clinical-Criteria-Guidelines.pdf

- If you would like a copy of the CCG, please contact Member Services at 800-268-9012 (TTY/TDD 877-855-8039).

Immediate Complete Dentures (Codes D5130-D5140 / D5221-D5224 / D5227-D5228)

A. Please refer to the MOC for criteria, process, and benefits for Medi-Cal Dental members: https://www.dental.dhcs.ca.gov/MCD_documents/providers/provider_handbook/PHB_section_05_MOC_SMA.pdf
B. For additional information please reference the CCG online at: https://www.libertydentalplan.com/Resources/Documents/National-Clinical-Criteria-Guidelines.pdf
   - If you would like a copy of the CCG, please contact Member Services at 800-268-9012 (TTY/TDD 877-855-8039).

Replacement of an Existing Complete or Partial Denture(s)

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

Repairs and Relines (Codes D5511-D5660)

A. Please refer to the MOC for criteria, process, and benefits for Medi-Cal Dental members: https://www.dental.dhcs.ca.gov/MCD_documents/providers/provider_handbook/PHB_section_05_MOC_SMA.pdf
B. For additional information please reference the CCG online at: https://www.libertydentalplan.com/Resources/Documents/National-Clinical-Criteria-Guidelines.pdf
   - If you would like a copy of the CCG, please contact Member Services at 800-268-9012 (TTY/TDD 877-855-8039).

IMPLANTS

A. Please refer to the MOC for criteria, process, and benefits for Medi-Cal Dental members: https://www.dental.dhcs.ca.gov/MCD_documents/providers/provider_hand

book/PHB_section_05_MOC_SMA.pdf

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

General Guidelines

A. A conservative treatment plan should be considered before providing a patient with one or more implants. Crown(s) and fixed partial prosthetics for dental implants may be contraindicated for the following reasons:
   1. Adverse systemic factors such as diabetes and smoking.
   2. Poor oral hygiene and tissue management by the patient.
   3. Inadequate osseointegration (movable) of the dental implant(s).
   4. Excessive parafunction or occlusal loading.
   5. Poor positioning of the dental implant(s).
   6. Excessive loss of bone around the implant before its restoration.
   7. Mobility of the implant(s) before placement of the prosthesis.
   8. Inadequate number of implants or poor bone quality for long-span prostheses.
   9. Need to restore the appearance of gingival tissues in high esthetic areas.
   10. When the patient is under sixteen (16) years of age, unless unusual conditions prevail.

Restoration

A. Please refer to the MOC for criteria, process, and benefits for Medi-Cal Dental members: https://www.dental.dhcs.ca.gov/MCD_documents/providers/provider_handbook/PHB_section_05_MOC_SMA.pdf

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

C. The restoration of dental implants differs in many ways from the restoration of teeth, and as such, the restoration of dental implants has separate guidelines.

D. Care must be exercised when restoring dental implants so that the occlusal and lateral loading of the prosthesis does not damage the integration of the dental implant system to the bone or affect the integrity of the implant system

itself.

E. Care must also be exercised when designing the prosthesis so that the hardness of the material used is compatible with that of the opposing occlusion.
F. Jaw relationship and intra-arch vertical distance should be considered in the initial treatment plan and selection of retentive and restorative appliances.

Outcomes

A. Please refer to the MOC for criteria, process, and benefits for Medi-Cal Dental members: https://www.dental.dhcs.ca.gov/MCD_documents/providers/provider_handbook/PHB_section_05_MOC_SMA.pdf
B. For additional information please reference the CCG online at: https://www.libertydentalplan.com/Resources/Documents/National-Clinical-Criteria-Guidelines.pdf
    - If you would like a copy of the CCG, please contact Member Services at 800-268-9012 (TTY/TDD 877-855-8039).

Orthodontic Services

California Children's Services (CCS services) are excluded ("carved-out") under LIBERTY Dental's Medi-Cal contract. LIBERTY Dental's participating providers are responsible for performing preliminary baseline health assessments and diagnostic evaluations to ascertain evidence or suspicion of a CCS-eligible condition or diagnosis. Potentially eligible members are referred to the local CCS Program for eligibility determination, comprehensive case management and prior authorization of services meeting the following criteria. These diagnoses are including but not limited to:

- Medi-Cal Member under 21 years of age
- Eligible for Medi-Cal benefits
- Cerebral Palsy
- Cystic fibrosis
- Hemophilia
- Certain heart diseases
- Certain cancers
- Traumatic injuries to the face and mouth
- Orthodontics to children with medically handicapping malocclusions, cleft lip/palate, and craniofacial anomalies

A. Please refer to the MOC for criteria, process, and benefits for Medi-Cal Dental members: https://www.dental.dhcs.ca.gov/MCD_documents/providers/provider_hand

book/PHB_section_05_MOC_SMA.pdf

B. For CCS eligibility guidelines please visit: https://www.dhcs.ca.gov/services/ccs/pages/medicaleligibility.aspx
C. For additional information please reference the CCG online at:
   - http://www.libertydentalplan.com/Resources/Documents/National-Clinical-Criteria-Guidelines.pdfIf you would like a copy of the CCG, please contact Member Services at 800-268-9012 (TTY/TDD 877-855-8039).

ADJUNCTIVE SERVICES

A. Please refer to the MOC for criteria, process, and benefits for Medi-Cal Dental members: https://www.dental.dhcs.ca.gov/MCD_documents/providers/provider_handbook/PHB_section_05_MOC_SMA.pdf
B. For additional information please reference the CCG online at: https://www.libertydentalplan.com/Resources/Documents/National-Clinical-Criteria-Guidelines.pdf

If you would like a copy of the CCG, please contact Member Services at 800-268-9012 (TTY/TDD 877-855-8039).

SECTION 11. SPECIALTY CARE REFERRAL GUIDELINES

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

Note: All codes listed in this section may not be covered under all benefit plans. Referrals are subject to a member's plan specific benefits, limitations, and exclusions. Please refer to the Patient Copayment Schedule for plan-specific details regarding procedure codes. Reimbursement of specialty services is contingent upon the member's eligibility at the time of service.

NON-EMERGENCY REFERRAL SUBMISSION AND INQUIRIES

General Dentist must submit a referral request to the Plan for prior approval. There are three options to submit a specialty care referral:

- Provider Portal:
  - https://www.libertydentalplan.com/Providers/Office-Vendor-Portal.aspx
- Telephone:
  - 800-268-9012
- Mail:

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

- If there is no contracted LIBERTY specialist available within reasonable proximity to your office, the Referral Unit will assist in referring the member to a non-contracted specialist.
- If a referral is made to a non-LIBERTY 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 payment of claims. The referral form can be found on the LIBERTY website at https://www.libertydentalplan.com/Providers/Provider-Resource-Library.aspx

The LIBERTY Specialty Care Referral Request Form or an attending dentist Statement must be completed and used when making a referral. The form may be photocopied and duplicated in your office as needed. The Specialty Care Referral Request Form can be found on the LIBERTY website at https://www.libertydentalplan.com/Providers/Provider-Resource-Library.aspx

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

EMERGENCY REFERRAL

If emergency specialty care is needed, the Referral Unit can issue an emergency authorization number to the General Dentist by calling LIBERTY's Referral Unit at 800-268-9012, Option 2 (TTY 877-855-8039).

ENDODONTICS

Teeth must have a good prognosis and be restorable to qualify for endodontic treatment. Endodontic referrals may be approved by report.

Referral Guidelines for the General Dentist

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

- Member's name, the Primary Member's name, LIBERTY identification number, group name, and group number.
- Name, address, and telephone number of the contracted LIBERTY network Endodontist.
- Procedure code(s), tooth number(s), and member copayments for the covered endodontic treatment, which requires a referral.

Inform the member that:

- Referral is only approved for services listed on the request from the referring General Dentist.
- The member will be financially responsible for non-covered and non-approved services provided by the Endodontist.

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

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

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

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

REFERRAL GUIDELINES FOR THE ENDODONTIST:

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

- For any services, other than those listed on the original authorization form from LIBERTY, you must submit a pre-estimate request to the Plan with a copy of pre-operative periapical radiograph(s) and of the member's LIBERTY Specialty Care Authorization.
- If an emergency endodontic service is needed but has not been listed on the original authorization form, the Endodontist should contact LIBERTY's Referral Unit at 800-268-9012, Option 2 for an emergency authorization number.
- After completion of treatment, submit your claim for payment with pre-operative and post-operative periapical x-ray(s). (To avoid delays in claim payment, please always attach a copy of the member's Authorization Form.)
- X-ray(s) and other supporting documentation will not be returned. Please do not submit the original x-ray(S). X-ray copies of diagnostic quality or paper copies of digitized images are acceptable. Faxed x-ray(s) are not of diagnostic quality and will not be accepted.

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

ORAL SURGERY

Teeth must exhibit active pathology and be outside the scope of the General Dentist to meet the following criteria. Referrals may be approved by report.

Referral Guidelines for the General Dentist:

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

- Member's name, the Primary Member's name, LIBERTY identification number, group name, and group number.
- Name, address, and telephone number of the contracted LIBERTY network Oral Surgeon.
- Procedure code(s) and, tooth number(s)/quadrant(s), which require referral.

Inform the member that:

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

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

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

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

Referral Guidelines for the Oral Surgeon:

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

- For any services, other than those listed on the referral from the patient's General Dentist, you must submit a preauthorization request to the Plan with a copy of pre-operative periapical radiograph(s) or panoramic radiograph and of the member's LIBERTY Specialty Care Authorization.
- If an emergency oral surgery service is needed but has not been listed by the General Dentist on the LIBERTY Specialty Care Authorization, the Oral Surgeon should contact LIBERTY's Referral Unit at 800-268-9012, Option 2 for an emergency authorization number.
- After completion of treatment, submit your claim for payment. To avoid delays in claim payment, please attach a copy of the member's LIBERTY Specialty Care Authorization or the Plan's authorization form. If emergency care was provided after obtaining a Plan emergency authorization number, print that number on the claim form and attach the radiograph(s). For a biopsy, also attach a copy of the laboratory's report.
- X-rays and other supporting documentation will not be returned. Please do not submit original X-rays. X-ray copies of diagnostic quality or paper copies of digitized images are acceptable.

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

ORTHODONTICS

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

Referral Guidelines for the General Dentist:

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

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

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

Inform the member that:

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

Referral Guidelines for the Orthodontist:

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

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

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

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

*Net payable claim amounts over $300.00 will be paid throughout active orthodontic treatment over twenty-four (24) months.

PEDIATRIC DENTISTRY

Referral Guidelines for the General Dentist:
GENERAL DENTISTS MUST MAKE AT LEAST ONE ATTEMPT TO SEE CHILDREN AGES 0-4 AND AT LEAST TWO ATTEMPTS FOR CHILDREN AGES 4-7.

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

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

Inform the member that:

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

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

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

Referral Guidelines for the Pediatric Dentist:

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

- For any services, other than those listed on the referral from the patient's assigned General Dentist, you must submit a pre-estimate request to the Plan with a copy of pre-operative periapical radiograph(s) and of the member's LIBERTY Specialty Care Authorization.
- If an emergency pediatric service is needed but has not been listed by the General Dentist on the LIBERTY Specialty Care Authorization, the Pediatric Dentist should contact the LIBERTY's Referral Unit at 800-268-9012, Option 2 for an emergency authorization number.
- After completion of treatment, submit your claim for payment with pre and post-operative periapical x-ray(s). To avoid delays in claim payment, please always attach a copy of the LIBERTY Specialty Care Authorization or the Plan's authorization for treatment when applicable.
- X-rays and other supporting documentation will not be returned. Please do not submit original X-rays. X-ray copies of diagnostic quality, including paper copies of digitized images, are acceptable.

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

PERIODONTICS

Referral Guidelines for the General Dentist:

A GENERAL DENTIST IS REQUIRED TO COMPLETE NON-SURGICAL SERVICES AND NECESSARY FOLLOW-UP EVALUATIONS. REFERRALS MAY BE APPROVED BY REPORT.

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

- Patient's name, the Primary Member's name, LIBERTY identification number, groupname, and group number.
- Name, address, and telephone number of the contracted LIBERTY network Periodontist.
- Procedure code(s), tooth number/quadrant(s), and member copayments for the covered periodontal treatment, which require referral.

Inform the member that:

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

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

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

Referral Guidelines for the Periodontist:

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

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

- Pre-operative x-ray(s). Submit x-rays that were enclosed with the original authorization form (or copies).
- Complete periodontal charting showing six-point probing of each natural tooth and any furcation involvements, abnormal mobility, or areas of recession.
- After completion of treatment, submit your claim for payment with a copy of the Plan's authorization for treatment.

PERIODONTICS GUIDELINES

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

For more information on LIBERTY's Periodontal Clinical Criteria and Guidelines please reference the Plan's Clinical Criteria, Guidelines and Parameters online at: https://www.libertydentalplan.com/Resources/Documents/National-Clinical-Criteria-Guidelines.pdf

PROSTHODONTIST

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

*Medi-Cal Dental does not limit the coverage of prosthodontists but pays them at the same rate as a general dentist.

SECTION 12. QUALITY MANAGEMENT

PROGRAM DESCRIPTION

LIBERTY's Quality Improvement and Oral Health Access Program (QIOHAP) provides a roadmap for the organization to continuously identify, monitor, measure, and document strategies that promote oral health and Access while improving the effectiveness and efficacy of care by prioritizing prevention and improvement of dental health status. LIBERTY's QIOHAP encompasses a comprehensive array of well-defined processes and functions that are critical to the delivery of dental services and the achievement of good oral health outcomes for all of our member population.

QIOHATP POLICY

The goal of LIBERTY's QIOHAP is to provide LIBERTY members with quality and accessible clinical dental care while maintaining a program to objectively assess services and concerns that directly and indirectly influence the member's oral health. LIBERTY strives for continuous improvement in the delivery of service and in the quality of clinical dental care provided to members.

QIOHATP SCOPE

The scope of the QIOHAP includes monitoring, identifying, evaluating, and remedying problems relating to access to care, continuity and quality of care, utilization and the cost of services, as well as services LIBERTY renders to members, customers, and providers. LIBERTYs QIOHAP includes standard operating procedures, policies, and procedures, and committees that are utilized to conduct quality of care oversight, including utilization review metrics, complaints, and grievances in compliance with applicable state and federal laws and regulations.

QIOHATP GOALS AND OBJECTIVES

The LIBERTY QIOHAP goals and objectives are comprehensive and support the overall organizational goal of providing the highest quality dental care to LIBERTY members in a cost-effective manner.

LIBERTY's QIOHAP focuses on a proactive problem-solving and continuous monitoring and improvement approach to ensure access to quality dental care, including in the following areas:

- Accessibility of care: the degree to which dental and specialty providers are available within a designated service area.
- Availability of Care: the ease and timeliness to which patients can obtain the care that they need.
- Continuity of Care: the degree to which the quality of care is coordinated from one setting of care or provider of care to another within a given timeframe.
- Coordination of Care: the degree to which the care needed by patients is coordinated in conjunction with Case Management and other Plan programs.
- Grievances and Appeals: the degree to which members grievances and appeals resolutions are effectively identified, investigated and resolved to ensure timely and member-centered outcomes.
- Health Access: a state in which everyone has a fair and just opportunity to attain their highest level of health.
- Member Satisfaction: the degree to which members are satisfied with the care they are receiving from LIBERTY contracted providers and the interactions with LIBERTY programs.
- Provider Participation and Satisfaction: the degree to which providers are satisfied with LIBERTY administrative and service coordination activities
- Quality of Care: the degree to which the correct dental care is provided, given the current standard of the community.
- Patient Safety: the degree to which the environment is free from hazard and danger to the patient.

The process may include:

- Standards and criteria development
- Problem and trend identification and assessment
- Development and implementation of QIOHAP studies, performance, measuring, monitoring, and member/provider surveys
- Credentialing and re-credentialing of providers
- Monitoring of dental office staff and provider performance
- Infection control monitoring
- Facility review audits
- Dental chart audits
- Utilization management and monitoring of over and under-utilization
- Monitoring of member and provider grievance/appeals and follow-up

- Disenrollment, enrollment, and primary care dentist transfer request tracking
- Provider/member education
- Staff orientation
- Corrective action plan development, implementation, and monitoring effectiveness, including disciplinary actions and terminations of any provider for serious quality deficiencies, and reporting the same to the appropriate authorities.
- Other QIOHAP activities identified during the monitoring process

COMMITTEES

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

- Quality Improvement & Oral Health Access Committee (QIOHAC)
- Credentialing Committee
- Access & Availability Committee
- Peer Review Committee
- Utilization Management Committee
- Population Health Management Committee
- Community Advisory Committee
- Dental Advisory Committee

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

The QIOHAC's oversight responsibilities include monitoring the activities of other QIOHAC's components, analyzing and evaluating the effectiveness of the Quality Improvement and Oral Health Access Transformation Program, Annual Workplan, operations, and oral health Access activities.

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

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

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

The Peer Review Committee (PRC) ensures that dental care is rendered following the policies, procedures, and standards set by the QIOHAC.
The PRC is responsible for:

- Provider quality of care issues identified through various means, including but not limited to, member grievances/appeals, on-site audits, and chart reviews.
- Potential or pending malpractice issues, National Practitioner's Data Bank reports, and Dental Board of the specified State reports, when requested to do so by the QIOHAC.
- Provider Dispute Resolutions (i.e., grievances, appeals, terminations, denial of panel participation).
- Member grievances and appeals or other dental care issues.
- Annual review and update of the Specialty Referral Criteria and Guidelines.
- Monitors patterns of disputes and makes recommendations to the Dental Director regarding a doctor, member, or group.

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

- The UMC evaluates a summary of treatment provided by the entire contracted general dentist network. The analysis is intended to indicate the number of members seeking treatment and the types of treatment they receive. Further evaluation of specific provider offices allows a determination of how those offices compare to the overall experience of the entire network and how individual provider offices compare to the established network standards.

- The Dental Director assesses over, and under-utilization of specialty referral trends and reports thefindings to the UMC. From these reports, the UMC can also monitor trends in specialty referral denials and make recommendations to the QIOHAC.
- The UMC also reviews access and availability and continuity of care issues by reviewing reports of appointment availability, wait times, and the number of actual appointments kept by the members. This will also include an evaluation of the number and location of the general and specialty dentist providers. The UMC addresses negative trends in these areas and makes recommendations for improvements that are forwarded to the QIOHAC.

The Population Health Management Committee (PHMC) is responsible for overseeing initiatives that address social determinants of health, reducing oral disparities, and increase health Access. The PHMC also monitors language, race, and ethnicity to develop a membership demographic profile and establish threshold languages that enable us to provide culturally appropriate communications and care to our diverse enrollee population. The committee reviews LIBERTY's Population Needs Assessment (PNA) and development of our Population Health Management Strategy. The PHMC tracks and reviews Case Management and Care Coordination referrals to ensure members with special health needs receive proper care. All grievances related to discrimination, language barriers, harassment or rude treatment, and cultural barriers are reviewed quarterly by the Committee to identify trends and implement quality controls when necessary.

The Community Advisory Committee (CAC) is an advisory Committee formed in accordance with state requirements as per Section 1369 of the HMO Act of 1973 (as amended), also known as the Knox-Keene Act. The CAC permits subscribers and members to participate in the public policy of the plan and will have access to information regarding public policy, including financial information and information about the specific nature and volume of complaints received by the plan and their disposition. CAC serves as a forum for members to collaborate with LIBERTY on areas of concern.

The Dental Advisory Committee (DAC) offers a quarterly forum for participating providers to review, discuss and provide their input on topic such as general operations, provider payment, grievance and appeals, cultural and linguistic competency, language assistance, dental utilization fees, provider credentialing, and other ongoing metrics.

MEMBER and PROVIDER EXPERIENCE:

A. Provider Surveys:

- LIBERTY conducts quarterly appointment access surveys.
- LIBERTY conducts an annual provider satisfaction survey.

B. Member Satisfaction Surveys:

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

GRIEVANCES AND APPEALS (G&A) SYSTEM:

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

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

CORRECTIVE ACTION PLANS

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

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

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

PROVIDER QIOHAP RESPONSIBILITIES

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

CREDENTIALING/RE-CREDENTIALING

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

- Current State dental license for each participating dentist.
- Current DEA license (does not apply to Orthodontists.)
- Current evidence of malpractice insurance for at least one million ($1,000,000) per incident and three million ($3,000,000) annual aggregate for each participating dentist.
- Current certificate of a recognized training residency program with completion (forspecialists).
- Current permit of general anesthesia or conscious oral sedation, if administered, for the appropriate dentist.
- Immediate notification of 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 before expiration to allow time to submit current copies.

RECORDS REVIEW

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

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

MEMBER GRIEVANCES AND APPEALS (G&A)

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

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

G&A RECORDS REQUESTS

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

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

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

G&A CULTURAL AND LINGUISTICS

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

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

LIBERTY provides members whose primary language is not English with translation services. We currently provide translation services in at least one hundred and fifty (150) languages. G&A forms can be obtained from LIBERTY's Member Services Department, from a dental provider facility, or the LIBERTY website.

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

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

G&A RESOLUTION

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

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

- Acknowledgement: LIBERTY mails written notification of the receipt of the G&A to the member and provider within five (5) business days of receipt.
- Expedited/Fast Track: Cases in which a member or provider on behalf of a member feels their health would be harmed by waiting for the standard resolution timeframe, can request an "expedited/fast track review".
    - 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.
- Standard: Cases are resolved as expeditiously as the member's condition requires but no later than thirty (30) calendar days from the date of receipt.
- Extensions: Members, providers on behalf of a member, or LIBERTY, if in the member's best interest, may request a fourteen (14) calendar day extension on an Expedited or Standard appeal request.
    - Appeal extension requests by LIBERTY will include verbal and written notification of the extension to the member along with their right to file a grievance if the member is not in agreement with the Plan's extension.
    - If LIBERTY does not 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.

COMMERCIAL AND EXCHANGE MEMBER G&A

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

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

- Exchange members will receive a response within seventy-two (72) hours from the time of receipt.
- Commercial members will receive a response within three (3) calendar days from receipt.

G&A SUBMISSION

Members, authorized representatives, and providers on behalf of members can submit a grievance and appeal via telephone by calling LIBERTY's Member Services Department toll-free, or by fax, online, a letter, or grievance and appeals form.

- Phone: 888-703-6999/TTY: 877-855-8039
- Online: https://www.libertydentalplan.com/Members/File-a-Grievance-or-Appeal.aspx

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

PROVIDER DISPUTE RESOLUTIONS (PDR)

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

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

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

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

All PDRS not associated with a claim must distinctly explain the issue and the provider's position. PDRs not including all required information may be returned to the submitter for completion. An amended PDR, including the missing information, may be submitted to LIBERTY within thirty (30) business days of receipt of a returned contracted provider dispute. PDRs sent to LIBERTY must include the information listed above for each contracted provider dispute.

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

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

All contracted provider disputes must be sent to the following address:

LIBERTY Dental Plan
Quality Management Department
P.O. Box 26110, Santa Ana, CA 92799-6110
Attn: Grievances and Appeals/PDR Department
Fax: 1-833-250-1814
Phone: 800-268-9012/TTY: 877-855-8039

CONTRACTED PDR INQUIRIES

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

SECTION 13. FRAUD, WASTE, AND ABUSE

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

Reporting Fraud, Waste and Abuse

LIBERTY has established several options which allow for confidential reporting of violations to LIBERTY, Medicaid Program Integrity (MPI), and U.S. Department of Health & Human Services, Office of Inspector General (HHS-OIG). These options include the following internal mechanisms:

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

FWA may be confidentially reported to the HHS-OIG Whistle Phone number at 1-800-HHS-TIPS 1-800-377-4950 or TTY 1-800-377-4950.

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

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

Examples of fraud may include:

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

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

Examples of waste may include:

- Over-utilization of services
- Misuse of resources

Abuse includes actions that may, directly or indirectly, result in unnecessary costs to the Medicare Program. Abuse involves paying for items or services when there is no legal entitlement to that payment, and the provider has not knowingly or intentionally misrepresented facts to obtain payment.

Examples of abuse may include:

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

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

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

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

State & Federal False Claims Laws:

Federal False Claims Act (31 U.S.C. §§ 3729 - 3733)

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

The Federal False Claims Act broadly defines the terms "knowing" and "knowingly." Specifically, knowledge will have been proven for purposes of the Federal False Claims Act if the person or entity: (1) has actual knowledge of the information; (2) acts in deliberate ignorance of the truth or falsity of the information; or (3) acts in reckless disregard of the truth

or falsity of the information. The law specifically provides that a specific intent to defraud is not required in order to prove that the law has been violated.

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

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

Anti-Kickback Statute: What is the Anti-Kickback Statute? The Anti-Kickback Statute is the popular name for the Medicare and Medicaid Fraud and Abuse Statute, 42 U.S.C. § 1320a-7b (b). The AKS is a federal criminal law. It prohibits offering or accepting kickbacks to generate health care business.
The Anti-Kickback Statute or AKS is a healthcare law that prohibits individuals and entities from a willful and payment of "remuneration" or rewarding anything of value – such as position, property, or privileges – in exchange for patient referrals that involve payables by the Federal healthcare programs. These payables include, but are not limited to, drugs, medical supplies, and healthcare services availed by Medicare or Medicaid beneficiaries.

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

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

The Physician Self-Referral Law, commonly referred to as the Stark law, prohibits physicians (including dentists) from referring patients to receive "designated health/dental services" payable by Medicare or Medicaid from entities with which the physician (including dentist) or immediate family member has a financial relationship. Law now insists that any medical professional who provides such a referral to a Medicare or Medicaid patient must concurrently provide written notice of that patient's right to go elsewhere along with a list of nearby alternatives.

Finalizing new, permanent exceptions for value-based arrangements to that will permit physicians and other health care providers to design and enter into value-based arrangements without fear that legitimate activities to coordinate and improve the quality of care for patients and lower costs would violate the physician self-referral law. This supports CMS' broader push to advance coordinated care and innovative payment models across Medicare, Medicaid, and private plans.

LIBERTY requires all its providers and subcontractors to report violations and suspected violations on the part of its employees, associates, persons, or entities providing care or services to all Medicaid enrollees. Examples of such violations include bribery, false claims, conspiracy to commit fraud, theft or embezzlement, false statements, mail fraud, health care fraud, obstruction of a state and/or federal health care fraud investigation, money laundering, failure to provider medically necessary services, marketing schemes, illegal remuneration schemes, identity theft, or enrollees' medication fraud.

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

This policy contains phone numbers for reporting fraud, waste, and abuse. State and federal regulations require mandatory Compliance and FWA Training to be completed by providers and subcontractors, as well as their employees, within 30 days of hire/contracting and annually thereafter. Records of the training must be maintained and readily available at the request of LIBERTY's Compliance Officer, AHCA, CMS, or agents of both agencies.

Note: An attestation for the completion of the FWA Training must be submitted as part of the credentialing process.

If you or your employees have not taken the Compliance and/or FWA Training, please log onto LIBERTY website: https://www.libertydentalplan.com/Providers/Provider-Training-1.aspx to complete the training. Please contact Provider Relations for additional instructions as needed. It is your responsibility and part of your contractual obligation to comply with all state and federal program requirements for your continued participation with LIBERTY dental plans.

REPORTING

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

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

and/or

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

and/or

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

SECTION 14. ALTERNATIVE TREATMENT

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

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

Example:

Provider's usual fee for the alternative treatment (i.e., fixed bridge)	$2,100.00
Provider's usual fee for the covered treatment (i.e., partial denture)	$975.00
Difference between 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 are recommended using upgraded materials, and these similar procedures are not a benefit under the member's copayment schedule. When a member selects an upgraded treatment, they are responsible for the cost of the upgrades. The cost of upgraded materials should be the actual laboratory costs of such materials. *Not applicable for Medi-Cal Dental members.

Example:

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

*Please refer to specific benefit plan designs for additional information

SECTION 15. FORMS AND RESOURCES

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

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

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

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

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

- ADA Claim Form
- Consent for Non-Covered Treatment
- Electronic Funds Transfer (EFT)
- Informed Consent for Alternate Treatment
- Provider Dispute/Appeal Request Form
- Specialty Care Referral Request Form
- Written Member Grievances and Appeals Form-California
- Appointment of Representative (AOR) Form
- Community-Health-Workers-Attestation.pdf