DENTAL PROVIDER MANUAL

(Provider Handbook)

Molina Healthcare of Ohio, Inc.

(Molina Healthcare or Molina)

MyCare Ohio

2025

Capitalized words or phrases used in this Provider Manual shall have the meaning set forth in the Provider Agreement with Molina. "Molina Healthcare" or "Molina" has the same meaning as "Health Plan" in the Provider Agreement with Molina. The Provider Manual is customarily updated annually but may be updated as needed. Providers can access the most current Provider Manual at MolinaHealthcare.com

Last Updated: 07/2025

MOLINA® HEALTHCARE

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1. Contact information

General Contact Information

Molina Healthcare of Ohio
3000 Corporate Exchange Drive
Columbus, Ohio 43231

Provider services

The Molina Provider Contact Center handles telephone inquiries from Providers regarding Claims, appeals, authorizations, eligibility, and general concerns. Molina Provider Contact Center representatives are available at (855) 322-4079 from 8 a.m. to 6 p.m., Monday through Friday, excluding state and federal holidays.

Molina strongly encourages participating Providers to submit Claims electronically via a clearinghouse or the SKYGEN DENTAL HUB whenever possible.

EDI Payer ID Number: SKYGEN

To verify the status of your Claims, please use the SKYGEN DENTAL HUB. Claims questions can be submitted through the Secure Messaging feature via the Claim Status module on the SKYGEN DENTAL HUB or by contacting the Molina Provider Contact Center.

Eligibility verifications can be conducted at your convenience via the Eligibility and Benefits module on the SKYGEN DENTAL HUB.

Phone: (855) 322-4079
Hearing Impaired (TTY/TDD): 711

Provider relations

The Provider Relations department manages Provider calls regarding issue resolution, Provider education, and training. The department has Provider Relations representatives who serve all of Molina's Provider network.

mdvsproviderservices@molinahealthcare.com
Phone: (844) 862-4564 7 a.m. to 6 p.m. Monday through Friday
Fax: (855) 297-3304

Member services

The Molina Member Contact Center handles all telephone inquiries regarding benefits, eligibility/identification, and Member complaints. Representatives are available Monday through Friday from 8 a.m. to 8 p.m., excluding state and federal holidays.

Molina Dual Options MyCare Ohio: (855) 665-4623
Molina MyCare Ohio Medicaid: (855) 687-7862
Hearing Impaired (TTY/TDD): 711

Claims

Molina strongly encourages participating Providers to submit Claims electronically via a clearinghouse or SKYGEN DENTAL HUB whenever possible.

- EDI Payer ID SKYGN

To verify the status of your Claims, please use the SKYGEN DENTAL HUB. For additional information, please refer to the **Claims and Compensation** section of this Provider Manual.

Phone: (855) 322-4079

Claims recovery

The Claims Recovery department manages recovery for overpayment and incorrect payment of Claims.

Provider disputes	Molina Healthcare of Ohio PO Box 2470 Spokane, WA 99210-2470
Refund checks lockbox	Molina Healthcare of Ohio PO Box 78000 Dept. 781661 Detroit, MI 48278-1661
Phone:	(866) 642-8999

Fax:	(888) 396-1517

Compliance and Fraud AlertLine

Suspected cases of fraud, waste, or abuse must be reported to Molina. You may do so by contacting the Molina Alertline or by submitting an electronic complaint using the website listed below. For additional information on fraud, waste, and abuse, please refer to the **Compliance** section of this Provider Manual.

Molina Healthcare of Ohio Medicare
Attn: Compliance Official
200 Oceangate Suite 100
Long Beach, CA 90802
Phone: (866) 606-3889
Online: MolinaHealthcare.Alertline.com

24-hour Nurse Advice Line

This telephone-based nurse advice line is available to all Molina Members. Members may call anytime they are experiencing symptoms or need health care information. Registered nurses are available 24 hours a day, 7 days a week.

Phone: (855) 895-9986
Hearing Impaired (TTY/TDD): 711

Pharmacy

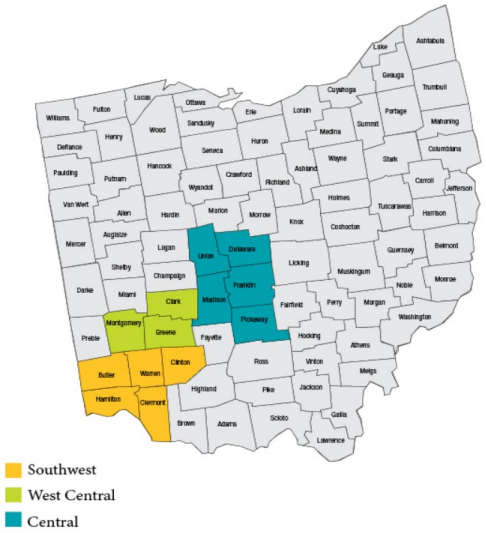
Providers are required to adhere to Molina's drug formularies and prescription policies. Molina drug formularies are available on the Drug List page at MolinaHealthcare.com.
A list of in-network pharmacies is available on the MolinaHealthcare.com website or by contacting Molina.
Phone: (800) 665-3086
Part D Fax: (866) 290-1309

Quality

Molina maintains a Quality department that works with Members and Providers to administer the Molina Quality Improvement (QI) Program.

Phone: (855) 322-4079

Molina Healthcare of Ohio, Inc. Service area



2. Provider responsibilities

Non-discrimination in health care service delivery

Providers must comply with the nondiscrimination in health care service delivery requirements as outlined in the **Cultural Competency and Linguistic Services** section of this Provider Manual.

Additionally, Molina requires Providers to deliver services to Molina Members without regard to the source of payment. Specifically, Providers may not refuse to serve Molina Members because they receive assistance with cost-sharing from a government-funded program. Providers serving Medicaid Members are required to maintain the same hours of operation as those offered to commercial benefit Members.

Section 1557 investigations

All Molina Providers shall disclose all investigations conducted pursuant to Section 1557 of the Patient Protection and Affordable Care Act (ACA) to Molina's Civil Rights Coordinator.

Molina Healthcare, Inc.
Civil Rights Coordinator
200 Oceangate, Suite 100
Long Beach, CA 90802

Phone: (866) 606-3889
Hearing Impaired (TTY/TDD): 711
Online: MolinaHealthcare.AlertLine.com
Email: civil.rights@MolinaHealthcare.com

For additional information, please refer to the Department of Health and Human Services (HHS) website at federalregister.gov/documents/2020/06/19/2020-11758/nondiscrimination-in-health-and-health-education-programs-or-activities-delegation-of-authority.

Facilities, equipment, personnel, and administrative services

The Provider's facilities, equipment, personnel, and administrative services must be at a level and quality necessary to perform duties and responsibilities to meet all applicable legal requirements, including the accessibility requirements of the Americans with Disabilities Act (ADA).

Provider data accuracy and validation

Providers must ensure Molina has accurate practice and business information. Accurate information allows us to better support and serve our Members and Provider Network.

Maintaining an accurate and current Provider Directory is a state and federal regulatory requirement and an NCQA-required element. Invalid information can negatively impact Member access to care. Additionally, current information is critical for timely and accurate Claims processing.

Providers must validate their Provider information on file with Molina at least once every 90 days for correctness and completeness.

Additionally, in accordance with the terms specified in the Provider Agreement with Molina, Providers must notify Molina of any changes as soon as possible, but at a minimum of 30 calendar days in advance of any changes in any Provider information on file with Molina. Changes include, but are not limited to:

- Change in office location(s)/address, office hours, phone, fax, or email
- Addition or closure of office location(s)
- Addition of a Provider (within an existing clinic/practice)
- Change in Provider or practice name, Tax ID, and/or National Provider Identifier (NPI)
- Opening or closing your practice to new patients (GD's only)
- Change in specialty
- Any other information that may impact Member access to care

For Provider terminations (within an existing clinic/practice), Providers must notify Molina in writing in accordance with the terms specified in your Provider Agreement with Molina.

Note: Some changes may impact credentialing. Providers are required to notify Molina of changes to Credentialing information in accordance with the requirements outlined in the **Credentialing and Recredentialing** section of this Provider Manual.

Molina is required to audit and validate our Provider network data and Provider directories on a routine basis. As part of our validation efforts, we may reach out to our provider network through various methods, such as letters, phone campaigns, face-to-face contact, fax, and fax-back verification. Molina also may use a vendor to conduct routine outreach to validate data that impacts the Provider directory or otherwise impacts its membership or ability to coordinate

Member care. Providers are required to supply timely responses to such communications.

All Molina Providers participating in a Medicaid network must be enrolled in the state Medicaid program to be eligible for reimbursement. If a Provider has not had a Medicaid number assigned, the Provider must apply for enrollment with the Ohio Department of Medicaid and meet the Medicaid Provider enrollment requirements set forth in the Provider Network Management (PNM) system, or Providers can start the process at medicaid.ohio.gov.

National Plan and Provider Enumeration System (NPPES) data verification

In addition to the above verification requirements, the Centers for Medicare & Medicaid Services (CMS) recommends that Providers routinely verify and attest to the accuracy of their NPPES data.

NPPES allows Providers to attest to the accuracy of their data. If the data is correct, the Provider can attest, and NPPES will reflect the attestation date. If the information is not correct, the Provider can request a change to the record and attest to the changed data, resulting in an updated certification date.

Molina supports the CMS recommendations around NPPES data verification and encourages our Provider network to verify Provider data via nppes.cms.hhs.gov. Molina may validate that the NPI submitted in a Claim transaction is a valid NPI and is recognized as part of the NPPES data. Additional information regarding the use of NPPES is available in the Frequently Asked Questions (FAQ) document published at cms.gov/Medicare/Health-Plans/ManagedCareMarketing/index.

Molina Electronic Solutions Requirements

Molina encourages Providers to utilize electronic solutions and tools whenever possible.

Molina asks all contracted Providers to participate in and comply with Molina's electronic solution requirements, which include, but are not limited to, electronic submission of prior authorization requests, prior authorization status inquiries, health plan access to electronic Dental records (EMR), electronic Claim submission, electronic fund transfers (EFT), electronic remittance advice (ERA), electronic Claim Appeal and registration for and use of the SKYGEN DENTAL HUB.

Electronic Claims include Claims submitted via a clearinghouse using the EDI process and Claims submitted through the SKYGEN DENTAL HUB.

Any Provider entering the network as a contracted Provider will be encouraged to comply with Molina's electronic solution policy by enrolling for EFT/ERA payments and registering for the SKYGEN DENTAL HUB within 30 days of entering the Molina network.

Molina is committed to complying with all HIPAA Transactions, Code Sets, and Identifiers (TCI) standards. Providers must comply with all HIPAA requirements when using electronic solutions with Molina. Providers must obtain an NPI and use their NPI in HIPAA transactions, including Claims submitted to Molina. Providers may obtain additional information by visiting Molina's HIPAA Resource Center located on our website at MolinaHealthcare.com.

Electronic solutions/tools available to providers

Electronic solutions/tools available to Molina Providers include:

- Electronic Claim submission options
- Electronic payment: EFT with ERA
- SKYGEN DENTAL HUB

Electronic Claim Submission Requirement

Molina encourages participating Providers to submit Claims electronically whenever possible. Electronic Claim submission provides significant benefits to the Provider, such as:

- Promoting HIPAA compliance
- Helping to reduce operational costs associated with paper Claims (printing, postage, etc.)
- Increasing the accuracy of data and efficient information delivery
- Reducing Claim processing delays as errors can be corrected and resubmitted electronically
- Eliminating mailing time and enabling Claims to reach Molina faster

Molina offers the following electronic Claim submission options:

- Submit Claims directly to Molina via the SKYGEN DENTAL HUB
- Submit Claims to Molina through your EDI clearinghouse using Payer ID SKYGN. Please refer to our website at MolinaHealthcare.com for additional information.

While both options are embraced by Molina, submitting Claims via the SKYGEN DENTAL HUB (available to all Providers at no cost) offers a number of additional Claim processing benefits beyond the possible cost savings achieved from the reduction of high-cost paper Claims.

Claim submission includes the ability to:

- Add attachments to Claims
- Submit corrected Claims
- Check Claim status
- Receive timely notification of a change in status for a particular Claim

For additional information on EDI Claim submission and Paper Claim submission, please refer to the **Claims and Compensation** section of this Provider Manual.

Electronic payment requirement

Participating Providers are encouraged to enroll in EFT and ERA. Providers enrolled in EFT payments will automatically receive ERAs as well. EFT/ERA services give Providers the ability to reduce paperwork, utilize searchable ERAs, and receive payment and ERA access faster than the paper check and remittance advice (RA) processes. There is no cost to the Provider for EFT enrollment and Providers are not required to be in-network to enroll. Molina uses a vendor to facilitate the HIPAA-compliant EFT payment and ERA delivery processes.

As a reminder, Molina's Payer ID is SKYGN.

Once your account is activated, you will begin receiving all payments through EFT, and you will no longer receive a paper EOP (i.e., remittance) through the mail. You will receive 835s (by your selection of routing or via manual download) and can view, print, download and save historical and new ERAs with a two (2)-year lookback.

Additional registration instructions are available under the EDI/ERA/EFT tab on Molina's website, MolinaHealthcare.com.

Providers and third-party billers can use the no-cost SKYGEN DENTAL HUB to perform many functions online without the need to call or fax Molina. Registration can be performed online, and once completed, the easy-to-use tool offers the following features:

- Verify Member Eligibility
- Claims:
  - Submit the ADA claim form with the attached files
  - Correct/void Claims
  - Add attachments to previously submitted Claims
  - Check Claim status
  - View ERA and EOP
  - Create and submit a Claim appeal with attached files
- Prior authorizations/service requests
  - Create and submit prior authorization/service requests
  - Check status of prior authorization/service requests
- Download forms and documents
- Send/receive secure messages to/from Molina

HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA)

Balance billing

The Provider is responsible for verifying eligibility and obtaining approval for those services that require prior authorization.

Providers agree that under no circumstances shall a Member be liable to the Provider for any sums that are the legal obligation of Molina to the Provider. Balance billing a Member for covered services is prohibited.

Member rights and responsibilities

Providers are required to comply with the Member Rights and Responsibilities as outlined in Molina's Member materials (such as Member Handbooks).

For additional information, please refer to the **Member Rights and Responsibilities** section in this Provider Manual.

Member information and marketing

Any written informational or marketing materials directed to Molina Members must be developed and distributed in a manner compliant with all state and federal laws and regulations and approved by Molina prior to use.

Please contact their Molina Provider Relations representative for information and a review of the proposed materials.

Member eligibility verification

Possession of a Molina Member ID card does not guarantee Member eligibility or coverage. Providers should verify the eligibility of Molina Members prior to rendering services. Payment for services rendered is based on enrollment and benefit eligibility. The contractual agreement between Providers and Molina places the responsibility for eligibility verification on the Provider of services.

Providers who contract with Molina may verify a Member's eligibility by checking the following:

- SKYGEN DENTAL HUB
- Molina Provider Contact Center automated Interactive Voice Response (IVR) system at (855) 322-4079.

For additional information, please refer to the **Eligibility, Enrollment, Disenrollment**, **and Grace Period** section of this Provider Manual.

Health care services (utilization management and care management)

Providers are required to participate in and comply with Molina's utilization management and care management programs, including all policies and procedures regarding Molina's facility admission, prior authorization, medical necessity review determination, and Interdisciplinary Care Team (ICT) procedures. Providers will also cooperate with Molina in audits to identify, confirm, and/or assess utilization levels of covered services.

For additional information, please refer to the **Health Care Services** section of this Provider Manual

Treatment alternatives and communication with Members

Molina endorses open Provider-Member communication regarding appropriate treatment alternatives and any follow-up care. Molina promotes open discussion between Providers and Members regarding medically necessary or appropriate patient care, regardless of covered benefits limitations. Providers are free to communicate all treatment options to Members regardless of benefit coverage limitations. Providers are also encouraged to promote and facilitate training in self-care and other measures that Members may take to promote their own health.

Participation in Quality Improvement (QI) Programs

Providers are expected to participate in Molina's QI Programs and collaborate with Molina in conducting peer review and audits of care rendered by Providers. Such participation includes, but is not limited to:

- Access to care standards
- Site and Dental record-keeping practice reviews as applicable
- Delivery of patient care information

For additional information, please refer to the **Quality** section of this Provider Manual.

Compliance

Providers must comply with all state and federal laws and regulations related to the care and management of Molina Members.

Confidentiality of Member health information and HIPAA transactions

Molina requires that Providers respect the privacy of Molina Members (including Molina Members who are not patients of the Provider) and comply with all

applicable laws and regulations regarding the privacy of patient and Member protected health information.

For additional information, please refer to the **Compliance** section of this Provider Manual.

Participation in grievance and appeals programs

Providers are required to participate in Molina's grievance and appeals programs and cooperate with Molina in identifying, processing, and promptly resolving all Member complaints, grievances, or inquiries. If a Member has a complaint regarding a Provider, the Provider will participate in the investigation of the grievance. If a Member submits an appeal, the Provider will participate by providing Dental records or statements if needed. This includes the maintenance and retention of Member records for a period of not less than 10 years and retained further if the records are under review or audit until such time that the review or audit is complete.

For additional information, please refer to the **Complaints, Grievance, and Appeals Process** section of this Provider Manual.

Participation in credentialing

Providers are required to participate in Molina's credentialing and re-credentialing process and will satisfy, throughout the term of their contract, all credentialing and re-credentialing criteria established by Molina and applicable accreditation, state, and federal requirements. This includes providing prompt responses to Molina's requests for information related to the credentialing or re-credentialing process.

For additional information on Molina's credentialing program, please refer to the **Credentialing and Recredentialing** section of this Provider Manual.

3. Cultural competency and linguistic services

Background

Molina works to ensure all Members receive culturally competent care across the service continuum to reduce health disparities and improve health outcomes. The Culturally and Linguistically Appropriate Services in Health Care (CLAS) standards published by the U.S. Department of Health and Human Services (HHS) and Office of Minority Health (OMH) guide the activities to deliver culturally competent services. Molina complies with Section 1557 of the ACA, prohibiting discrimination in health programs and activities receiving federal financial assistance on the basis of race, color and national origin, sex, age, and disability per Title VI of the Civil Rights Act of 1964, Title IX of the Education Amendments of 1972, the Age Discrimination Act of 1975 and Section 504 of the Rehabilitation Act of 1975 (29 U.S.C. § 794). Molina complies with applicable portions of the Americans with Disabilities Act of 1990. Molina also complies with all implementing regulations for the foregoing. Compliance ensures the provision of linguistic access and disability-related access to all Members, including those with Limited English Proficiency (LEP) and Members who are deaf, hard of hearing, non-verbal, have a speech impairment, or have an intellectual disability. Policies and procedures address how individuals and systems within the organization will effectively provide services to people of all cultures, races, ethnic backgrounds, genders, gender identities, sexual orientations, ages, and religions, as well as those with disabilities in a manner that recognizes values, affirms, and respects the worth of the individuals and protects and preserves the dignity of each.

Additional information on cultural competency and linguistic services is available at MolinaHealthcare.com, from local Molina Provider relations

representatives, or by calling the Molina Provider Contact Center at (855) 322-4079.

Non-discrimination in health care service delivery

Molina complies with Section 1557 of the ACA. As a Provider participating in Molina's Provider Network, you and your staff must also comply with the nondiscrimination provisions and guidance set forth by the Department of Health and Human Services, Office for Civil Rights (HHS-OCR), state law, and federal program rules, including Section 1557 of the ACA.
You are required to do, at a minimum, the following:

1. You **MAY NOT** limit your practice because of a Member's Dental (physical or mental) condition or the expectation for the need of frequent or high-cost care.
2. You **MUST** post a non-discrimination notice in a conspicuous location in their office. A sample of the Non-Discrimination Notice can be found in the Member Handbook, located at MolinaHealthcare.com.
3. You **MUST** post in a conspicuous location in your office a Tagline Document that explains how to access non-English language services. A sample of the Tagline Document that you will post can be found in the Member Handbook located at MolinaHealthcare.com.
4. If a Molina Member is in need of language assistance services while at your office and you are a recipient of federal financial assistance, you **MUST** take reasonable steps to make your services accessible to persons with LEP. You can find resources on meeting your LEP obligations at hhs.gov/civil-rights/for-individuals/special-topics/limited-english-proficiency/index and hhs.gov/civil-rights/for-providers/clearance-medicare-providers/technical-assistance/limited-english-proficiency/index.
5. If a Molina Member complains of discrimination, you **MUST** provide them with the following information so that they may file a complaint with Molina's Civil Rights Coordinator or the HHS-OCR:

Civil Rights Coordinator Molina Healthcare, Inc. 200 Oceangate, Suite 100 Long Beach, CA 90802 Phone (866) 606-3889 (TTY/TDD, 711) civil.rights@MolinaHealthcare.com	Office of Civil Rights U.S. Department of Health and Human Services 200 Independence Avenue, SW Room 509F, HHH Building Washington, D.C. 20201 Website: ocrportal.hhs.gov/ocr/portal/lobby

	Complaint Form: hhs.gov/ocr/complaints/index

If you or a Molina Member needs additional help or more information, call the Office of Civil Rights at (800) 368-1019; TTY/TDD:(800) 537-7697.

Cultural competency

Molina is committed to reducing health care disparities. Training employees, Providers, and their staff, and quality monitoring are the cornerstones of successful, culturally competent service delivery. Molina integrates cultural competency training into the overall Provider training and quality-monitoring programs. An integrated quality approach enhances the way people think about our Members, service delivery, and program development so that cultural competency becomes a part of everyday thinking.

Provider and community training

Molina offers educational opportunities in cultural competency concepts for Providers, their staff, and community-based organizations. Molina conducts Provider training during Provider orientation, with annual reinforcement training offered through Provider Relations and/or online/web-based training modules.

Training modules, delivered through a variety of methods, include:

1. Provider-written communications and resource materials
2. On-site cultural competency training
3. Online cultural competency provider training modules
4. Integration of cultural competency concepts and non-discrimination of service delivery into Provider communications

Integrated quality improvement

Molina ensures Member access to language services such as oral interpretation, American Sign Language (ASL), and written translation. Molina must also ensure access to programs, aids, and services that are congruent with cultural norms. Molina supports Members with disabilities and assists Members with LEP.

Molina develops Member materials according to Plain Language Guidelines. Members or Providers may also request written materials in alternate languages and formats (e.g., Braille, audio, large print), leading to better communication, understanding, and Member satisfaction. Online materials found on

MolinaHealthcare.com and information delivered in digital form meet Section 508 accessibility requirements to support Members with visual impairments.

The Molina Member website also provides Key Member information, including appeal and grievance forms, in threshold languages.

Access to interpreter services

Providers may request interpreters for Members whose primary language is other than English by calling the Molina Member Contact Center at:

- Molina MyCare Ohio Dual Options Medicare-Medicaid Plan: (855) 665-4623 (TTY 711), Monday through Friday from 8 a.m. to 8 p.m.
- Molina MyCare Ohio Medicaid Only: (855) 687-7862 (TTY 711), Monday through Friday from 8 a.m. to 8 p.m.

If Molina Member Contact Center representatives are unable to interpret in the requested language, the representative will immediately connect you and the Member to a qualified language service provider.

Molina Providers must support Member access to telephonic interpreter services by offering a telephone with speaker capability or a telephone with a dual headset. Providers may offer Molina Members interpreter services if the Members do not request them on their own. Please remember it is never permissible to ask a family member, friend, or minor to interpret.

All eligible Members with LEP are entitled to receive interpreter services. Pursuant to Title VI of the Civil Rights Act of 1964, services provided for Members with LEP, limited reading proficiency (LRP), or limited hearing or sight are the financial responsibility of the Provider. Under no circumstances are Molina Members responsible for the cost of such services. Each office or facility is to maintain written procedures regarding its process for obtaining such services. Molina is available to assist providers with locating these services if needed.

An individual with LEP has a limited ability or inability to read, speak, or write English well enough to understand and communicate effectively (whether because of language, cognitive, or physical limitations).

Molina Members are entitled to:

- Be provided with effective communications with Dental Providers as established by the Americans with Disabilities Act of 1990, the Rehabilitation Act of 1973, and the Civil Rights Act of 1964

- Be given access to Case managers trained to work with individuals with cognitive impairments
- Be notified by the Dental Provider that interpreter services are available at no cost
- Decide, with the Dental Provider, to use an interpreter and receive unbiased interpretation
- Be assured of confidentiality, as follows:
    - Interpreters must adhere to Health and Human Services Commission (HHSC) policies and procedures regarding confidentiality of Member records
    - Interpreters may, with the Member's written consent, share information from the Member's records only with appropriate Dental professionals and agencies working on the Member's behalf
    - Interpreters must ensure that this shared information is similarly safeguarded
- Have interpreters, if needed, during appointments with the Member's Providers and when talking to the health plan

Interpreters include people who can speak the Member's native language, assist with a disability, or help the Member understand the information.

When Molina Members need an interpreter, limited hearing, and/or limited reading services for health care services, the Provider should:

- Verify the Member's eligibility and Dental benefits
- Inform the Member that an interpreter, limited hearing, and/or limited reading services are available
- Molina is available to assist Providers with locating these services if needed:
    - Providers needing assistance finding on-site interpreter services
    - Providers needing assistance finding translation services
    - Providers with Members who cannot hear or have limited hearing ability may use the National TTY/TDD relay service at 711
    - Providers with Members with limited vision may contact Molina for documents in large print, Braille, or an audio version
    - Providers with Members with LRP The Molina Contact Center representative will verbally explain the information, up to and including reading the documentation to the Members or offering the documents in an audio version

Documentation

As a contracted Molina Provider, your responsibilities for documenting Member language services/needs in the Member's Dental record are as follows:

- Record the Member's language preference in a prominent location in the Dental record. This information is provided to you on the electronic Member lists that are sent to you each month by Molina.
- Document all Member requests for interpreter services.
- Document who provided the interpreter service. This includes the name of Molina's internal staff or someone from a commercial interpreter service vendor. Information should include the interpreter's name, operator code, and vendor.
- Document all counseling and treatment done using interpreter services.
- Document if a Member insists on using a family member, friend, or minor as an interpreter or refuses the use of interpreter services after notification of their right to have a qualified interpreter at no cost.

Members who are deaf or hard of hearing

TTY/TDD connection is accessible by dialing 711. This connection provides access to the Molina Member and Provider Contact Center, quality health care services, and all other health plan functions.

Molina strongly recommends that Provider offices make assistive listening devices available for Members who are deaf and hard of hearing. Assistive listening devices enhance the sound of the Provider's voice to facilitate better interaction with the Member.

Molina will provide face-to-face service delivery for ASL to support our Members who are deaf or hard of hearing. To ensure the service's availability, requests should be made at least three (3) business days in advance of an appointment. In most cases, Members will have made this request via the Molina Member Contact Center.

24-hour Nurse Advice Line

Molina provides a nurse advice line for Members 24 hours per day, 7 days per week. The 24-hour Nurse Advice Line provides access to 24-hour interpretive services. Members may call Molina's 24-hour Nurse Advice Line directly at English line (855) 895-9986 or TTY/TDD 711 for persons with hearing impairments. The 24-hour Nurse Advice Line telephone numbers are also printed on Molina Member ID cards.

Program and policy review guidelines

Molina conducts assessments at regular intervals of the following information to ensure its programs are most effectively meeting the needs of its Members and Providers:

- Annual collection and analysis of race, ethnicity, and language data from:
  - Eligible individuals to identify significant cultural and linguistically diverse populations within a plan's membership
  - Contracted Providers to assess gaps in network demographics
- Revalidate data at least annually
- Local geographic population demographics and trends derived from publicly available sources (Community Health Measures and State Rankings Report)
- Applicable national demographics and trends derived from publicly available sources
- Assessment of Provider network
- Collection of data and reporting for the Diversity of Membership HEDIS® measure
- Annual determination of threshold languages and processes in place to provide Members with vital information in threshold languages
- Identification of specific cultural and linguistic disparities found within the plan's diverse populations
- Analysis of HEDIS® and Consumer Assessment of Healthcare Providers and Systems (CAHPS®) survey results for potential cultural and linguistic disparities that prevent Members from obtaining the recommended key chronic and preventive services.

CAHPS® is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ)

Member rights and responsibilities

Providers must comply with the rights and responsibilities of Molina Members as outlined in the Molina Member Handbook and on the Molina Member website.

The Member Handbook that is provided to Members annually is hereby incorporated into this Provider Manual. The most current Member Rights and Responsibilities can be found on the Member pages of Molina's website. The most current Member Handbook can be found on the Member pages of Molina's website at MyCare Ohio: Member Handbook.

State and federal law requires that health care Providers and health care facilities recognize Member rights while the Members are receiving Dental care, and that Members respect the health care Providers or health care facility's right to expect certain behavior on the part of the Members.

For additional information, please contact the Molina Provider Contact Center at (855) 322-4079, Monday through Friday from 8 a.m. to 6 p.m., TTY/TDD: 711 for persons with hearing impairments.

Second Opinions

If Members do not agree with their Provider's plan of care, they have the right to a second opinion from another Provider. Members should call the Molina Member Contact Center to find out how to get a second opinion. Second opinions may require prior authorization.

4. Eligibility, enrollment, disenrollment

Enrollment

Enrollment in Molina Dual Option MyCare Ohio Medicare-Medicaid Plan

Molina Dual Options MyCare Ohio Medicare-Medicaid Plan is the brand name of Molina's Medicare-Medicaid Plan (MMP), part of the MyCare Ohio program. Members who wish to enroll in Molina Dual Options must meet the following eligibility criteria:

- Age 18 or older at the time of enrollment.
- Entitled to benefits under Medicare Part A, and enrolled under Medicare Parts B and D, and receiving full Medicaid benefits.
- Individuals eligible for full Medicaid per the spousal impoverishment rule codified at section 1924 of the Social Security Act.
- Reside in the applicable MyCare Ohio demonstration counties: Franklin, Delaware, Union, Madison, Pickaway, Clark, Greene, Montgomery, Clinton, Warren, Butler, Hamilton, and Clermont.

- Molina Dual Options will accept all Members who meet the above criteria and elect to join the Molina Dual Options plan during appropriate enrollment periods.
- Member or Member's legal representative completes an enrollment election form completely and accurately.
- Is fully informed and agrees to abide by the rules of Molina Dual Options.
- The Member makes a valid enrollment request that is received by the plan during an election period.
- For Molina Dual Options: Is entitled to Medicaid benefits as defined by the State of Ohio.

Furthermore, Molina does not impose any additional eligibility requirements as a condition of enrollment other than those established by CMS in Chapter 2 of the Medicare Managed Care Manual.

Effective date of enrollment

The Member's effective date is determined by ODM and CMS and passed to Molina on the ODM eligibility file.

Eligibility verification

Medicaid programs

The state of Ohio, through the Ohio Department of Medicaid Provider Network Management (PNM) system, determines eligibility for the Medicaid programs. Payment for services rendered is based on eligibility and benefit entitlement. The contractual agreement between Providers and Molina places the responsibility for eligibility verification on the Provider of services.

Eligibility listing for Medicaid programs

Providers who contract with Molina may verify a Member's eligibility by checking the following:

- Molina Provider Contact Center automated IVR system at (855) 322-4079
- Eligibility can also be verified through the state at the Ohio Department of Medicaid Provider Network Management (PNM) system
- SKYGEN DENTAL HUB

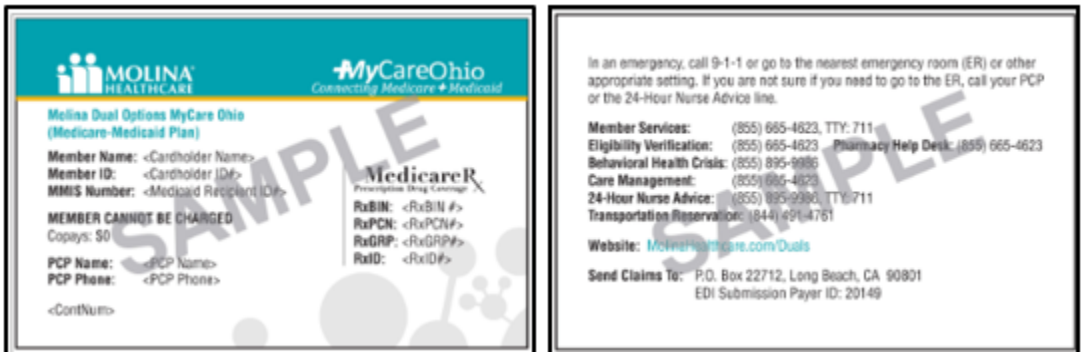
Possession of a Molina Member ID Card does not mean a recipient is eligible for Medicaid services. A Provider should verify a recipient's eligibility each time the recipient receives services. The verification sources can be used to verify a

recipient's enrollment in a managed care plan. The name and telephone number of the managed care plan are given along with other eligibility information.

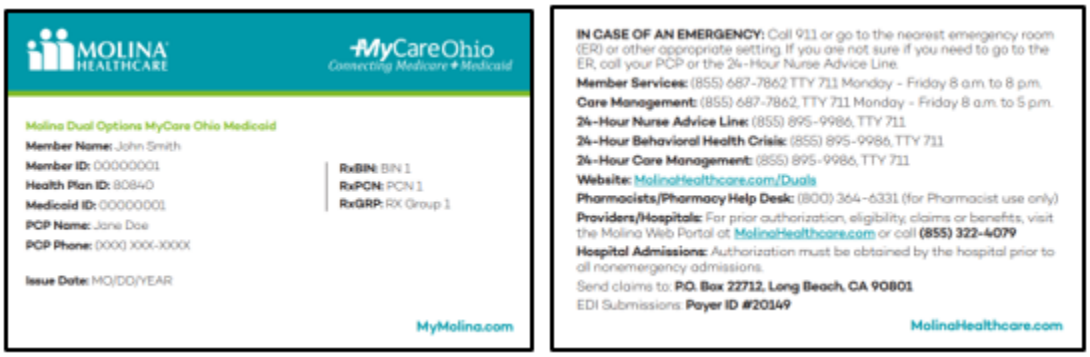
Identification cards

Molina sample Member ID card

Molina Dual Options MyCare Ohio (full benefits)



Molina MyCare Ohio Medicaid only (opt-out)



Members are reminded in their Member Handbooks to present Molina Member ID cards when requesting Dental services. The Molina Member ID card can be a physical or digital ID card. It is the Provider's responsibility to ensure Molina Members are eligible for benefits prior to rendering services. Unless an emergency Dental condition exists, Providers may refuse service if the Member cannot produce the proper identification and eligibility cards.

Disenrollment

Voluntary disenrollment

Molina Dual Options will refer the Member to ODM (or their designated vendor) to process disenrollment of Members from the health plan only as allowed by Centers for Medicare & Medicaid Services (CMS) regulations. Molina Dual Options may request that a Member be disenrolled under the following circumstances:

- Member requests disenrollment.
- Member enrolls in another plan (during a valid enrollment period);
- Member leaves the service area and directly notifies Molina of the permanent change of residence;
- Member loses entitlement to Medicare Part A or Part B benefits;
- Member loses Medicaid eligibility;
- Molina loses or terminates its contract with CMS. In the event of plan termination by CMS, Molina will send CMS-approved notices and a description of alternatives for obtaining benefits. The notice will be sent timely, before the termination of the plan; and/or,
- Molina discontinues offering services in specific service areas where the Member resides.

In all circumstances except death, Molina will provide a written notice to the Member explaining the reason for the disenrollment. All notices will be in compliance with CMS regulations and will be approved by CMS.

Voluntary disenrollment does not preclude Members from filing a grievance with Molina for incidents occurring while they were covered.

Involuntary disenrollment

The reasons that Molina can ask to terminate membership include:

- Fraud or misuse of the Member's Molina ID card.
- Molina Dual Options may request that a Member be disenrolled under the following circumstances:
  - Member enrolls in another plan.
  - Member has engaged in disruptive behavior, which is defined as behavior that substantially impairs the plan's ability to arrange for or provide services to the individual or other plan Members.
    - An individual cannot be considered disruptive if such behavior is related to the use of medical services or compliance (or noncompliance) with medical advice or treatment.

Molina will send three written notices to the Beneficiary, including:

- an explanation of the disruptive conduct and its impact on the Integrated Care Delivery System (ICDS) Plan's ability to provide services.
- Examples of the types of reasonable accommodations the ICDS Plan has already offered.

- the Grievance procedures.
- an explanation of the availability of other accommodations.

The following reasons are additional causes for disenrollment (where Molina will notify ODM to begin the disenrollment process):

- Member abuses the identification card by allowing others to use it to fraudulently obtain services.
- Member has not moved permanently but has been out of the service area for six months or more.
- Molina Dual Options loses or terminates its contract with CMS:
    - In the event of plan termination by CMS, Molina Dual Options will send CMS-approved notices and a description of alternatives for obtaining benefits.
    - The notice will be sent in a timely manner, before the termination of the plan.
- Molina Dual Options discontinues offering services in specific service areas where the Member resides.

When Members permanently move out of Molina's service area or leave Molina's service area for more than six consecutive months, they must disenroll from Molina's programs. There are a number of ways that the Molina Enrollment Accounting Department may be informed that the Member has relocated:

- Out-of-area notification received from ODM and forwarded to CMS on the monthly membership report.
- Through the CMS daily transaction reply report (DTRR) file, which confirms that the Member has disenrolled.
- The Member may call to advise Molina Dual Options that they have relocated, and Molina will direct the Member to ODM for formal notification.
- Other means of notification may be made through the Claims department if out-of-area Claims are received with a residential address other than the one on file. (Molina does not offer a visitor/traveler program to Members).

In all circumstances except death, ODM (or its designated enrollment vendor) will provide a written notice to the Member. All notices will be in compliance with CMS regulations and will be approved by CMS. Each notice will include the process for filing a grievance.

In the event of death, a verification of disenrollment will be sent to the deceased Member's estate.

Providers or Members may contact our Member Services Department to discuss enrollment and disenrollment processes and options at:

- Molina Dual Options MyCare Ohio: (855) 665-4623 (TTY 711), Monday through Friday from 8 a.m. to 8 p.m.
- Molina MyCare Ohio Medicaid: (855) 687-7862 (TTY 711), Monday through Friday from 8 a.m. to 8 p.m.

Missed appointments

Billing Members for missed appointments is prohibited. Molina provides transportation to Members for scheduled appointments and educates them regarding the importance of maintaining appointments. Providers should call Provider Services at (855) 322-4079 to determine if billing Members for any services is appropriate.

Benefits and covered services

This section provides an overview of the Dental benefits and covered services for Molina Members. Some benefits may have limitations. If you have questions about whether a service is covered or requires prior authorization, please consult the state Medicaid website.

Services covered by Molina

CODE	CODE DESCRIPTION	AGE	BENEFIT FREQUENCY	AUTH REQD	REQUIRED DOCUMENTATION
D0120	PERIODIC ORAL EXAM	0-999	ONE PER 180 DAYS	NO	
D0140	LIMITED ORAL EVALUATION - PROBLEM FOCUSED	0-999		NO	
D0150	COMPREHENSIVE ORAL EVALUATION - NEW OR ESTABLISHED PATIENT	0-999	ONE PER 5 FLOATING YEAR	NO	
D0180	COMPREHENSIVE PERIODONTAL EVALUATION	0-999	ONE PER 1 FLOATING YEAR	YES	NARRATIVE OF MEDICAL NECESSITY
D0210	INTRAORAL - COMPREHENSIVE SERIES OF RADIOGRAPHIC IMAGES	0-999		NO	
D0220	INTRAORAL - PERIAPICAL FIRST RADIOGRAPHIC IMAGE	0-999	ONE PER DAY	NO	
D0230	INTRAORAL - PERIAPICAL EACH ADDITIONAL IMAGE	0-999	THREE PER DAY	NO	
D0240	INTRAORAL - OCCLUSAL RADIOGRAPHIC IMAGE	0-999	TWO PER DAY	NO	
D0250	EXTRAORAL - 2D PROJECTION RADIOGRAPHIC IMAGE	0-999		NO	
D0270	BITEWING - SINGLE RADIOGRAPHIC IMAGE	0-999	ONE PER 6 MONTHS	NO	

CODE	CODE DESCRIPTION	AGE	BENEFIT FREQUENCY	AUTH REQD	REQUIRED DOCUMENTATION
D0272	BITEWINGS - TWO RADIOGRAPHIC IMAGES	0-999	ONE PER 6 MONTHS	NO	
D0273	BITEWINGS - THREE RADIOGRAPHIC IMAGES	0-999	ONE PER 6 MONTHS	NO	
D0274	BITEWINGS - FOUR RADIOGRAPHIC IMAGES	0-999	ONE PER 6 MONTHS	NO	
D0321	OTHER TEMPOROMANDIBULAR JOINT RADIOGRAPHIC IMAGES, BY REPORT	0-999		NO	
D0330	PANORAMIC RADIOGRAPHIC IMAGE	0-999		YES	NARRATIVE OF MEDICAL NECESSITY
D0340	2D CEPHALOMETRIC RADIOGRAPHIC IMAGE	0-999		NO	
D0350	ORAL/FACIAL PHOTOGRAPHIC IMAGES	0-999	ONE PER 12 MONTHS	NO	
D0350	ORAL/FACIAL PHOTOGRAPHIC IMAGES	0-999	THREE PER 12 MONTHS	NO	
D0367	CONE BEAM - BOTH JAWS	0-999		NO	
D0372	INTRAORAL TOMOSYNTHESIS – COMPREHENSIVE SERIES OF RADIOGRAPHIC IMAGES	0-999		YES	NARRATIVE OF MEDICAL NECESSITY
D0373	INTRAORAL TOMOSYNTHESIS – BITEWING RADIOGRAPHIC IMAGE	0-999		YES	NARRATIVE OF MEDICAL NECESSITY
D0374	INTRAORAL TOMOSYNTHESIS – PERIAPICAL RADIOGRAPHIC IMAGE	0-999		YES	NARRATIVE OF MEDICAL NECESSITY
D0387	INTRAORAL TOMOSYNTHESIS – COMPREHENSIVE SERIES OF RADIOGRAPHIC IMAGES – IMAGE CA	0-999		YES	NARRATIVE OF MEDICAL NECESSITY
D0388	INTRAORAL TOMOSYNTHESIS – BITEWING RADIOGRAPHIC IMAGE – IMAGE CAPTURE ONLY	0-999		YES	NARRATIVE OF MEDICAL NECESSITY
D0389	INTRAORAL TOMOSYNTHESIS – PERIAPICAL RADIOGRAPHIC IMAGE – IMAGE CAPTURE ONLY	0-999		YES	NARRATIVE OF MEDICAL NECESSITY
D0396	3D PRINTING OF A 3D DENTAL SURFACE SCAN	0-999		NO	
D0411	HBA1C IN-OFFICE POINT OF SERVICE TESTING	0-999		YES	NARRATIVE OF MEDICAL NECESSITY
D0412	TEST FOR DIABETES	0-999		YES	NARRATIVE OF MEDICAL NECESSITY
D0470	DIAGNOSTIC CASTS	0-999	TWO PER 12 MONTHS	NO	
D0604	ANTIGEN TESTING FOR A PUBLIC HEALTH RELATED PATHOGEN, INCLUDING CORONAVIRUS	0-999		NO	
D0605	ANTIBODY TESTING FOR A PUBLIC HEALTH RELATED PATHOGEN, INCLUDING CORONAVIRUS	0-999		NO	
D0606	MOLECULAR TESTING FOR A PUBLIC HEALTH RELATED PATHOGEN, INCLUDING CORONAVIRUS	0-999		NO	

CODE	CODE DESCRIPTION	AGE	BENEFIT FREQUENCY	AUTH REQD	REQUIRED DOCUMENTATION
D0801	3D INTRAORAL SURFACE SCAN	0-999		YES	NARRATIVE OF MEDICAL NECESSITY
D0802	3D DENTAL SURFACE SCAN – INDIRECT A SURFACE SCAN OF A DIAGNOSTIC CAST	0-999		YES	NARRATIVE OF MEDICAL NECESSITY
D0803	3D FACIAL SURFACE SCAN – DIRECT	0-999		YES	NARRATIVE OF MEDICAL NECESSITY
D0804	3D FACIAL SURFACE SCAN – INDIRECT A SURFACE SCAN OF CONSTRUCTED FACIAL FEATURE	0-999		YES	NARRATIVE OF MEDICAL NECESSITY
D0999	FQHC ENCOUNTER PAYMENT	0-999		NO	
D1110	PROPHYLAXIS - ADULT	14-999	ONE PER 180 DAYS	NO	
D1110	PROPHYLAXIS - ADULT	14-999	THREE PER 365 DAYS	NO	
D1120	PROPHYLAXIS - CHILD	0-13	ONE PER 180 DAYS	NO	
D1206	TOPICAL APPLICATION OF FLUORIDE VARNISH	0-20		NO	
D1208	TOPICAL APPLICATION OF FLUORIDE	0-20		NO	
D1301	IMMUNIZATION COUNSELING	0-999		NO	
D1320	TOBACCO COUNSELING FOR THE CONTROL AND PREVENTION OF ORAL DISEASE	0-999	TWO PER 365 DAYS	NO	
D1321	COUNSELING FOR THE CONTROL AND PREVENTION OF ADVERSE ORAL, BEHAVIORAL, AND SYSTEM	0-999	TWO PER 365 DAYS	NO	
D1351	SEALANT - PER TOOTH	0-20	ONE PER 5 FLOATING YEARS	NO	
D1354	INTERIM CARIES ARRESTING MEDICAMENT APPLICATION	0-999	THREE PER 1 FLOATING YEAR	NO	
D1510	SPACE MAINTAINER – FIXED, UNILATERAL - PER QUADRANT	0-20	ONE PER LIFETIME	NO	
D1516	SPACE MAINTAINER - FIXED - BILATERAL, MAXILLARY	0-20		NO	
D1517	SPACE MAINTAINER - FIXED - BILATERAL, MANDIBULAR	0-20		NO	
D1520	SPACE MAINTAINER – REMOVABLE, UNILATERAL - PER QUADRANT	0-20	ONE PER LIFETIME	NO	
D1526	SPACE MAINTAINER - REMOVABLE - BILATERAL, MAXILLARY	0-20		NO	
D1527	SPACE MAINTAINER - REMOVABLE - BILATERAL, MANDINULAR	0-20		NO	
D2140	AMALGAM - ONE SURFACE, PRIMARY OR PERMANENT	0-999		NO	
D2150	AMALGAM - TWO SURFACES, PRIMARY OR PERMANENT	0-999		NO	
D2160	AMALGAM - THREE SURFACES, PRIMARY OR PERMANENT	0-999		NO	

CODE	CODE DESCRIPTION	AGE	BENEFIT FREQUENCY	AUTH REQD	REQUIRED DOCUMENTATION
D2161	AMALGAM - FOUR OR MORE SURFACES, PRIMARY OR PERMANENT	0-999		NO	
D2330	RESIN-BASED COMPOSITE - ONE SURFACE, ANTERIOR	0-999		NO	
D2331	RESIN-BASED COMPOSITE - TWO SURFACES, ANTERIOR	0-999		NO	
D2332	RESIN-BASED COMPOSITE - THREE SURFACES, ANTERIOR	0-999		NO	
D2335	RESIN-BASED COMPOSITE – FOUR OR MORE SURFACES (ANTERIOR)	0-999		NO	
D2390	RESIN-BASED COMPOSITE CROWN, ANTERIOR	0-20		NO	
D2391	RESIN-BASED COMPOSITE - ONE SURFACE, POSTERIOR	0-999		NO	
D2392	RESIN-BASED COMPOSITE - TWO SURFACES, POSTERIOR	0-999		NO	
D2393	RESIN-BASED COMPOSITE - THREE SURFACES, POSTERIOR	0-999		NO	
D2394	RESIN-BASED COMPOSITE - FOUR OR MORE SURFACES, POSTERIOR	0-999		NO	
D2740	CROWN - PORCELAIN/CERAMIC	0-999		YES	PRE-OPERATIVE X-RAY
D2751	CROWN - PORCELAIN FUSED TO PREDOMINANTLY BASE METAL	0-999		YES	PRE-OPERATIVE X-RAY
D2752	CROWN - PORCELAIN FUSED TO NOBLE METAL	0-999		YES	PRE-OPERATIVE X-RAY
D2920	RE-CEMENT OR RE-BOND CROWN	0-999		NO	
D2928	PREFABRICATED PORCELAIN/CERAMIC CROWN – PERMANENT TOOTH	0-999		NO	
D2929	PREFABRICATED PORCELAIN / CERAMIC CROWN - PRIMARY TOOTH	0-999	ONE PER 36 MONTHS	NO	
D2930	PREFABRICATED STAINLESS STEEL CROWN - PRIMARY TOOTH	0-20		NO	
D2931	PREFABRICATED STAINLESS STEEL CROWN - PERMANENT TOOTH	0-999	ONE PER 36 MONTHS	NO	
D2933	PREFABRICATED STAINLESS STEEL CROWN WITH RESIN WINDOW	0-20	ONE PER 36 MONTHS	NO	
D2934	PREFABRICATED ESTHETIC COATED STAINLESS-STEEL CROWN - PRIMARY TOOTH	0-20	ONE PER 36 MONTHS	NO	
D2940	PLACEMENT OF INTERIM DIRECT RESTORATION PROTECTIVE RESTORATION	0-999	ONE PER 180 DAYS	NO	
D2941	INTERIM THERAPEUTIC RESTORATION	0-999	ONE PER 180 DAYS	NO	
D2950	CORE BUILDUP, INCLUDING ANY PINS WHEN REQUIRED	0-999	ONE PER LIFETIME	NO	

CODE	CODE DESCRIPTION	AGE	BENEFIT FREQUENCY	AUTH REQD	REQUIRED DOCUMENTATION
D2951	PIN RETENTION - PER TOOTH, IN ADDITION TO RESTORATION	0-999	THREE PER LIFETIME	NO	
D2952	POST AND CORE IN ADDITION TO CROWN, INDIRECTLY FABRICATED	0-999	ONE PER 1 DAY	YES	PRE-OPERATIVE X-RAY
D2954	PREFABRICATED POST AND CORE IN ADDITION TO CROWN	0-999	ONE PER 1 DAY	YES	PRE-OPERATIVE X-RAY
D2976	BAND STABILIZATION – PER TOOTH	0-999		NO	
D2989	EXCAVATION OF A TOOTH RESULTING IN THE DETERMINATION OF NON-RESTORABILITY	0-999		NO	
D2991	APPLICATION OF HYDROXYAPATITE REGENERATION MEDICAMENT – PER TOOTH	0-999	APPROVAL UP TO FOUR (4) TEETH PER DATE OF SERVICE AND NOT IN CONJUNCTION WITH D1206 OR D1208.	YES	DIAGNOSTIC-QUALITY RADIOGRAPHIC IMAGES ARE REQUIRED. X-RAYS WITH AI MARKUP ARE UNACCEPTABLE. NOT APPROVED IN CONJUNCTION WITH D1351 OR D1354 FOR 6 MONTHS. APPROVAL FOR RADIOGRAPHIC INCIPIENT DECAY. X-RAYS AND PHOTOS OF AFFECTED SURFACES ARE REQUIRED.
D3220	THERAPEUTIC PULPOTOMY	0-20		NO	
D3310	ENDODONTIC THERAPY, ANTERIOR TOOTH (EXCLUDING FINAL RESTORATION)	0-999	ONE PER LIFETIME	NO	
D3320	ENDODONTIC THERAPY, PREMOLAR TOOTH (EXCLUDING FINAL RESTORATION)	0-999	ONE PER LIFETIME	NO	
D3330	ENDODONTIC THERAPY, MOLAR TOOTH (EXCLUDING FINAL RESTORATION)	0-999	ONE PER LIFETIME	NO	
D3351	APEXIFICATION / RECALCIFICATION - INITIAL VISIT	0-999		NO	
D3352	APEXIFICATION / RECALCIFICATION - INTERIM	0-999		NO	
D3353	APEXIFICATION / RECALCIFICATION - FINAL VISIT	0-999		NO	
D3410	APICOECTOMY - ANTERIOR	0-999	ONE PER LIFETIME	NO	
D4210	GINGIVECTOMY OR GINGIVOPLASTY - FOUR OR MORE CONTIGUOUS TEETH	0-999		YES	NARRATIVE OF MEDICAL NECESSITY, PRE-OP X-RAYS AND PHOTOS
D4211	GINGIVECTOMY OR GINGIVOPLASTY - ONE TO THREE CONTIGUOUS TEETH	0-999		YES	NARRATIVE OF MEDICAL NECESSITY, PRE-OP X-RAYS AND PHOTOS
D4286	REMOVAL OF NON-RESORBABLE BARRIER	0-999		YES	NARRATIVE OF MEDICAL NECESSITY
D4341	PERIODONTAL SCALING AND ROOT PLANING - FOUR OR MORE TEETH PER QUADRANT	0-999		YES	TREATMENT PLAN, FMX (EXCLUDING PAN), PERIO CHART
D4342	PERIODONTAL SCALING AND ROOT PLANING - ONE TO THREE TEETH PER QUADRANT	0-999		YES	TREATMENT PLAN, FMX (EXCLUDING PAN), PERIO CHART

CODE	CODE DESCRIPTION	AGE	BENEFIT FREQUENCY	AUTH REQD	REQUIRED DOCUMENTATION
D4910	PERIODONTAL MAINTENANCE	0-999	TWO PER 365 DAYS	NO	
D5110	COMPLETE DENTURE - MAXILLARY	0-999	ONE PER 8 FLOATING YEARS	YES	FMX OR PAN INIT DEN/DATE PR PLMNT OR NARR-EDENT/LTC-CONS FORM, NURSING CARE PLAN
D5120	COMPLETE DENTURE - MANDIBULAR	0-999	ONE PER 8 FLOATING YEARS	YES	FMX OR PAN INIT DEN/DATE PR PLMNT OR NARR-EDENT/LTC-CONS FORM, NURSING CARE PLAN
D5130	IMMEDIATE DENTURE - MAXILLARY	0-999		YES	FMX OR PAN / IF LTC-PAT. CONSENT FORM, NURSING CARE PLAN & NARR.
D5140	IMMEDIATE DENTURE - MANDIBULAR	0-999		YES	FMX OR PAN / IF LTC-PAT. CONSENT FORM, NURSING CARE PLAN & NARR.
D5211	MAXILLARY PARTIAL DENTURE - RESIN BASE	0-999		YES	FMX OR PAN / IF LTC-PAT. CONSENT FORM, NURSING CARE PLAN & NARR.
D5212	MANDIBULAR PARTIAL DENTURE - RESIN BASE	0-999		YES	FMX OR PAN / IF LTC-PAT. CONSENT FORM, NURSING CARE PLAN & NARR.
D5213	MAXILLARY PARTIAL DENTURE - CAST METAL FRAMEWORK WITH RESIN DENTURE BASES	0-999		YES	FMX OR PAN / IF LTC-PAT. CONSENT FORM, NURSING CARE PLAN & NARR.
D5214	MANDIBULAR PARTIAL DENTURE - CAST METAL FRAMEWORK WITH RESIN DENTURE BASES	0-999		YES	FMX OR PAN / IF LTC-PAT. CONSENT FORM, NURSING CARE PLAN & NARR.
D5225	MAXILLARY PARTIAL DENTURE - FLEXIBLE BASE (INCLUDING ANY RETENTIVE CLASPING MATE	0-999	ONE PER 8 FLOATING YEARS	YES	FULL MOUTH SERIES OR PANORAMIC X-RAY
D5226	MANDIBULAR PARTIAL DENTURE - FLEXIBLE BASE (INCLUDING ANY RETENTIVE CLASPING MAT	0-999	ONE PER 8 FLOATING YEARS	YES	FULL MOUTH SERIES OR PANORAMIC X-RAY
D5282	REMOVABLE UNILATERAL PARTIAL DENTURE - ONE PIECE CAST METAL (INCLUDING RETENTIVE	0-999		YES	NARRATIVE OF MEDICAL NECESSITY
D5283	REMOVABLE UNILATERAL PARTIAL DENTURE - ONE PIECE CAST METAL (INCLUDING RETENTIVE	0-999		YES	NARRATIVE OF MEDICAL NECESSITY
D5511	REPAIR BROKEN COMPLETE DENTURE BASE - MANDIBULAR	0-999	ONE PER 3 FLOATING YEARS	NO	
D5512	REPAIR BROKEN COMPLETE DENTURE BASE - MAXILLARY	0-999	ONE PER 3 FLOATING YEARS	NO	
D5520	REPLACE MISSING OR BROKEN TEETH – COMPLETE DENTURE (EACH TOOTH) – PER TOOTH	0-999		NO	
D5611	REPAIR RESIN DENTURE BASE - MANDIBULAR	0-999	ONE PER 3 FLOATING YEARS	NO	
D5612	REPAIR RESIN DENTURE BASE - MAXILLARY	0-999	ONE PER 3 FLOATING YEARS	NO	

CODE	CODE DESCRIPTION	AGE	BENEFIT FREQUENCY	AUTH REQD	REQUIRED DOCUMENTATION
D5621	REPAIR CAST FRAMEWORK - MANDIBULAR	0-999	ONE PER 3 FLOATING YEARS	NO	
D5622	REPAIR CAST FRAMEWORK - MAXILLARY	0-999	ONE PER 3 FLOATING YEARS	NO	
D5630	REPAIR OR REPLACE BROKEN CLASP - PER TOOTH	0-999		NO	
D5640	REPLACE MISSING OR BROKEN TEETH – PARTIAL DENTURE – PER TOOTH	0-999		NO	
D5650	ADD TOOTH TO EXISTING PARTIAL DENTURE – PER TOOTH	0-999		NO	
D5660	ADD CLASP TO EXISTING PARTIAL DENTURE - PER TOOTH	0-999		NO	
D5750	RELINE COMPLETE MAXILLARY DENTURE (INDIRECT)	0-999	ONE PER 36 MONTHS	NO	
D5751	RELINE COMPLETE MANDIBULAR DENTURE (INDIRECT)	0-999	ONE PER 36 MONTHS	NO	
D5760	RELINE MAXILLARY PARTIAL DENTURE (INDIRECT)	0-999	ONE PER 36 MONTHS	NO	
D5761	RELINE MANDIBULAR PARTIAL DENTURE (INDIRECT)	0-999	ONE PER 36 MONTHS	NO	
D5876	ADD METAL SUBSTRUCTURE TO ACRYLIC FULL DENTURE (PER ARCH) USE OF METAL SUBSTRUCT	0-999		YES	NARRATIVE OF MEDICAL NECESSITY
D5899	UNSPECIFIED REMOVABLE PROSTHODONTIC PROCEDURE, BY REPORT	0-999		YES	NARRATIVE OF MEDICAL NECESSITY AND DESCRIPTION OF PROCEDURE
D5913	NASAL PROSTHESIS	0-999		YES	NARRATIVE OF MEDICAL NECESSITY WITH CLAIM
D5915	ORBITAL PROSTHESIS	0-999		YES	NARRATIVE OF MEDICAL NECESSITY WITH CLAIM
D5916	OCULAR PROSTHESIS	0-999		YES	NARRATIVE OF MEDICAL NECESSITY WITH CLAIM
D5931	OBTURATOR PROSTHESIS, SURGICAL	0-999		YES	NARRATIVE OF MEDICAL NECESSITY WITH CLAIM
D5932	OBTURATOR PROSTHESIS, DEFINITIVE	0-999		YES	NARRATIVE OF MEDICAL NECESSITY WITH CLAIM
D5934	MANDIBULAR RESECTION PROSTHESIS WITH GUIDE FLANGE	0-999		YES	NARRATIVE OF MEDICAL NECESSITY WITH CLAIM
D5935	MANDIBULAR RESECTION PROSTHESIS WITHOUT GUIDE FLANGE	0-999		YES	NARRATIVE OF MEDICAL NECESSITY WITH CLAIM
D5955	PALATAL LIFT PROSTHESIS, DEFINITIVE	0-999		YES	NARRATIVE OF MEDICAL NECESSITY WITH CLAIM
D5999	UNSPECIFIED MAXILLOFACIAL PROSTHESIS, BY REPORT	21-999		YES	NARRATIVE OF MEDICAL NECESSITY AND DESCRIPTION OF PROCEDURE
D6089	ACCESSING AND RETORQUING LOOSE IMPLANT SCREW -PER SCREW	0-999		NO	

CODE	CODE DESCRIPTION	AGE	BENEFIT FREQUENCY	AUTH REQD	REQUIRED DOCUMENTATION
D6096	REMOVE BROKEN IMPLANT RETAINING SCREW	0-999		YES	NARRATIVE OF MEDICAL NECESSITY
D6105	REMOVAL OF IMPLANT BODY NOT REQUIRING BONE REMOVAL OR FLAP ELEVATION	0-999		YES	NARRATIVE OF MEDICAL NECESSITY
D6106	GUIDED TISSUE REGENERATION – RESORBABLE BARRIER, PER IMPLANT	0-999		YES	NARRATIVE OF MEDICAL NECESSITY
D6107	GUIDED TISSUE REGENERATION – NON-RESORBABLE BARRIER, PER IMPLANT	0-999		YES	NARRATIVE OF MEDICAL NECESSITY
D6197	REPLACEMENT OF RESTORATIVE MATERIAL USED TO CLOSE AN ACCESS OPENING OF A SCREW-R	0-999		YES	NARRATIVE OF MEDICAL NECESSITY
D7140	EXTRACTION, ERUPTED TOOTH OR EXPOSED ROOT	0-999		NO	
D7210	EXTRACTION, ERUPTED TOOTH	0-999		NO	
D7220	REMOVAL OF IMPACTED TOOTH - SOFT TISSUE	0-999		YES	PRE-OP X-RAYS (EXCLUDING BITEWINGS) AND NARRATIVE OF MEDICAL NECESSITY
D7230	REMOVAL OF IMPACTED TOOTH - PARTIALLY BONY	0-999		YES	PRE-OP X-RAYS (EXCLUDING BITEWINGS) AND NARRATIVE OF MEDICAL NECESSITY
D7240	REMOVAL OF IMPACTED TOOTH - COMPLETELY BONY	0-999		YES	PRE-OP X-RAYS (EXCLUDING BITEWINGS) AND NARRATIVE OF MEDICAL NECESSITY
D7241	REMOVAL OF IMPACTED TOOTH - COMPLETELY BONY, UNUSUAL SURGICAL COMPLICATIONS	0-999		YES	PRE-OP X-RAYS (EXCLUDING BITEWINGS) AND NARRATIVE OF MEDICAL NECESSITY
D7250	REMOVAL OF RESIDUAL TOOTH (CUTTING PROCEDURE)	0-999		YES	PRE-OP X-RAYS (EXCLUDING BITEWINGS) AND NARRATIVE OF MEDICAL NECESSITY
D7260	OROANTRAL FISTULA CLOSURE	0-999		YES	PRE-OP X-RAYS (EXCLUDING BITEWINGS) AND NARR OF MED NEC WITH CLAIM
D7270	REIMPLANTATION AND/OR STABILIZATION OF ACCIDENTALLY EVULSED / DISPLACED TOOTH	0-999		NO	
D7280	EXPOSURE OF AN UNERUPTED TOOTH	0-999	ONE PER LIFETIME	YES	PRE-OP X-RAYS (EXCLUDING BITEWINGS) AND NARR OF MED NEC WITH CLAIM
D7283	PLACEMENT OF DEVICE TO FACILITATE ERUPTION OF IMPACTED TOOTH	0-20	ONE PER LIFETIME	YES	PRE-OPERATIVE X-RAY
D7284	EXCISIONAL BIOPSY OF MINOR SALIVARY GLANDS	0-999		NO	
D7296	CORTICOTOMY - ONE TO THREE TEETH OR TOOTH SPACES, PER QUADRANT	0-999		YES	NARRATIVE OF MEDICAL NECESSITY
D7297	CORTICOTOMY - FOUR OR MORE TEETH OR TOOTH SPACES, PER QUADRANT	0-999		YES	NARRATIVE OF MEDICAL NECESSITY
D7310	ALVEOLOPLASTY IN CONJUNCTION WITH EXTRACTIONS - FOUR OR MORE TEETH	0-999	ONE PER LIFETIME	NO	

CODE	CODE DESCRIPTION	AGE	BENEFIT FREQUENCY	AUTH REQD	REQUIRED DOCUMENTATION
D7311	ALVEOLOPLASTY IN CONJUNCTION WITH EXTRACTIONS - ONE TO THREE TEETH	0-999		NO	
D7320	ALVEOLOPLASTY NOT IN CONJUNCTION WITH EXTRACTIONS - FOUR OR MORE TEETH	0-999	ONE PER LIFETIME	NO	
D7450	REMOVAL OF BENIGN ODONTOGENIC CYST OR TUMOR - DIA UP TO 1.25 CM	0-999		NO	
D7451	REMOVAL OF BENIGN ODONTOGENIC CYST OR TUMOR - DIA GREATER THAN 1.25 CM	0-999		NO	
D7460	REMOVAL OF BENIGN NONODONTOGENIC CYST OR TUMOR - DIA UP TO 1.25 CM	0-999		NO	
D7461	REMOVAL OF BENIGN NONODONTOGENIC CYST OR TUMOR - DIA GREATER THAN 1.25 CM	0-999		NO	
D7471	REMOVAL OF LATERAL EXOSTOSIS (MAXILLA OR MANDIBLE)	0-999	ONE PER LIFETIME	NO	
D7472	REMOVAL OF TORUS PALATINUS	0-999		NO	
D7473	REMOVAL OF TORUS MANDIBULARIS	0-999		NO	
D7509	MARSUPIALIZATION OF ODONTOGENIC CYST SURGICAL DECOMPRESSION OF A LARGE CYSTIC LE	0-999		YES	NARRATIVE OF MEDICAL NECESSITY
D7510	INCISION AND DRAINAGE OF ABSCESS - INTRAORAL SOFT TISSUE	0-999		NO	
D7520	INCISION AND DRAINAGE OF ABSCESS - EXTRAORAL SOFT TISSUE	0-999		NO	
D7670	ALVEOLUS - CLOSED REDUCTION, MAY INCLUDE STABILIZATION OF TEETH	0-999		NO	
D7671	ALVEOLUS - OPEN REDUCTION, MAY INCLUDE STABILIZATION OF TEETH	0-999		YES	NARRATIVE OF MEDICAL NECESSITY, X-RAYS, OR PHOTOS OPTIONAL
D7899	UNSPECIFIED TMD THERAPY, BY REPORT	0-999		YES	NARRATIVE OF MEDICAL NECESSITY AND DESCRIPTION OF PROCEDURE
D7939	INDEXING FOR OSTEOTOMY USING DYNAMIC ROBOTIC ASSISTED OR DYNAMIC NAVIGATION	0-999		NO	
D7956	GUIDED TISSUE REGENERATION, EDENTULOUS AREA – RESORBABLE BARRIER, PER SITE	0-999		YES	NARRATIVE OF MEDICAL NECESSITY
D7957	GUIDED TISSUE REGENERATION, EDENTULOUS AREA – NON-RESORBABLE BARRIER, PER SITE	0-999		YES	NARRATIVE OF MEDICAL NECESSITY
D7961	BUCCAL / LABIAL FRENECTOMY (FRENULECTOMY)	0-999		NO	

CODE	CODE DESCRIPTION	AGE	BENEFIT FREQUENCY	AUTH REQD	REQUIRED DOCUMENTATION
D7962	LINGUAL FRENECTOMY (FRENULECTOMY)	0-999		NO	
D7970	EXCISION OF HYPERPLASTIC TISSUE - PER ARCH	0-999		NO	
D7979	NON-SURGICAL SIALOLITHOTOMY	0-999		YES	NARRATIVE OF MEDICAL NECESSITY
D8080	COMPREHENSIVE ORTHODONTIC TREATMENT OF THE ADOLESCENT DENTITION	0-20	ONE PER LIFETIME	YES	PAN OR FMX / CEPH / DIAG PHOTOS (5-7) / REF EVAL CRIT FORM (ODM03630 FORM)
D8210	REMOVABLE APPLIANCE THERAPY	0-999		NO	
D8220	FIXED APPLIANCE THERAPY	0-999	TWO PER 1 DAY	YES	PANOREX AND/OR CEPHALOMETRIC, NARRATIVE OF MEDICAL NECESSITY
D8670	PERIODIC ORTHODONTIC TREATMENT VISIT	0-20	SEVEN PER LIFETIME	YES	COPY OF ORIGINAL APPROVAL, BANDING DATE, PAYMENT HISTORY
D8680	ORTHODONTIC RETENTION (REMOVAL OF APPLIANCES, PLACE RETAINERS)	0-20	TWO PER LIFETIME	YES	IF NO APPROVED D8080 - HISTORY OF ORTHO CASE, PAN, CEPH, PHOTOS
D8695	REMOVAL OF FIXED ORTHODONTIC APPLIANCES - REASONS OTHER THAN TREATMENT COMPLETED	0-999		YES	NARRATIVE OF MEDICAL NECESSITY
D8999	UNSPECIFIED ORTHODONTIC PROCEDURE, BY REPORT	0-999		YES	NARRATIVE OF MEDICAL NECESSITY AND COC FORM
D9130	TEMPOROMANDIBULAR JOINT DYSFUNCTION - NON-INVASIVE PHYSICAL THERAPIES	0-999		YES	NARRATIVE OF MEDICAL NECESSITY
D9222	DEEP SEDATION/GENERAL ANESTHESIA - FIRST 15 MINUTES	0-999	ONE PER 1 DAY	NO	
D9223	DEEP SEDATION / GENERAL ANESTHESIA - EACH SUBSEQUENT 15 MINUTE INCREMENT	0-999	FOUR PER 1 DAY	NO	
D9230	INHALATION OF NITROUS/ANALGESIA, ANXIOLYSIS	0-999	ONE PER 1 DAY	NO	
D9239	INTRAVENOUS MODERATE (CONSCIOUS) SEDATION/ANALGESIA - FIRST 15 MINUTES	0-999	ONE PER 1 DAY	NO	
D9243	INTRAVENOUS MODERATE (CONSCIOUS) SEDATION/ANALGESIA - EACH SUBSEQUENT 15 MINUTE	0-999	FOUR PER 1 DAY	NO	
D9610	THERAPEUTIC PARENTERAL DRUG, SINGLE ADMINISTRATION	0-999	ONE PER 1 DAY	NO	
D9612	THERAPEUTIC PARENTERAL DRUGS, TWO OR MORE ADMINISTRATIONS	0-999		NO	
D9613	INFILTRATION OF SUSTAINED RELEASE THERAPEUTIC DRUG, PER QUADRANT	0-999		YES	NARRATIVE OF MEDICAL NECESSITY
D9920	BEHAVIOR MANAGEMENT, BY REPORT	0-999		YES	NARRATIVE OF MEDICAL NECESSITY

CODE	CODE DESCRIPTION	AGE	BENEFIT FREQUENCY	AUTH REQD	REQUIRED DOCUMENTATION
D9938	FABRICATION OF A CUSTOM REMOVABLE CLEAR PLASTIC TEMPORARY AESTHETIC APPLIANCE	0-999		NO	
D9939	PLACEMENT OF A CUSTOM REMOVABLE CLEAR PLASTIC TEMPORARY AESTHETIC APPLIANCE	0-999		NO	
D9944	OCCLUSAL GUARD	21-999		NO	
D9945	OCCLUSAL GUARD	21-999		NO	
D9946	OCCLUSAL GUARD	21-999		NO	
D9947	CUSTOM SLEEP APNEA APPLIANCE FABRICATION AND PLACEMENT	0-999		YES	NARRATIVE OF MEDICAL NECESSITY
D9948	ADJUSTMENT OF CUSTOM SLEEP APNEA APPLIANCE	0-999		YES	NARRATIVE OF MEDICAL NECESSITY
D9949	REPAIR OF CUSTOM SLEEP APNEA APPLIANCE	0-999		YES	NARRATIVE OF MEDICAL NECESSITY
D9953	RELINE CUSTOM SLEEP APNEA APPLIANCE (INDIRECT) RESURFACE DENTITION SIDE OF APPLI	0-999		YES	NARRATIVE OF MEDICAL NECESSITY
D9954	FABRICATION AND DELIVERY OF ORAL APPLIANCE THERAPY (OAT) MORNING REPOSITIONING D	0-999		NO	
D9955	ORAL APPLIANCE THERAPY (OAT) TITRATION VISIT	0-999		NO	
D9956	ADMINISTRATION OF HOME SLEEP APNEA TEST	0-999		NO	
D9957	SCREENING FOR SLEEP RELATED BREATHING DISORDERS	0-999		NO	
D9961	DUPLICATE / COPY PATIENT'S RECORDS	0-999		YES	NARRATIVE OF MEDICAL NECESSITY
D9990	TRANSLATION SERVICES	0-999		YES	NARRATIVE OF MEDICAL NECESSITY
D9995	TELEDENTISTRY - SYNCHRONOUS; REAL-TIME ENCOUNTER	0-999		NO	
D9996	TELEDENTISTRY - ASYNCHRONOUS; INFORMATION STORED AND FORWARDED TO DENTIST	0-999		YES	NARRATIVE OF MEDICAL NECESSITY
D9997	DENTAL CASE MANAGEMENT	0-999		YES	NARRATIVE OF MEDICAL NECESSITY
D9999	UNSPECIFIED ADJUNCTIVE PROCEDURE, BY REPORT	0-999		YES	DESC OF PROCEDURE/ NARR OF MED NEC/ NAME OF HOSPITAL/OR FACILITY (IF NECESSARY)

Molina covers the services described in the Summary of Benefits documentation. If there are questions as to whether a service is covered, please

consult the state Medicaid website. You may also contact the Molina Provider Contact Center at (855) 322-4079 (7 a.m. to 8 p.m. EST, Monday through Friday).

Non-emergency transportation

For Molina Members who have non-emergency Dental transportation as a covered service, Molina covers transportation to Dental facilities when the Member's medical and physical condition does not allow them to take regular means of public or private transportation (car, bus, etc.). This requires a written prescription from the Member's doctor. Examples of non-emergency medical transportation include but are not limited to litter vans and wheelchair-accessible vans. Members require prior authorization from Molina for ground and air ambulance services before the services are rendered. Prior authorization is not required for vans, taxis, etc., where they are covered benefits. Additional information regarding the availability of this benefit is available by contacting the Molina Provider Contact Center at (855) 322-4079 (7 a.m. to 8 p.m. EST, Monday through Friday).

Emergency services

Emergency Services means: a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in any of the following: placing the health of the individual (or, with respect to a pregnant Member, the health of the Member or their unborn child) in serious jeopardy; serious impairment to bodily functions; or serious dysfunction of any bodily organ or part.

Molina covers emergency and urgent care Services without authorization. This includes non-contracted Providers inside or outside Molina's service area.

24-hour Nurse Advice Line

Members may call the 24-hour Nurse Advice Line any time they are experiencing symptoms or need health care information. Registered nurses are available 24 hours a day, 7 days a week, 365 days a year.

Molina is committed to helping our Members:

- Prudently use the services of the Provider's office
- Understand how to handle routine health problems at home
- Avoid making non-emergent visits to the emergency room

These registered nurses do not diagnose. They assess symptoms and guide the patient to the most appropriate level of care following specially designed algorithms unique to the 24-hour Nurse Advice Line. The 24-hour Nurse Advice Line may refer back to the PCD, a specialist, 911, or the emergency room. Educating patients reduces costs and over-utilization of the health care system.

5. Health care services

Introduction

Health care services (HCS) are comprised of utilization management (UM) and care management (CM) departments that work together to achieve an integrated model based upon empirically validated best practices that have demonstrated positive results. Research and experience show that a higher-touch, Member-centric care environment for at-risk Members supports better health outcomes. Molina provides CM services to Members to address a broad spectrum of needs, including chronic conditions that require the coordination and provision of health care services. Elements of the Molina management program include pre-service authorization review, inpatient authorization management that includes pre-admission, admission, and concurrent Dental necessity review and restrictions on the use of out-of-network or non-participating Providers.

Utilization management (UM)

Molina ensures the service delivered is medically necessary and demonstrates an appropriate use of resources based on the level of care needed for a Member. This program promotes the provision of quality, cost-effective, and medically appropriate services that are offered across a continuum of care, as well as integrating a range of services appropriate to meet individual needs. Molina's UM program maintains flexibility to adapt to changes in the Member's condition and is designed to influence a Member's care by:

- Managing available benefits effectively and efficiently while ensuring quality care
- Evaluating the Dental necessity and efficiency of health care services across the continuum of care
- Defining the review criteria, information sources, and processes that are used to review and approve the provision of items and services, including prescription drugs
- Coordinating, directing, and monitoring the quality and cost effectiveness of health care resource utilization

- Implementing comprehensive processes to monitor and control the utilization of health care resources
- Ensuring services are available in a timely manner, in appropriate settings, and are planned, individualized, and measured for effectiveness
- Reviewing processes to ensure care is safe and accessible
- Ensuring qualified health care professionals perform all components of the UM processes
- Ensuring that UM decision making tools are appropriately applied in determining Dental necessity decision

Key functions of the UM program

All prior authorizations are based on a specific standardized list of services. The key functions of the UM program are listed below.

- **Eligibility and oversight**
  - Eligibility verification
  - Benefit administration and interpretation
  - Verification that authorized care correlates to Member's Dental necessity need(s) and benefit plan
  - Verifying of current physician/hospital contract status
- **Resource management**
  - Prior authorization and referral management
  - Admission and inpatient review
  - Referrals for discharge planning and care transitions
  - Staff education on consistent application of UM functions
- **Quality Management**
  - Evaluate satisfaction of the UM program using Member and Provider input
  - Utilization data analysis
  - Monitor for possible over- or under-utilization of clinical resources
  - Quality oversight
  - Monitor for adherence to CMS, NCQA, state and health plan UM standards

For more information about Molina's UM program or to obtain a copy of the HCS program description, clinical criteria used for decision making, and how to contact a UM reviewer, access the Molina website or contact the UM department.

UM decisions

An organizational determination is any decision made by Molina, SKYGEN or other delegated entity with respect to the following:

- Determination to authorize, provide, or pay for services (favorable determination
- Determination to delay, modify, or deny authorization or payment of request (adverse determination)

Molina follows a hierarchy of medical necessity decision making with federal and state regulations taking precedence. Molina covers all services and items required by state and federal regulations.

Board-certified licensed reviewers from appropriate specialty areas are utilized to assist in making determinations of medical necessity, as appropriate. All utilization determinations are made in a timely manner to accommodate the clinical urgency of the situation, in accordance with federal and state regulatory requirements and NCQA standards.

Requests for authorization not meeting medical necessity criteria are reviewed by a designated Molina Dental director or other appropriate clinical professional. Only a licensed physician or pharmacist, doctoral-level clinical psychologist, or certified addiction medicine specialist, as appropriate, may determine to delay, modify, or deny authorization of services to a Member.

Where applicable, Molina clinical policies can be found on the public website at MolinaClinicalPolicy.com. Please note that Molina follows state-specific criteria, if available, before applying Molina-specific criteria.

Medical necessity

This is for the purpose of preventing, evaluating, diagnosing, or treating an illness, injury, disease, or its symptoms. Those services must be deemed by Molina to be:

1. In accordance with generally accepted standards of Dental practice.
2. Clinically appropriate and clinically significant, in terms of type, frequency, extent, site, and duration. They are considered effective for the patient's illness, injury, or disease.
3. Not primarily for the convenience of the patient, physician, or other health care Provider. The services must not be more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury, or disease.

For these purposes, "generally accepted standards of Dental practice" means standards that are based on credible scientific evidence published in peer-reviewed Dental literature. This literature is generally recognized by the relevant

Dental community, dental specialty society recommendations, the views of dentists practicing in relevant clinical areas, and any other relevant factors.

The fact that a Provider has prescribed, recommended, or approved Dental or allied goods or services does not, by itself, make such care, goods, or services medically necessary, a medical necessity, or a covered service/benefit.

Medical necessity review

Molina only reimburses for services that are medically necessary. Medical necessity review may take place prospectively or retrospectively. To determine medical necessity, in conjunction with independent professional medical judgment, Molina uses nationally recognized evidence-based guidelines, third-party guidelines, CMS guidelines, state guidelines, Molina clinical policies, guidelines from recognized professional societies, and advice from authoritative review articles and textbooks.

Levels of administrative and clinical review

The Molina review process begins with an administrative review, followed by a clinical review if appropriate. Administrative review includes verifying eligibility, the appropriate vendor or Participating Provider, and benefit coverage. The Clinical review includes medical necessity and level of care.

All UM requests that may lead to a medical necessity adverse determination are reviewed by a Dental Consultant at SKYGEN.

Molina's Provider training includes information on the UM processes and authorization requirements.

Clinical information

Molina requires copies of clinical information to be submitted for documentation. Molina does not accept clinical or telephone summaries as meeting the clinical information requirements unless state or federal regulations allow such documentation to be acceptable.

Prior authorization

Molina requires prior authorization for specified services as long as the requirement complies with federal or state regulations and the Provider Agreement with Molina.

Providers must include the following information:

- Member demographic information (name, date of birth, Molina Member ID number)
- Provider demographic information (referring Provider and referred to Provider/facility, including address and NPI number)
- Requested service/procedure, including all appropriate CDT codes
- Location where the service will be performed
- Clinical information sufficient to document the Dental necessity of the requested service is required, including:
    - Pertinent Dental history (include treatment, diagnostic tests, and examination data)
    - Rationale for expedited processing

Services performed without authorization may not be eligible for payment. Services provided emergently (as defined by federal and state law) are excluded from the prior authorization requirements. Obtaining authorization does not guarantee payment. Molina retains the right to review benefit limitations and exclusions, beneficiary eligibility on the date of service, correct coding, billing practices, and whether the service was provided in the most appropriate and cost-effective setting of care. Molina does not retroactively authorize services that require prior authorization.

Molina follows all prior authorization requirements related to care for newborns and their mothers in alignment with the Newborns' and Mothers' Health Protection Act of 1996 (NMHPA).

SKYGEN makes UM decisions in a timely manner to accommodate the urgency of the situation as determined by the Member's clinical situation. The definition of expedited/urgent is when the standard time frame or decision-making process could seriously jeopardize the life or health of the Member, the health or safety of the Member, or others due to the Member's psychological state or in the opinion of the Provider with knowledge of the Member's medical, dental or behavioral health condition, would subject the Member to adverse health consequences without the care or treatment that is subject of the request or could jeopardize the Member's ability to regain maximum function. Supporting documentation is required to justify the expedited request.

Molina will make an organizational determination as promptly as the Member's health requires and no later than contractual and regulatory requirements. Expedited time frames are followed when the Provider indicates or if we determine that a standard authorization decision time frame could jeopardize a Member's life or health.

Providers who request prior authorization for services and/or procedures may request to review the criteria used to make the final decision. A Molina Dental director is available by appointment to discuss medical necessity decisions with the requesting Provider.

Upon approval, the requestor will receive an authorization number. The number may be provided by telephone, fax, or via the SKYGEN DENTAL HUB. If a request is denied, the requestor and the Member will receive a letter explaining the reason for the denial and additional information regarding the grievance and appeals process. Denials are also communicated to the Provider via fax.

Peer-to-peer review

Upon receipt of an adverse determination, the Provider (peer) may request a peer-to-peer discussion within five (5) business days from the notification.

A "peer" is considered the Member's or Provider's clinical representative (licensed Dental professional). Contracted external parties, administrators, or facility UM staff can only request that a peer-to-peer telephone communication be arranged and performed, but the discussion should be performed by a peer.

When requesting a peer-to-peer discussion, please be prepared with the following information:

- Member name and Molina Member ID number
- Authorization ID number
- Requesting the Provider's name, contact number, and best times to call

Requesting prior authorization

Notwithstanding any provision in the Provider Agreement with Molina that requires the Provider to obtain prior authorization directly from Molina, Molina may choose to contract with external vendors to help manage prior authorization requests.

Participating Providers are encouraged to use the SKYGEN DENTAL HUB for prior authorization submissions whenever possible. Instructions for how to submit a prior authorization request are available on the SKYGEN DENTAL HUB. The benefits of submitting your prior authorization request through the SKYGEN DENTAL HUB are:

- Create and submit prior authorization requests
- Check status of prior authorization requests
- Receive notification of changes in the status of prior authorization requests

- Attach Dental documentation required for timely Dental review and decision-making

Open communication about treatment

Molina prohibits contracted Providers from limiting Provider or Member communication regarding a Member's health care. Providers may freely communicate with and act as an advocate for their patients. Molina requires provisions within Provider contracts that prohibit solicitation of Members for alternative coverage arrangements for the primary purpose of securing financial gain. No communication regarding treatment options may be represented or construed to expand or revise the scope of benefits under a health plan or insurance contract.

Molina and its contracted Providers may not enter into contracts that interfere with any ethical responsibility or legal right of Providers to discuss information with a Member about the Member's health care. This includes, but is not limited to, treatment options, alternative plans, or other coverage arrangements.

Delegated utilization management functions

Molina delegates UM functions to qualifying delegated entities at SKYGEN. The entities must have the ability to perform the delegated activities and maintain specific delegation criteria in compliance with all current Molina policies and regulatory and certification requirements. For more information about delegated UM functions and the oversight of such delegation, please refer to the **Delegation** section of this Provider Manual.

Emergency services

Emergency Services means services provided to evaluate or treat an Emergency Medical Condition

Emergency Medical Condition or Emergency means: An Emergency Medical Condition is a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, with an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

1. Serious jeopardy to the health of the individual or, in the case of a pregnant Member, the health of the Member or their unborn child;
2. Serious impairment to bodily functions; or
3. Serious dysfunction of any bodily organ or part.

A medical screening exam performed by licensed medical personnel in the emergency department and subsequent emergency services rendered to the Member does not require prior authorization from Molina.
Emergency services are covered on a 24-hour basis without the need for prior authorization for all Members experiencing an emergency Dental condition.

Post-stabilization care services are covered services that are:

1. Related to an emergency Dental condition
2. Provided after the Member is stabilized
3. Provided to maintain the stabilized condition or, under certain circumstances, to improve or resolve the Member's condition

Molina also provides Members with a 24-hour Nurse Advice Line for Dental advice. The 911 information is given to all Members at the onset of any call to the plan.

For Members within our service area, Molina contracts with vendors that provide 24-hour emergency services for ambulances and hospitals. An out-of-network emergency hospital stay may only be covered until the Member has stabilized sufficiently to transfer to an available participating facility. Services provided after stabilization in a non-participating facility may not be covered, and the Member may be responsible for payment.

Molina Care managers will contact Members over-utilizing the emergency department to provide assistance whenever possible and determine the reason for using emergency services.

Care managers will also contact the dentist to ensure that Members are not accessing the emergency department because they cannot be seen by the dentist.

Affirmative statement about incentives

All Dental decisions are coordinated and rendered by qualified Practitioners and licensed staff, unhindered by fiscal or administrative concerns. Molina and its delegated contractors do not use incentive arrangements to reward the restriction of Dental care to Members.

Molina requires that all utilization-related decisions regarding Member coverage and/or services are based solely on the appropriateness of care and the existence of coverage. Molina does not specifically reward Practitioners or other individuals for issuing denials of coverage or care. Molina does not receive

financial incentives or other types of compensation to encourage decisions that result in underutilization.

Out-of-network providers and services

Molina maintains a contracted network of qualified health care professionals who have undergone a comprehensive credentialing process in order to provide Dental care to Molina Members. Molina requires Members to receive Dental care within the participating, contracted network of Providers unless it is for emergency services as defined by federal law. If there is a need to go to a non-contracted Provider, all care provided by non-contracted, non-network Providers must be prior authorized by Molina. Non-network Providers may provide emergency services for a Member who is temporarily outside the service area without prior authorization or as otherwise required by federal or state laws or regulations.

Avoiding conflict of interest

The HCS department affirms that its decision-making is based on the appropriateness of care and service and the existence of benefit coverage.

Molina does not reward Providers or other individuals for issuing coverage or care denials. Furthermore, Molina never provides financial incentives to encourage authorization decision makers to make determinations that result in underutilization. Molina also requires our delegated vendor to avoid this kind of conflict of interest.

Coordination of care and services

Molina HCS staff work with Providers to coordinate referrals, services, and benefits for Members who have been identified for Molina's Integrated Care Management (ICM) program via assessment or referral, such as self-referral, Provider referral, etc. In addition, the coordination of care process assists Molina Members, as necessary, in transitioning to other care when benefits end.

Molina staff provide an integrated approach to care needs by assisting Members with identifying resources available to them, such as community programs, national support groups, appropriate specialists, and facilities. They also identify best practices or new and innovative approaches to care. Care coordination by Molina staff is done in partnership with Providers, Members, and/or their authorized representative(s) to ensure efforts are efficient and non-duplicative.

Continuity of care and transition of Members

It is Molina's policy to provide Members with advance notice when a Provider they are seeing will no longer be in-network. Members and Providers are encouraged to use this time to transition care to an in-network Provider. The Provider leaving the network shall provide all appropriate information related to the course of treatment, Dental treatment, etc. to the Provider(s) assuming care. Under certain circumstances, Members may be able to continue treatment with the out-of-network Provider for a given period of time and provide continued services to Members undergoing a course of treatment by a Provider that has terminated their contractual agreement if the following conditions exist at the time of termination.

- Acute condition or serious chronic condition – Following termination, the terminated Provider will continue to provide covered services to the Member for up to 90 days or longer, if necessary, for a safe transfer to another Provider as determined by Molina or its delegated vendor.
- High risk of second or third-trimester pregnancy – The terminated Provider will continue to provide services following termination until postpartum services related to delivery are completed or longer, if necessary, for a safe transfer.

For additional information regarding continuity of care and member transitions, please call Molina at (855) 322-4079.

Continuity and coordination of Provider communication

Molina stresses the importance of timely communication between Providers involved in a Member's care. This is especially critical between specialists, including behavioral health Providers, and the Member's general dentist. Information should be shared to facilitate communication of urgent needs or significant findings.

Reporting of suspected abuse and/or neglect

A vulnerable adult is a person who is receiving or may be in need of receiving community care services by reason of mental or other disability, age, or illness; and who is or may be unable to take care of themself or unable to protect themself against significant harm or exploitation. When working with children, one may encounter situations suggesting abuse, neglect, and/or unsafe living environments.

Every person who knows or has reasonable suspicion that a child or adult is being abused or neglected must report the matter immediately. Specific professionals mentioned under the law as mandated reporters are:

- Physicians, dentists, interns, residents, or nurses
- Public or private school employees or child caregivers
- Psychologists, social workers, family protection workers, or family protection specialists
- Attorneys, ministers, or law enforcement officers

Suspected abuse and/or neglect should be reported as follows:

Child Abuse

The Ohio Department of Job and Family Services has launched 855-O-H-Child (855-642-4453), an automated telephone directory that will link callers directly to a child welfare or law enforcement office in their county.

Adult Abuse

Adult protective services for adults age 60 and older can be reached at the Ohio Department of Job and Family Services at 855-OHIO-APS (855-644-6277).

Molina's HCS teams will work with PCPs and Medical Groups/IPAs and other delegated entities who are obligated to communicate with each other when there is a concern that a Member is being abused. Final actions are taken by the PCP/Medical Group/IPA, other delegated entities, or other clinical personnel. Under state and federal law, a person participating in good faith in making a report or testifying about alleged abuse, neglect, abandonment, financial exploitation, or self-neglect of a vulnerable adult in a judicial or administrative proceeding may be immune from liability resulting from the report or testimony.

Molina will follow up with Members who are reported to have been abused, exploited or neglected to ensure appropriate measures were taken, and follow up on safety issues. Molina will track, analyze, and report aggregate information regarding abuse reporting to the Health Care Services Committee and the proper state agency.

Molina's HCS teams will work with providers and other delegated entities who are obligated to communicate with each other when there is a concern that a Member is being abused. Under state and federal law, a person participating in good faith in making a report or testifying about alleged abuse, neglect, abandonment, financial exploitation, or self-neglect of a vulnerable adult in a

judicial or administrative proceeding may be immune from liability resulting from the report or testimony.

Molina will follow up with Members who are reported to have been abused, exploited, or neglected to ensure appropriate measures were taken and follow up on safety issues. Molina will track, analyze, and report aggregate information regarding abuse reporting to the Health Care Services Committee and the proper state agency.

Health management

The tools and services described here are educational support for Molina Members and may be changed at any time as necessary to meet their needs. Level 1 Members can be engaged in the program for up to 90 days, depending on their preferences and the clinical judgment of the health management team.

Member newsletters

Member newsletters are posted on the MolinaHealthcare.com website at least once a year. The articles cover topics asked by Members and offer tips to help them stay healthy.

Member health education materials

Members can access our easy-to-read, evidence-based educational materials about nutrition, preventive services guidelines, stress management, exercise, cholesterol management, asthma, diabetes, depression, and other relevant health topics identified during our engagement with Members. Materials are available through the My Molina® Member Portal, direct mail as requested, email, and the My Molina mobile app.

Program eligibility criteria and referral source

HM programs are designed for Molina Members with a confirmed diagnosis. Identified Members will receive targeted outreach such as educational materials, telephonic outreach, or other materials to access information on their condition. Members can contact Molina Member Services at any time and request to be removed from the program.

Members may be identified for or referred to HM programs from multiple pathways, which may include the following:

- Pharmacy Claims data for all classifications of medications.

- Encounter Data or paid Claims with a relevant CMS-accepted diagnosis or procedure code.
- Member Services welcome calls made by staff to new Member households, and incoming Member calls have the potential to identify eligible program participants. Eligible Members are referred to the program registry.
- Member assessment calls made by staff for the initial Health Risk Assessment (HRA) for newly enrolled Members.
- External referrals from Provider(s), caregivers, or community-based organizations.
- Internal referrals from the 24-hour Nurse Advice Line, medication management, or utilization management.
- Member self-referral due to general plan promotion of the program through the Member newsletter or other Member communications.

Provider participation

Provider resources and services may include:

- Annual Provider feedback letters containing a list of patients identified with the relevant disease
- Clinical resources such as patient assessment forms and diagnostic tools
- Patient education resources
- Provider Newsletters promoting the health management programs, including how to enroll patients and the programs' outcomes.
- Clinical Practice Guidelines
- Preventive Health Guidelines
- Case management collaboration with the Member's Provider
- Faxing a Provider Collaboration Form to the Member's Provider when indicated

Additional information on health management programs is available from your local Molina HCS department.

6. Quality

Maintaining quality improvement processes and programs

Molina works with Members and Providers to maintain a comprehensive Quality Improvement (QI) program. You can contact the Molina Quality department at (855) 322-4079. The address for mail requests is:

Molina Healthcare of Ohio, Inc.
Quality Department

3000 Corporate Exchange Drive
Columbus, OH 43231

This Provider Manual contains excerpts from the Molina QI program. For a complete copy of Molina's QI program, you can contact your Provider Relations representative or call the telephone number above to receive a written copy.

Molina has established a QI program that complies with regulatory requirements and accreditation standards. The QI program provides structure and outlines specific activities designed to improve the care, service, and health of our Members. In our QI program description, we describe our program governance, scope, goals, measurable objectives, structure, and responsibilities.

Patient safety program

Molina's Patient Safety Program identifies appropriate safety projects and error avoidance for Molina Members in collaboration with their providers. Molina continues to support safe health practices for our Members through our safety program, pharmaceutical management, care management/health management programs, and education. Molina monitors nationally recognized quality index ratings for facilities including adverse events and hospital-acquired conditions as part of a national strategy to improve health care quality mandated by the Patient Protection and Affordable Care Act (ACA) and the Department of Health and Human Services (HHS) to identify areas that have the potential for improving health care quality to reduce the incidence of events.

Dental records

Molina requires that Dental records be maintained in a manner that is current, detailed, and organized to ensure that care rendered to Members is consistently documented and that necessary information is readily available in the Dental record. All entries will be indelibly added to the Member's Dental record. Providers should maintain the following Dental record components that include but are not limited to:

- Dental record confidentiality and release of Dental records within Dental and behavioral health care records
- Dental record content and documentation standards, including preventive health care
- Storage maintenance and disposal processes
- Process for archiving Dental records and implementing improvement activities

Dental record-keeping practices

Below is a list of the minimum items that are necessary for the maintenance of the Member Dental records:

- Each patient has a separate Dental record
- Dental records are stored away from patient areas and preferably locked
- Dental records are available during each visit and archived records are available within 24 hours
- If hard copy, pages are securely attached in the Dental record, and records are organized by dividers or color-coded when the thickness of the record dictates
- If electronic, all those with access have individual passwords
- Record keeping is monitored for quality and HIPAA compliance, including privacy of confidential information, such as race, ethnicity, language, sexual orientation, and gender identity
- Storage maintenance for the determined timeline and disposal are managed per record management processes
- Process is in place for archiving Dental records and implementing improvement activities
- Dental records are kept confidential and there is a process for the release of Dental records including behavioral health care records

Content

Providers must remain consistent in their practices with Molina's Dental record documentation guidelines. Dental records are maintained and should include but not limited to the following information. All Dental records should contain:

- The patient's name or ID number on each page in the record
- The patient's name, date of birth, sex, marital status, address, employer, home and work telephone numbers and emergency contact
- Legible signatures and credentials of the Provider and other staff members within a paper chart
- A list of all Providers who participate in the Member's care
- Information about services that are delivered by these Providers
- A problem list that describes the Member's Dental and behavioral health conditions
- Presenting complaints, diagnoses, and treatment plans, including follow-up visits and referrals to other Providers
- Prescribed medications, including dosages and dates of initial or refill prescriptions

- Medication reconciliation within 30 days of an inpatient discharge with evidence of current and discharge medication reconciliation and the date performed
- Allergies and adverse reactions (or notation that none are known)
- Past Dental and surgical history, including physical examinations treatments, preventive services, and risk factors
- Treatment plans that are consistent with diagnosis
- A working diagnosis that is recorded with the clinical findings
- Pertinent history for the presenting problem
- Pertinent physical exam for the presenting problem
- Clear and thorough progress notes that state the intent for all ordered services and treatments
- Notations regarding follow-up care, calls, or visits that include the specific time of return are noted in weeks, months or as needed, included in the next preventative care visit when appropriate
- Notes from consultants as applicable
- All staff and Provider notes are signed physically or electronically with either name or initials
- All entries are dated
- Documentation of all emergency care provided in any setting
- A signed document stating with whom protected health information may be shared

Organization

- The Dental record is legible to someone other than the writer
- Each patient has an individual record
- Chart pages are bound, clipped, or attached to the file
- Chart sections are easily recognized for the retrieval of information
- A release document for each Member authorizing Molina to release Dental information for the facilitation of Dental care

Retrieval

- The Dental record is available to the Provider at each encounter
- The Dental record is available to Molina for purposes of quality improvement
- The Dental record is available to the applicable state and/or federal agency and the external quality review organization upon request
- The Dental record is available to the Member upon their request
- A storage system for inactive Member Dental records which allows retrieval within 24 hours, is consistent with state and federal requirements, and the record is maintained for not less than 10 years from the last date of treatment or for a minor, one (1) year past their 20th birthday but, never less than 10 years

- An established and functional data recovery procedure in the event of data loss

Confidentiality

Molina Providers shall develop and implement confidentiality procedures to guard Member protected health information, in accordance with HIPAA privacy standards and all other applicable federal and state regulations. This should include and is not limited to the following:

- Ensure that Dental information is released only in accordance with applicable federal or state law in pursuant to court orders or subpoenas
- Maintain records and information in an accurate and timely manner
- Ensure timely access by Members to the records and information that pertain to them
- Abide by all federal and state laws regarding confidentiality and disclosure of Dental records or other health and enrollment information
- Dental records are protected from unauthorized access
- Access to computerized confidential information is restricted
- Precautions are taken to prevent inadvertent or unnecessary disclosure of protected health information
- Education and training for all staff on handling and maintaining protected health care information
- Ensure that confidential information, such as patient race, ethnicity, preferred language, sexual orientation, gender identity, and social determinants of health is protected

Additional information on Dental records is available from your local Molina Quality department. For additional information regarding HIPAA please refer to the **Compliance** section of this Provider Manual.

Access to care

Molina maintains access to care standards and processes for ongoing monitoring of access to health care provided by contracted providers and participating specialists. Providers are required to conform to the access to care appointment standards listed below to ensure that health care services are provided in a timely manner. The provider or their designee must be available 24 hours a day, 7 days a week to Members.

Appointment access

All Providers who oversee the Member's health care are responsible for providing the following appointments to Molina Members in the timeframes noted.

Dental appointment

Type of Visit	Description	Minimum Standard
Emergency Dental Service	Services that are needed to evaluate, treat, or stabilize an emergency dental condition.	24 hours, 7 days/week
Urgent Dental Care	Care that is provided for a non-emergent illness or injury with acute symptoms that require immediate care; examples include but are not limited to sprains, flu symptoms, minor cuts and wounds, sudden onset of stomach pain, and severe, non-resolving headaches. Acute illness or substance dependence impacts the ability to function but does not present an imminent danger.	24 hours, 7 days/week, within 48 hours of request
Dental Appointment	Non-emergent/non-urgent dental services, including routine and preventive care.	Within 6 weeks of the request

Additional information on appointment access standards is available from your local Molina Quality department.

Office wait time

The wait time in offices for scheduled appointments should not exceed 30 minutes. All providers are required to monitor waiting times and adhere to this standard.

After hours

All Providers must have backup (on-call) coverage after hours or during the Provider's absence or unavailability. Molina requires Providers to maintain a 24-hour telephone service, 7 days a week. This access may be through an answering service or a recorded message after office hours. The service or recorded message should instruct Members with an emergency to hang up and call 911 or go immediately to the nearest emergency room. Voicemail alone after hours is not acceptable.

Monitoring access for compliance with standards

The Quality Improvement and Health Equity Transformation Committee reviews, revises as necessary, and approves access to care standards on an annual basis.

Provider network adherence to access standards is monitored via one or more of the following mechanisms:

1. Provider access studies – Provider office assessment of appointment availability, after-hours access, Provider ratios, and geographic access.
2. Member complaint data – assessment of Member complaints related to access and availability of care.
3. Member satisfaction survey – evaluation of Members' self-reported satisfaction with appointments and after-hours access.

Analysis of access data includes assessment of performance against established standards, review of trends over time, and identification of barriers. Results of the analysis are reported to the Quality Improvement and Health Equity Transformation Committee at least annually for review and determination of opportunities for improvement. Corrective actions are initiated when performance goals are not met and for identified provider-specific and/or organizational trends. Performance goals are reviewed and approved annually by the Quality Improvement and Health Equity Transformation Committee.

Quality of provider office sites

Molina Providers are to maintain office-site and dental record keeping practices standards. Molina continually monitors Member appeals and complaints/grievances for all office sites to determine the need for an office site visit and will conduct office site visits as needed. Molina assesses the quality, safety, and accessibility of office sites where care is delivered against standards and thresholds. A standard survey form is completed at the time of each visit. This includes an assessment of:

- Physical accessibility
- Physical appearance
- Adequacy of waiting and examining room space

Physical accessibility

Molina evaluates office sites as applicable to ensure that Members have safe and appropriate access to them. This includes, but is not limited to, ease of

entry into the building, accessibility of space within the office site, and ease of access for patients with physical disabilities.

Physical appearance

The site visits include, but are not limited to, an evaluation of office site cleanliness, appropriateness of lighting, and patient safety as needed.

Adequacy of waiting and examining room space

During the site visit, as required, Molina assesses waiting and examining room spaces to ensure that the office offers appropriate accommodations to Members. The evaluation includes, but is not limited to, appropriate seating in the waiting room areas and the availability of exam tables in exam rooms.

Administration and confidentiality of facilities

Facilities contracted with Molina must demonstrate overall compliance with the guidelines listed below:

- Office appearance demonstrates that housekeeping and maintenance are performed appropriately on a regular basis, the waiting room is well-lit, office hours are posted, and the parking area and walkways demonstrate appropriate maintenance.
- Accessible parking is available, the building and exam rooms are accessible with an incline ramp or flat entryway, and the restroom is accessible with a bathroom grab bar.
- Adequate seating includes space for an average number of patients in an hour, and there is a minimum of two (2) office exam rooms per Provider.
- Basic emergency equipment is located in an easily accessible area. This includes a pocket mask and Epinephrine, plus any other medications appropriate to the practice.
- Yearly Occupational Safety and Health Administration (OSHA) training (fire, safety, bloodborne pathogens, etc.) is documented for offices with 10 or more employees.
- A container for sharps is located in each room where injections are given.
- Labeled containers, policies, contracts, and evidence of a hazardous waste management system in place.
- Patient check-in systems are confidential. Alternative methods include signatures on fee slips, separate forms, stickers, or labels.
- Confidential information is discussed away from patients. When reception areas are unprotected by sound barriers, scheduling and triage phones are best placed at another location.

- Dental records are stored away from patient areas. Record rooms and/or file cabinets are preferably locked.
- Prescription pads are not kept in exam rooms.
- Narcotics are locked, preferably double-locked. Medication and sample access are restricted.
- A system is in place to ensure expired sample medications are not dispensed, and injectables and emergency medications are checked monthly for outdates.
- Drug refrigerator temperatures are documented daily.

Early and periodic screening, diagnostic, and treatment (EPSDT) services to enrollees under 21 years of age

Molina maintains systematic and robust monitoring mechanisms to ensure all required EPSDT services to Enrollees under 21 years of age are timely according to required preventive guidelines. All Enrollees under 21 years of age should receive preventive, diagnostic, and treatment services at intervals as set forth in Section 1905 (R) of the Social Security Act. Molina's Quality or the Provider Relations department is also available to perform Provider training to ensure that best practice guidelines are followed in relation to well-child services and care for acute and chronic health care needs.

Monitoring for compliance with standards

Molina monitors compliance with the established performance standards as outlined above at least annually. Performance below Molina's standards may result in a corrective action plan (CAP) with a request that the Provider submit a written CAP to Molina within 30 calendar days. Follow-up to ensure resolution is conducted at regular intervals until compliance is achieved. The information and any response made by the Provider are included in the Provider's permanent credentials file. If compliance is not attained at follow-up, an updated CAP will be required. Providers who do not submit a CAP may be terminated from network participation or closed to new Members.

Quality improvement activities and programs

Molina maintains an active QI program. The program provides structure and key processes to carry out our ongoing commitment to improving care and service. Through the QI program, Molina focuses on reducing health care disparities. The goals identified are based on an evaluation of programs and services, regulatory, contractual, and accreditation requirements, and strategic planning initiatives.

Health management and care management

The Molina health management and care management programs provide for the identification, assessment, stratification, and implementation of appropriate interventions for members with chronic diseases.

For additional information, please refer to the Health Management and Care Management headings in the **Health Care Services** section of this Provider Manual.

Clinical practice guidelines

Molina adopts and disseminates clinical practice guidelines (CPG) to reduce inter-provider variation in diagnosis and treatment. CPG adherence is measured at least annually. All guidelines are based on scientific evidence, review of Dental literature, and/or appropriately established authority.

Preventive health guidelines

Molina provides coverage of diagnostic preventive procedures based on recommendations published by the U.S. Preventive Services Task Force (USPSTF), Bright Futures/American Academy of Pediatrics, and the Centers for Disease Control and Prevention (CDC) in accordance with CMS guidelines.

All preventive health guidelines are updated at least annually and more frequently as needed when clinical evidence changes and are approved by the Quality Improvement and Health Equity Transformation Committee. A review is conducted at least monthly to identify new additions or modifications. On an annual basis or when changes are made during the year, preventive health guidelines are distributed to Providers at MolinaHealthcare.com and the Provider Manual. Notification of the availability of the preventive health guidelines is published in the Molina Provider Newsletter.

Culturally and linguistically appropriate services

Molina works to ensure all Members receive culturally competent care across the service continuum to reduce health disparities and improve health outcomes. For additional information about Molina's program and services, please refer to the **Cultural Competency and Linguistic Services** section of this Provider Manual.

Measurement of clinical and service quality

Molina monitors and evaluates the quality of care and services provided to Members through the following mechanisms:

- HEDIS®
- CAHPS®
- Provider satisfaction survey
- Effectiveness of quality improvement initiatives

Molina evaluates continuous performance according to or in comparison with objectives, measurable performance standards and benchmarks at the national, regional and/or at the local/health plan level.

Contracted Providers and facilities must allow Molina to use its performance data collected in accordance with the Provider Agreement with Molina. The use of performance data may include but is not limited to the following:

1. Development of quality improvement activities
2. Public reporting to consumers
3. Preferred status designation in the network
4. Reduced Member cost-sharing

Molina's most recent results can be obtained from your local Molina Quality department or by visiting our website at MolinaHealthcare.com.

HEDIS®

Molina utilizes NCQA HEDIS® as a measurement tool to provide a fair and accurate assessment of specific aspects of managed care organization performance. HEDIS® is an annual activity conducted in the spring. The data comes from on-site dental record review and available administrative data. All reported measures must follow rigorous specifications and are externally audited to assure continuity and comparability of results. The HEDIS® measurement set currently includes a variety of health care aspects including immunizations, women's health screening, diabetes care, well check-ups, medication use, and cardiovascular disease.

HEDIS® results are used in a variety of ways. The results are used to evaluate the effectiveness of multiple quality improvement activities and clinical programs. The standards are based on established clinical guidelines and protocols, providing a firm foundation to measure the effectiveness of these programs.

Selected HEDIS® results are provided to federal and state regulatory agencies and accreditation organizations. The data are also used to compare against established health plan performance benchmarks.

CAHPS®

CAHPS® is the tool used by Molina to summarize Member satisfaction with Providers, health care and service they receive. CAHPS® examines specific measures, including Getting Needed Care, Getting Care Quickly, How Well Doctors Communicate, Coordination of Care, Customer Service, Rating of Health Care, and Getting Needed Prescription Drugs (for Medicare). The CAHPS® survey is administered annually in the spring to randomly selected Members by an NCQA-certified vendor.

CAHPS® results are used in much the same way as HEDIS® results, only the focus is on the service aspect of care rather than clinical activities. They form the basis for several of Molina's quality improvement activities and are used by external agencies to help ascertain the quality of services being delivered.

Effectiveness of quality improvement initiatives

Molina monitors the effectiveness of clinical and service activities through metrics selected to demonstrate clinical outcomes and service levels. The plan's performance is compared to that of available national benchmarks, indicating "best practices." The evaluation includes an ongoing assessment of clinical and service improvements. The results of these measurements guide activities for successive periods.

In addition to the methods described above, Molina also compiles complaint and appeals data, as well as requests for out-of-network services, to determine opportunities for service improvements

What can providers do?

- Ensure patients are up to date with their annual physical exam and preventive health screenings, including related lab orders and referrals to specialists, such as ophthalmology.
- Review the HEDIS® preventive care listing of measures for each patient to determine if anything applicable to your patients' age and/or condition has been missed.
- Check that staff are properly coding all services provided.
- Be sure patients understand what *they* need to do.

7. Risk adjustment management program

What is risk adjustment?

CMS defines risk adjustment as a process that helps to accurately measure the health status of a plan's membership based on medical conditions and demographic information.

This process helps ensure health plans receive accurate payment for services provided to Molina Members and prepares for resources that may be needed in the future to treat Members who have multiple clinical conditions.

Why is risk adjustment important?

Molina relies on our Provider Network to care for our Members based on their health care needs. Risk adjustment considers numerous clinical data elements of a Member's health profile to determine documentation gaps from past visits and identifies opportunities for gap closure for future visits. In addition, risk adjustment allows us to:

- Focus on quality and efficiency
- Recognize and address current and potential health conditions
- Identify Members for care management referral
- Ensure adequate resources for the acuity levels of Molina Members
- Have the resources to deliver the highest quality of care to Molina Members

Your role as a provider

As a Provider, complete and accurate documentation in a dental record is critical to a Member's quality of care. We encourage Providers to record all diagnoses to the highest specificity. This will ensure Molina receives adequate resources to provide quality programs to you and our Members.

For a complete and accurate dental record, all Provider documentation must:

- Address clinical data elements (e.g., diabetic patient needs an eye exam or multiple comorbid conditions) provided by Molina and reviewed with the Member
- Be compliant with the CMS National Correct Coding Initiative (NCCI)
- Use the correct ICD-10 code by documenting the condition to the highest level of specificity (if required)
- Only use diagnosis codes confirmed during a Provider visit with the Member. The visit may be face-to-face or telehealth, depending on state or CMS requirements

- Contain a treatment plan and progress notes
- Contain the Member's name and date of service
- Have the Provider's signature and credentials

Contact information

For questions about Molina's risk adjustment programs, please contact your Molina Provider Relations representative.

8. Compliance

Fraud, waste, and abuse

Introduction

Molina is dedicated to the detection, prevention, investigation, and reporting of potential health care fraud, waste, and abuse. As such, Molina's Compliance department maintains a comprehensive plan that addresses how Molina will uphold and follow state and federal statutes and regulations pertaining to fraud, waste, and abuse. The plan also addresses fraud, waste, and abuse prevention, detection, and correction, along with the education of appropriate employees, vendors, Providers, and associates doing business with Molina.

Molina's Special Investigation Unit (SIU) supports Compliance in its efforts to prevent, detect, and correct fraud, waste, and abuse by conducting investigations aimed at identifying suspect activity and reporting these findings to the appropriate regulatory and/or law enforcement agency.

Mission statement

Our mission is to pay claims correctly the first time, and that mission begins with the understanding that we need to proactively detect fraud, waste, and abuse, correct it, and prevent it from recurring. Since not all fraud, waste, or abuse can be prevented, Molina employs processes that retrospectively address fraud, waste, or abuse that may have already occurred. Molina strives to detect, prevent, investigate, and report suspected health care fraud, waste, and abuse in order to reduce health care costs and promote quality health care.

Regulatory requirements

Federal False Claims Act

The False Claims Act is a federal statute that covers fraud involving any federally funded contract or program. The act establishes liability for any person who knowingly presents or causes to be presented a false or fraudulent claim to the U.S. government for payment.

The term "knowing" is defined to mean that a person, with respect to information:

- Has actual knowledge of the falsity of information in the Claim
- Acts in deliberate ignorance of the truth or falsity of the information in a Claim
- Acts in reckless disregard of the truth or falsity of the information in a Claim

The Act does not require proof of a specific intent to defraud the U.S. government. Instead, health care Providers can be prosecuted for a wide variety of conduct that leads to the submission of fraudulent claims to the government, such as knowingly making false statements, falsifying records, double billing for items or services, submitting bills for services never performed or items never furnished or otherwise causing a false Claim to be submitted.

Deficit Reduction Act (DRA)

The DRA aims to cut fraud, waste and abuse from the Medicare and Medicaid programs.

As a contractor doing business with Molina, Providers, and their staff have the same obligation to report any actual or suspected violation or fraud, waste, or abuse. Entities must have written policies that inform employees, contractors, and agents of the following:

- The federal False Claims Act and state laws pertaining to submitting false Claims
- How Providers will detect and prevent fraud, waste, and abuse
- Employee protection rights as whistleblowers
- Administrative remedies for false Claims and statements

These provisions encourage employees (current or former) and others to report instances of fraud, waste, or abuse to the government. The government may then proceed to file a lawsuit against the organization/individual accused of violating the False Claims Act. The whistleblower may also file a lawsuit independently. Cases found in favor of the government will result in the whistleblower receiving a portion of the amount awarded to the government.

Whistleblower protections state that employees who have been discharged, demoted, suspended, threatened, harassed, or otherwise discriminated against due to their role in disclosing or reporting a false Claim are entitled to all relief necessary to make the employee whole including:

- Employment reinstatement at the same level of seniority
- Two (2) times the amount of back pay plus interest
- Compensation for special damages incurred by the employee as a result of the employer's inappropriate actions

Affected entities who fail to comply with the law will be at risk of forfeiting all payments until compliance is met. Molina will take steps to monitor Molina contracted Providers to ensure compliance with the law. Healthcare entities (e.g., providers, facilities, delegates, and/or vendors) to which Molina has paid $5 million or more in Medicaid funds during the previous federal fiscal year (October 1-September 30) will be required to submit a signed "Attestation of Compliance with the Deficit Reduction Act of 2005, Section 6032" to Molina.

Anti-kickback Statute (42 U.S.C. § 1320a-7b(b))

Anti-kickback Statute (AKS) is a criminal law that prohibits the knowing and willful payment of "remuneration" to induce or reward patient referrals or the generation of business involving any item or service payable by the federal health care programs (e.g., drugs, supplies or health care services for Medicare or Medicaid patients). In some industries, it is acceptable to reward those who refer business to you. However, in the federal health care programs, paying for referrals is a crime. The statute covers the payers of kickbacks-those who offer or pay remuneration-as well as the recipients of kickbacks-those who solicit or receive remuneration.

Molina conducts all business in compliance with federal and state AKS statutes and regulations and federal and state marketing regulations. Providers are prohibited from engaging in any activities covered under this statute.

AKS statutes and regulations prohibit paying or receiving anything of value to induce or reward patient referrals or the generation of business involving any item or service payable by federal and state health care programs. The phrase "anything of value" can mean cash, discounts, gifts, excessive compensation, contracts not at fair market value, etc. Examples of prohibited AKS actions include a health care Provider who is compensated based on patient volume or a Provider who offers remuneration to patients to influence them to use their services.

Under Molina's policies, Providers may not offer, solicit an offer, provide, or receive items of value of any kind that are intended to induce referrals of federal health care program business. Providers must not, directly, or indirectly, make or offer items of value to any third party for the purpose of obtaining, retaining, or directing our business. This includes giving, favors, preferential hiring, or anything of value to any government official.

Marketing Guidelines and Regulations

Providers must conduct all marketing activities in accordance with the relevant contractual requirements and marketing statutes and regulations, both state and federal.

Under Molina's policies, marketing means any communication to a beneficiary who is not enrolled with Molina that can reasonably be interpreted as intended to influence the beneficiary to enroll with Molina's Medicaid, Marketplace, or Medicare products. This also includes communications that can be interpreted to influence a beneficiary to not enroll in or to disenroll from another health plan's products.

Restricted marketing activities vary from state to state but generally relate to the types and forms of communications that health plans, Providers, and others can have with Members and prospective Members. Examples of such communications include those related to enrolling Members, Member outreach, and other types of communications.

Stark statute

The Physicians Self-Referral Law (Stark Law) prohibits physicians from referring patients to receive "designated health services" payable by Medicare or Medicaid from entities with which the physician or an immediate family member has a financial relationship unless an exception applies. Financial relationships include both ownership/investment interests and compensation arrangements. The Stark law prohibits the submission or causing the submission of Claims in violation of the law's restrictions on referrals. "Designated health services" are identified in the Physician Self-Referral Law (42 U.S.C. § 1395nn).

Sarbanes-Oxley Act of 2002

The Sarbanes-Oxley Act requires certification of financial statements by both the Chief Executive Officer and the Chief Financial Officer. The Act states that a corporation must assess the effectiveness of its internal controls and report this assessment annually to the Securities and Exchange Commission.

Definitions

Fraud means an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to themself or some other person. It includes any act that constitutes fraud under applicable federal or state law (42 CFR § 455.2).

Waste means health care spending that can be eliminated without reducing the quality of care. Quality waste includes overuse, underuse, and ineffective use. Inefficiency waste includes redundancy, delays, and unnecessary process complexity. An example would be the attempt to obtain reimbursement for items or services where there was no intent to deceive or misrepresent, however the outcome resulted in poor or inefficient billing methods (e.g., coding) causing unnecessary costs to state and federal health care programs.

Abuse means Provider practices that are inconsistent with sound fiscal, business, or dental practices and result in unnecessary costs to state and federal health care programs or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care. It also includes recipient practices that result in unnecessary costs to state and federal health care programs (42 CFR § 455.2).

Examples of fraud, waste, and abuse by a provider

The types of questionable Provider schemes investigated by Molina include, but are not limited to the following:

- A Provider knowingly and willfully referring a Member to health care facilities in which or with which the Provider has a financial relationship (Stark Law).
- Altering Claims and/or dental record documentation in order to get a higher level of reimbursement.
- Balance billing a Molina Member for covered services. This includes asking the Member to pay the difference between the discounted and negotiated fees and the Provider's usual and customary fees.
- Billing and providing services to Members that are not medically necessary.
- Billing for services, procedures, and/or supplies that have not been rendered.
- Billing under an invalid place of service in order to receive or maximize reimbursement.
- Completing certificates of medical necessity for Members, not personally and professionally known by the Provider.
- Concealing a Member's misuse of a Molina Member identification card.
- Failing to report a Member's forgery or alteration of a prescription or other dental document.

- False coding in order to receive or maximize reimbursement.
- Inappropriate billing of modifiers in order to receive or maximize reimbursement.
- Inappropriately billing of a procedure that does not match the diagnosis in order to receive or maximize reimbursement.
- Knowingly and willfully soliciting or receiving payment of kickbacks or bribes in exchange for referring patients.
- Not following incident-to-billing guidelines in order to receive or maximize reimbursement.
- Overutilization.
- Participating in schemes that involve collusion between a Provider and a Member that result in higher costs or charges.
- Questionable prescribing practices.
- Unbundling services in order to get more reimbursement, which involves separating a procedure into parts and charging for each part rather than using a single global code.
- Underutilization, which means failing to provide services that are medically necessary.
- Upcoding, which is when a Provider does not bill the correct code for the service rendered and instead uses a code for a like service that costs more.
- Using the adjustment payment process to generate fraudulent payments.

Examples of fraud, waste, and abuse by a Member

The types of questionable Member schemes investigated by Molina include, but are not limited to, the following:

- Benefit sharing with persons not entitled to the Member's benefits
- Conspiracy to defraud state and federal health care programs
- Doctor shopping, which occurs when a Member consults a number of Providers for the purpose of inappropriately obtaining services
- Falsifying documentation in order to get services approved
- Forgery related to health care
- Prescription diversion, which occurs when a Member obtains a prescription from a Provider for a condition that they do not suffer from, and the Member sells the medication to someone else

Review of provider Claims and Claims system

Molina Claims examiners are trained to recognize unusual billing practices, which are key in identifying fraud, waste, and abuse. If the Claims examiner suspects fraudulent, abusive, or wasteful billing practices, the billing practice is

documented and reported to the SIU through our Compliance Alertline/reporting repository.

The Claim payment system utilizes system edits and flags to validate that claim elements are billed in accordance with standardized billing practices, ensure that Claims are processed accurately, and ensure that payments reflect the service performed as authorized.

Molina performs auditing to ensure the accuracy of data input into the Claim system. The Claims department conducts regular audits to identify system issues or errors. If errors are identified, they are corrected, and a thorough review of system edits is conducted to detect and locate the source of the errors.

Prepayment of fraud, waste, and abuse detection activities

Through the implementation of Claim edits, Molina's Claim payment system is designed to audit Claims concurrently in order to detect and prevent paying Claims that are inappropriate.

Molina has a pre-payment Claim auditing process that identifies frequent correct coding billing errors, ensuring that Claims are coded appropriately according to state and federal coding guidelines. Code edit relationships and edits are based on guidelines from specific state Medicaid guidelines, federal CMS guidelines, American Dental Association (ADA), and published specialty-specific coding rules.

Additionally, Molina may, at the request of a state program or at its own discretion, subject a Provider to prepayment reviews, whereupon the Provider is required to submit supporting source documents that justify the amount charged. Where no supporting documents are provided or insufficient information is provided to substantiate a charge, the claim will be denied until the Provider can provide sufficient, accurate support.

Post-payment recovery activities

The terms expressed in this section of this Provider Manual are incorporated into the Provider Agreement with Molina and are intended to supplement, rather than diminish, any and all other rights and remedies that may be available to Molina under the Provider Agreement with Molina or at law or equity.

In the event of any inconsistency between the terms expressed here and any terms expressed in the Provider Agreement with Molina, the parties agree that Molina shall in its sole discretion exercise the terms that are expressed in the

Provider Agreement with Molina, the terms that are expressed here, its rights under law and equity or some combination thereof.

The Provider will provide Molina, governmental agencies, and their representatives or agents, access to examine, audit, and copy any and all records deemed by Molina, in Molina's sole discretion, necessary to determine compliance with the terms of the Provider Agreement with Molina, including for the purpose of investigating potential fraud, waste and abuse. Documents and records must be readily accessible at the location where the Provider provides services to any Molina Members. Auditable documents and records include but are not limited to dental charts, billing records, and coordination of benefits information. Production of auditable documents and records must be provided in a timely manner, as requested by Molina, and without charge to Molina. In the event Molina identifies fraud, waste or abuse, the Provider agrees to repay funds or Molina may seek recoupment.

If a Molina auditor is denied access to the Provider's records, all of the Claims for which the Provider received payment from Molina is immediately due and owing. If the Provider fails to provide all requested documentation for any claim, the entire amount of the paid Claim is immediately due and owed. Molina may offset such amounts against any amounts owed by Molina to the Provider. The Provider must comply with all requests for documentation and records timely (as reasonably requested by Molina) and without charge to Molina. Claims for which the Provider fails to furnish supporting documentation during the audit process are not reimbursable and are subject to chargeback.

The Provider acknowledges that HIPAA specifically permits a covered entity, such as the Provider, to disclose protected health information for its own payment purposes (see 45 CFR 164.502 and 45 CFR 164.501). The Provider further acknowledges that in order to receive payment from Molina, the Provider is required to allow Molina to conduct audits of its pertinent records to verify the services performed and the payment claimed and that such audits are permitted as a payment activity of the Provider under HIPAA and other applicable privacy laws.

Provider education

When Molina identifies, through an audit or other means, a situation with a Provider (e.g., coding, billing) that is either inappropriate or deficient, Molina may determine that a Provider education visit is appropriate.

Molina will notify the Provider of the deficiency and will take steps to educate the Provider, which may include the Provider submitting a CAP to Molina

addressing the issues identified and how it will cure these issues moving forward.

Reporting fraud, waste, and abuse

Suspected cases of fraud, waste or abuse must be reported to Molina by contacting the Molina Alertline. The Molina Alertline is an external telephone and web-based reporting system hosted by NAVEX Global, a leading provider of compliance and ethics hotline services. The Molina Alertline telephone and web-based reporting is available 24 hours a day, 7 days a week, 365 days a year. When a report is made, callers can choose to remain confidential or anonymous. When calling the Molina Alertline, a trained professional at NAVEX Global will note the caller's concerns and provide them to the Molina Compliance department for follow-up. When electing to use the web-based reporting process, a series of questions will be asked concluding with the submission of the report. Reports to the Molina Alertline can be made from anywhere within the United States with telephone or internet access.

The Molina Alertline can be reached at (866) 606-3889 or you may use the service's website to make a report at any time at MolinaHealthcare.Alertline.com.

Fraud, waste, or abuse cases may also be reported to Molina's Compliance department anonymously without fear of retaliation.

Molina Healthcare of Ohio Medicare
Attn: Compliance Official
200 Oceangate Suite 100
Long Beach, CA 90802

The following information should be included when reporting:

- Nature of complaint
- The names of individuals and/or entities involved in suspected fraud and/or abuse, including address, phone number, Molina Member ID number, and any other identifying information

Suspected fraud, waste, and abuse may also be reported directly to the state at:

- Ohio Department of Medicaid (ODM) (614) 466-0722 or at medicaid.ohio.gov/wps/portal/gov/medicaid/stakeholders-and-partners/helpfullinks/reporting-suspected-medicaid-fraud
- Office of the Ohio Attorney General, Medicaid Fraud Control Unit (MFCU) (800) 642-2873 or at

medicaid.ohio.gov/wps/portal/gov/medicaid/stakeholders-and-partners/helpfullinks/reporting-suspected-medicaid-fraud or ohioattorneygeneral.gov/Individuals-and-Families/Victims/Submit-a-Tip/Report-Medicaid-Fraud

- Ohio Department of Job and Family Services (614) 752-3222 or at jfs.ohio.gov/fraud/index.stm

HIPAA requirements and information

Molina's commitment to patient privacy

Protecting the privacy of Members' personal health information is a core responsibility that Molina takes very seriously. Molina is committed to complying with all federal and state laws regarding the privacy and security of Members' protected health information (PHI).

Provider responsibilities

Molina expects that its contracted Providers will respect the privacy of Molina Members (including Molina Members who are not patients of the Provider) and comply with all applicable laws and regulations regarding the privacy of patient and Member PHI. Molina provides its Members with a privacy notice upon their enrollment in our health plan. The privacy notice explains how Molina uses and discloses their PHI and includes a summary of how Molina safeguards their PHI.

Telehealth/telemedicine Providers: telehealth transmissions are subject to HIPAA-related requirements outlined under state and federal law, including:

- 42 C.F.R. Part 2 regulations
- Health Information Technology for Economic and Clinical Health Act, (HITECH Act)

Applicable laws

Providers must understand all state and federal health care privacy laws applicable to their practice and organization. Currently, there is no comprehensive regulatory framework that protects all health information in the United States; instead, there is a patchwork of laws that Providers must comply with. In general, most health care Providers are subject to various laws and regulations pertaining to the privacy of health information, including, without limitation, the following:

1. **Federal laws and regulations**
    - HIPAA

- HITECH
- 42 C.F.R. Part 2
- Medicare and Medicaid laws
- The Affordable Care Act

2. **State medical privacy laws and regulations.**
   Providers should be aware that HIPAA provides a floor for patient privacy but that state laws should be followed in certain situations, especially if the state law is more stringent than HIPAA. Providers should consult with their own legal counsel to address their specific situation.

Artificial intelligence

The Provider shall comply with all applicable state and federal laws and regulations related to artificial intelligence and the use of artificial intelligence tools (AI). Artificial Intelligence or AI means a machine-based system that can, with respect to a given set of human-defined objectives, input, or prompt, as applicable, make predictions, recommendations, data sets, work product (whether or not eligible for copyright protection), or decisions influencing physical or virtual environments. The Provider is prohibited from using AI for any functions that result in a denial, delay, reduction, or modification of covered services to Molina Members including, but not limited to utilization management, prior authorizations, complaints, appeals and grievances, and quality of care services, without review of the denial, delay, reduction, or modification by a qualified clinician.

Notwithstanding the foregoing, the Provider shall give advance written notice to your Molina Contract Manager for monitoring by the Provider that may impact the provision of covered services to Molina Members) that describes (i) Providers' use of the AI tool(s) and (ii) how the Provider oversees, monitors and evaluates the performance and legal compliance of such AI tool(s). If the use of AI is approved by Molina, the Provider further agrees to (i) allow Molina to audit Providers' AI use, as requested by Molina from time to time, and (ii) to cooperate with Molina with regard to any regulatory inquiries and investigations related to Providers' AI use related to the provision of covered services to Molina Members.

If you have additional questions, please contact your Molina Contract Manager.

Uses and disclosures of PHI

Member and patient PHI should only be used or disclosed as permitted or required by applicable law. Under HIPAA, a Provider may use and disclose PHI for their own treatment, payment, and health care operations activities (TPO) without the consent or authorization of the patient who is the subject of the PHI.

Uses and disclosures for TPO apply not only to the Provider's own TPO activities, but also for the TPO of another covered entity[1]. Disclosure of PHI by one covered entity to another covered entity or health care Provider, for the recipient's TPO is specifically permitted under HIPAA in the following situations:

1. A covered entity may disclose PHI to another covered entity or a health care Provider for the payment activities of the recipient. Please note that "payment" is a defined term under the HIPAA Privacy Rule that includes, without limitation, utilization review activities, such as preauthorization of services, concurrent review, and retrospective review of services[2].
2. A covered entity may disclose PHI to another covered entity for the health care operations activities of the covered entity that receives the PHI, if each covered entity either has or had a relationship with the individual who is the subject of the PHI being requested, the PHI pertains to such relationship and the disclosure is for the following health care operations activities:

    - Quality improvement
    - Disease management
    - Care management and care coordination
    - Training programs
    - Accreditation, licensing, and credentialing

Importantly, this allows Providers to share PHI with Molina for our health care operations activities, such as HEDIS® and quality improvement.

Confidentiality of substance use disorder patient records

Federal confidentiality of substance use disorder patient records regulations apply to any entity or individual providing federally assisted alcohol or drug abuse prevention treatment. Records of the identity, diagnosis, prognosis, or treatment of any patient which are maintained in connection with substance use disorder treatment or programs are confidential and may be disclosed only as permitted by 42 CFR Part 2. Although HIPAA protects substance use disorder information, the federal confidentiality of substance use disorder patient records regulations are more restrictive than HIPAA and they do not allow disclosure without the Member's written consent except as set forth in 42 CFR Part 2.

[1] See Sections 164.506(c) (2) & (3) of the HIPAA Privacy Rule.
[2] See the definition of Payment, Section 164.501 of the HIPAA Privacy Rule

Inadvertent disclosures of PHI

Molina may, on occasion, inadvertently misdirect or disclose PHI pertaining to Molina Member(s) who are not the patients of the Provider. In such cases, the Provider shall return or securely destroy the PHI of the affected Molina Members in order to protect their privacy. The Provider agrees to not further use or disclose such PHI and further agrees to provide an attestation of return, destruction, and non-disclosure of any such misdirected PHI upon the reasonable request of Molina.

Written authorizations

Uses and disclosures of PHI that are not permitted or required under applicable law require the valid written authorization of the patient. Authorizations should meet the requirements of HIPAA and applicable state law.

Patient rights

Patients are afforded various rights under HIPAA. Molina Providers must allow patients to exercise any of the below-listed rights that apply to the Provider's practice:

1. **Notice of privacy practices**
   Providers that are covered under HIPAA and that have a direct treatment relationship with the patient should provide patients with a notice of privacy practices that explains the patient's privacy rights and the process the patient should follow to exercise those rights. The Provider should obtain a written acknowledgment that the patient received the notice of privacy practices.
2. **Requests for restrictions on uses and disclosures of PHI**
   Patients may request that a health care Provider restrict its uses and disclosures of PHI. The Provider is not required to agree to any such request for restrictions.
3. **Requests for confidential communications**
   Patients may request that a health care Provider communicate PHI by alternative means or at alternative locations. Providers must accommodate reasonable requests from the patient.
4. **Requests for Patient Access to PHI**
   Patients have a right to access their own PHI within a Provider's designated record set. Personal representatives of patients have the right to access the PHI of the subject patient. The designated record set of a Provider includes the patient's dental record, as well as billing and other

records used to make decisions about the Member's care or payment for care.

5. **Request to amend PHI**
   Patients have a right to request that the Provider amend information in their designated record set.
6. **Request accounting of PHI disclosures**
   Patients may request an accounting of disclosures of PHI made by the Provider during the preceding six (6) year period. The list of disclosures does not need to include disclosures made for treatment, payment, or health care operations.

HIPAA security

Providers must implement and maintain reasonable and appropriate safeguards to protect the confidentiality, availability, and integrity of Molina Member and patient PHI. As more Providers implement electronic health records, Providers need to ensure that they have implemented and maintain appropriate cybersecurity measures. Providers should recognize that identity theft - both financial and dental - is a rapidly growing problem and that their patients trust their health care Providers to keep their most sensitive information private and confidential.

Dental identity theft is an emerging threat in the health care industry. Dental identity theft occurs when someone uses a person's name and sometimes other parts of their identity - such as health insurance information - without the person's knowledge or consent to obtain health care services or goods. Dental identity theft frequently results in erroneous entries being put into existing dental records. Providers should be aware of this growing problem and report any suspected fraud to Molina.

HIPAA transactions and code sets

Molina strongly supports the use of electronic transactions to streamline health care administrative activities. Molina Providers are encouraged to submit Claims and other transactions to Molina using electronic formats. Certain electronic transactions in health care are subject to HIPAA's Transactions and Code Sets Rule, including, but not limited to, the following:

- Claims and Encounters
- Member eligibility status inquiries and responses
- Claims status inquiries and responses
- Authorization requests and responses
- Remittance advices

Molina is committed to complying with all HIPAA Transaction and Code Sets standard requirements. Providers should refer to Molina's website at MolinaHealthcare.com for additional information regarding HIPAA standard transactions.

1. Click on the area titled "Health Care Professionals"
2. Click the tab titled "HIPAA"
3. Click on the tab titled "HIPAA Transactions" or "HIPAA Code Sets"

Code sets

HIPAA regulations require that only approved code sets may be used in standard electronic transactions.

National Provider Identifier (NPI)

Providers must comply with the NPI rule promulgated under HIPAA. The Provider must obtain an NPI from NPPES for itself or for any subparts of the Provider. The Provider must report its NPI and any subparts to Molina and to any other entity that requires it. Any changes in its NPI or subparts information must be reported to NPPES within 30 days and should also be reported to Molina within 30 days of the change. Providers must use their NPI to identify it on all electronic transactions required under HIPAA and on all Claims and Encounters submitted to Molina.

Reimbursement for copies of PHI

Molina does not reimburse Providers for copies of PHI related to our Members. These requests may include, although they are not limited to, the following purposes:

- Utilization management
- Care coordination and/or complex dental care management services
- Claims review
- Resolution of an appeal and/or grievance
- Anti-fraud program review
- Quality of care issues
- Regulatory audits
- Risk adjustment
- Treatment, payment, and/or operation purposes
- Collection of HEDIS® dental records

Information security and cybersecurity

NOTE: This section (Information Security and Cybersecurity) is only applicable to Providers who have been delegated by Molina to perform a health plan function(s) and in connection with such delegated functions.

1. Definitions:

   (a) "Molina Information" means any information: (i) provided by Molina to Provider; (ii) accessed by Provider or available to Provider on Molina's Information Systems; or (iii) any information with respect to Molina or any of its consumers developed by Provider or other third parties in Provider's possession, including without limitation any Molina Nonpublic Information.

   (b) "Cybersecurity Event" means any actual or reasonably suspected contamination, penetration, unauthorized access or acquisition or other breach of confidentiality, data integrity, or security compromise of a network or server resulting in the known or reasonably suspected accidental, unauthorized, or unlawful destruction, loss, alteration, use, disclosure of or access to Molina Information. For clarity, a Breach, or Security Incident as these terms are defined under HIPAA constitute a Cybersecurity Event for the purpose of this section. Unsuccessful security incidents, which are activities such as pings and other broadcast attacks on Provider's firewall, port scans, unsuccessful log-on attempts, denials of service, and any combination of the above, do not constitute a Cybersecurity Event under this definition so long as no such incident results in or is reasonably suspected to have resulted in unauthorized access, use, acquisition or disclosure of Molina Information or sustained interruption of service obligations to Molina.

   (c) "HIPAA" means the Health Insurance Portability and Accountability Act, as may be amended from time to time.

   (d) "HITECH" means the Health Information Technology for Economic and Clinical Health Act, as may be amended from time to time.

   (e) "Industry Standards" mean as applicable, codes, guidance (from regulatory and advisory bodies, whether mandatory or not), international and national standards, relating to security of network and information systems and security breach and incident reporting requirements, all as amended or updated from time to time and including but not limited to the current standards and benchmarks set forth and maintained by the following, in accordance with the latest revisions and/or amendments:

i. HIPAA and HITECH
ii. HITRUST Common Security Framework
iii. Center for Internet Security
iv. National Institute for Standards and Technology ("NIST") Special Publications 800.53 Rev.5 and 800.171 Rev. 1 or as currently revised
v. Federal Information Security Management Act ("FISMA")
vi. ISO/ IEC 27001
vii. Federal Risk and Authorization Management Program ("FedRamp")
viii. NIST Special Publication 800-34 Revision 1 – "Contingency Planning Guide for Federal Information Systems."
ix. International Organization for Standardization (ISO) 22301 – "Societal security – Business continuity management systems – Requirements."

(f) "Information Systems" means all computer hardware, databases and data storage systems, computer, data, database, and communications networks (other than the Internet), cloud platform, architecture interfaces and firewalls (whether for data, voice, video or other media access, transmission, or reception) and other apparatus used to create, store, transmit, exchange, or receive information in any form.

(g) "Multi-Factor Authentication" means authentication through verification of at least two of the following types of authentication factors: (1) knowledge factors, such as a password; (2) possession factors, such as a token or text message on a mobile phone; (3) inherence factors, such as a biometric characteristic; or (4) any other industry standard and commercially accepted authentication factors.

(h) "Nonpublic Information" includes:
i. Molina's proprietary and/or confidential information;
ii. Personally Identifiable Information as defined under applicable state data security laws, including, without, limitation, "nonpublic personal information," "personal data," "personally identifiable information," "personal information" or any other similar term as defined pursuant to any applicable law; and
iii. Protected Health Information as defined under HIPAA and HITECH.

2. Information Security and Cybersecurity Measures. Provider shall implement and at all times maintain appropriate administrative, technical, and physical measures to protect and secure the Information Systems, as well as Nonpublic Information stored thereon and Molina Information that are accessible to or held by, Provider. Such measures shall conform to generally recognized industry standards and best practices and shall comply with applicable privacy and data security laws, including implementing and maintaining administrative, technical, and physical safeguards pursuant to HIPAA, HITECH, and other applicable U.S. federal, state, and local laws.

   (a) Policies, Procedures and Practices. Provider must have policies, procedures and practices that address its information security and cybersecurity measures, safeguards, and standards, including as applicable, a written information security program, which Molina shall be permitted to audit via written request and which shall include at least the following:

      i. Access Controls. Access controls, including Multi-Factor Authentication, to limit access to the Information Systems and Molina Information accessible to or held by Provider.

      ii. Encryption. Use of encryption to protect Molina Information, in transit and at rest, accessible to or held by Provider.

      iii. Security. Safeguarding the security of the Information Systems and Molina Information accessible to or held by Provider, which shall include hardware and software protections such as network firewall provisioning, intrusion and threat detection controls designed to protect against malicious code and/or activity, regular (three or more annually) third party vulnerability assessments, physical security controls and personnel training programs that include phishing recognition and proper data management hygiene.

      iv. Software Maintenance. Software maintenance, support, updates, upgrades, third party software components and bug fixes such that the software is and remains secure from vulnerabilities in accordance with the applicable Industry Standards.

   (b) Technical Standards. Provider shall comply with the following requirements and technical standards related to network and data security:

      i. Network Security. Network security shall conform to generally recognized industry standards and best practices.

Generally recognized industry standards include, but are not limited to, the applicable Industry Standards.

ii. Cloud Services Security: If Provider employs cloud technologies, including infrastructure as a service (IaaS), software as a service (SaaS), or platform as a service (PaaS), for any services, Provider shall adopt a "zero-trust architecture" satisfying the requirements described in NIST 800-207 (or any successor cybersecurity framework thereof).

iii. Data Storage. Provider agrees that any and all Molina Information will be stored, processed, and maintained solely on designated target servers or cloud resources. No Molina Information at any time will be processed on or transferred to any portable or laptop computing device or any portable storage medium, unless that device or storage medium is in use as part of the Provider's designated backup and recovery processes and is encrypted in accordance with the requirements set forth herein.

iv. Data Encryption. Provider agrees to store all Molina Information as part of its designated backup and recovery processes in encrypted form, using a commercially supported encryption solution. Provider further agrees that any and all Molina Information stored on any portable or laptop computing device or any portable storage medium be likewise encrypted. Encryption solutions will be deployed with no less than a 128-bit key for symmetric encryption, a 1024 (or larger) bit key length for asymmetric encryption and the Federal Information Processing Standard Publication 140-2 ("FIPS PUB 140-2").

v. Data Transmission. Provider agrees that any and all electronic transmission or exchange of system and application data with Molina and/or any other parties expressly designated by Molina shall take place via secure means (using HTTPS or SFTP or equivalent) and solely in accordance with FIPS PUB 140-2 and the Data Re-Use requirements set forth herein.

vi. Data Re-Use. Provider agrees that any and all Molina Information exchanged shall be used expressly and solely for the purposes enumerated in the Provider Agreement with Molina and this section. Data shall not be distributed, repurposed, or shared across other applications, environments, or business units of Provider. Provider further agrees that no Molina Information or data of any kind shall be

transmitted, exchanged, or otherwise passed to other affiliates, contractors or interested parties, except on a case-by-case basis as specifically agreed to in advance and in writing by Molina.

3. Business Continuity ("BC") and Disaster Recovery ("DR"). Provider shall have documented procedures in place to ensure continuity of Provider's business operations, including disaster recovery, in the event of an incident that has the potential to impact, degrade or disrupt Provider's delivery of services to Molina.

   (a) Resilience Questionnaire. Provider shall complete a questionnaire provided by Molina to establish Provider's resilience capabilities.

   (b) BC/DR Plan.

      i. Provider's procedures addressing continuity of business operations, including disaster recovery, shall be collected and/or summarized in a documented BC and DR plan or plans in written format ("BC/DR Plan"). The BC/DR Plan shall identify the service level agreement(s) established between Provider and Molina. The BC/DR Plan shall include the following:

         a) Notification, escalation, and declaration procedures.
         b) Roles, responsibilities, and contact lists.
         c) All Information Systems that support services provided to Molina.
         d) Detailed recovery procedures in the event of the loss of people, processes, technology and/or third parties or any combination thereof providing services to Molina.
         e) Recovery procedures in connection with a Cybersecurity Event, including ransomware.
         f) Detailed list of resources to recover services to Molina including but not limited to applications, systems, vital records, locations, personnel, vendors, and other dependencies.
         g) Detailed procedures to restore services from a Cybersecurity Event including ransomware.
         h) Documented risk assessment which shall address and evaluate the probability and impact of risks to the organization and services provided to Molina. Such risk assessment shall evaluate natural, manufactured, political, and cybersecurity incidents.

ii. To the extent that Molina Information is held by Provider, Provider shall maintain backups of such Molina Information that are adequately protected from unauthorized alterations or destruction consistent with applicable Industry Standards.

iii. Provider shall develop information technology disaster recovery or systems contingency plans consistent with applicable Industry Standards and in accordance with all applicable laws.

(c) Notification. Provider shall notify Molina's Chief Information Security Officer by telephone and email (provided herein) as promptly as possible, but not to exceed 24 hours, of either of the following:

i. Provider's discovery of any potentially disruptive incident that may impact or interfere with the delivery of services to Molina or that detrimentally affects Provider's Information Systems or Molina's Information.

ii. Provider's activation of business continuity plans. Provider shall provide Molina with regular updates by telephone or email (provided herein) on the situation and actions taken to resolve the issue, until normal services have been resumed.

(d) BC and DR Testing. For services provided to Molina, Provider shall exercise its BC/DR Plan at least once each calendar year. Provider shall exercise its cybersecurity recovery procedures at least once each calendar year. At the conclusion of the exercise, Provider shall provide Molina a written report in electronic format upon request. At a minimum, the written report shall include the date of the test(s), objectives, participants, a description of activities performed, results of the activities, corrective actions identified and modifications to plans based on results of the exercise(s).

4. Cybersecurity Events.

(a) Provider agrees to comply with all applicable data protection and privacy laws and regulations. Provider will implement best practices for incident management to identify, contain, respond to, and resolve Cybersecurity Events.

(b) In the event of a Cybersecurity Event that threatens or affects Molina's Information Systems (in connection with Provider having access to such Information Systems); Provider's Information Systems; or Molina Information accessible to or held by Provider, Provider shall notify Molina's Chief Information Security Officer of

such event by telephone and email as provided below (with follow-up notice by mail) as promptly as possible, but in no event later than 24 hours from Provider's discovery of the Cybersecurity Event.

i. In the event that Provider makes a ransom or extortion payment in connection with a Cybersecurity Event that involves or may involve Molina Information, Provider shall notify Molina's Chief Information Security Officer (by telephone and email, with follow-up notice by mail) within 24 hours following such payment.

ii. Within 15 days of such a ransom payment that involves or may involve Molina Information, Provider shall provide a written description of the reasons for which the payment was made, a description of alternatives to payment considered, a description of due diligence undertaken to find alternatives to payment and evidence of all due diligence and sanctions checks performed in compliance with applicable rules and regulations, including those of the Office of Foreign Assets Control.

(c) Notification to Molina's Chief Information Security Officer shall be provided to:

Molina Chief Information Security Officer
Telephone: (844) 821-1942
Email: CyberIncidentReporting@Molinahealthcare.com

Molina Chief Information Security Officer
Molina Healthcare, Inc.
200 Oceangate Blvd., Suite 100
Long Beach, CA 90802

(d) In the event of a Cybersecurity Event, Provider will, at Molina's request, (i) fully cooperate with any investigation concerning the Cybersecurity Event by Molina, (ii) fully cooperate with Molina to comply with applicable law concerning the Cybersecurity Event, including any notification to consumers and (iii) be liable for any expenses associated with the Cybersecurity Event including without limitation: (a) the cost of any required legal compliance (e.g., notices required by applicable law) and (b) the cost of providing two (2) years of credit monitoring services or other assistance to affected consumers. In no event will Provider serve any notice of or otherwise publicize a Cybersecurity Event involving Molina Information without the prior written consent of Molina

(e) Following notification of a Cybersecurity Event, Provider must promptly provide Molina any documentation requested by Molina to complete an investigation, or, upon request by Molina, complete an investigation pursuant to the following requirements:
   i. make a determination as to whether a Cybersecurity Event occurred;
   ii. assess the nature and scope of the Cybersecurity Event;
   iii. identify Molina's Information that may have been involved in the Cybersecurity Event; and
   iv. perform or oversee reasonable measures to restore the security of the Information Systems compromised in the Cybersecurity Event to prevent further unauthorized acquisition, release, or use of Molina Information.

(f) Provider must provide Molina the following required information regarding a Cybersecurity Event in electronic form. Provider shall have a continuing obligation to update and supplement the initial and subsequent notifications to Molina concerning the Cybersecurity Event. The information provided to Molina must include at least the following, to the extent known:
   i. the date of the Cybersecurity Event;
   ii. a description of how the information was exposed, lost, stolen, or breached;
   iii. how the Cybersecurity Event was discovered;
   iv. whether any lost, stolen, or breached information has been recovered and if so, how this was done;
   v. the identity of the source of the Cybersecurity Event;
   vi. whether Provider has filed a police report or has notified any regulatory, governmental or law enforcement agencies and, if so, when such notification was provided;
   vii. a description of the specific types of information accessed or acquired without authorization, which means particular data elements including, for example, types of dental information, types of financial information or types of information allowing identification of the consumer;
   viii. the period during which the Information System was compromised by the Cybersecurity Event;
   ix. the number of total consumers in each state affected by the Cybersecurity Event;
   x. the results of any internal review identifying a lapse in either automated controls or internal procedures or confirming that all automated controls or internal procedures were followed;

xi. a description of efforts being undertaken to remediate the situation which permitted the Cybersecurity Event to occur;

xii. a copy of Provider's privacy policy and a statement outlining the steps Provider will take to investigate and if requested by Molina, the steps that Provider will take to notify consumers affected by the Cybersecurity Event; and

xiii. the name of a contact person who is familiar with the Cybersecurity Event and authorized to act on behalf of Provider.

(g) Provider shall maintain records concerning all Cybersecurity Events for a period of at least five (5) years from the date of the Cybersecurity Event or such longer period as required by applicable laws and produce those records upon Molina's request.

5. Right to Conduct Assessments; Provider Warranty. Provider agrees to fully cooperate with any security risk assessments performed by Molina and/or any designated representative or vendor of Molina. Provider agrees to promptly provide accurate and complete information with respect to such security risk assessments. If Molina performs a due diligence/security risk assessment of Provider, Provider (i) warrants that the services provided pursuant to the Provider Agreement with Molina will be in compliance with generally recognized industry standards and as provided in Provider's response to Molina's due diligence/security risk assessment questionnaire; (ii) agrees to inform Molina promptly of any material variation in operations from what was provided in Provider's response to Molina's due diligence/security risk assessment; and (iii) agrees that any material deficiency in operations from those as described in the Provider's response to Molina's due diligence/security risk assessment questionnaire may be deemed a material breach of the Provider Agreement with Molina.

6. Other Provisions. Provider acknowledges that there may be other information security and data protection requirements applicable to Provider in the performance of services which may be addressed in an agreement between Molina and Provider but are not contained in this section.

7. Conflicting Provisions. In the event of any conflict between the provisions of this section and any other agreement between Molina and Provider, the stricter of the conflicting provisions will control.

9. Claims and compensation

Payer ID	SKYGN
SKYGEN Dental Hub	SKYGEN DENTAL HUB
Clean claim, Timely filing	365 days after the date of service for outpatient services

Electronic Claim Submission

Molina strongly encourages participating Providers to submit Claims electronically, including secondary Claims. Electronic Claim submission provides significant benefits to the Provider, including:

- Helps to reduce operation costs associated with Paper Claims (printing, postage, etc.)
- Increases the accuracy of data and efficient information delivery
- Reduces Claim delays since errors can be corrected and resubmitted electronically
- Eliminates mailing time and Claims reach Molina faster

Molina offers the following electronic Claim submission options:

- Submit Claims directly to Molina via the SKYGEN DENTAL HUB
- Submit Claims to Molina via your regular EDI clearinghouse

The SKYGEN DENTAL HUB is a no-cost online platform that offers a number of Claims processing features:

- Submit ADA claim form with the attached files
- Correct/void Claims
- Add attachments to previously submitted Claims
- Check Claim status
- View ERA and EOP
- Create and submit a Claim appeal with attached files

EDI Claim Submission Issues

Providers experiencing EDI submission issues should work with their clearinghouse to resolve them. If the clearinghouse is unable to resolve the issue, the Provider should contact their Molina Provider Relations representative for additional support.

Timely Claim Filing

Providers shall promptly submit to Molina Claims for covered services rendered to Members. All Claims shall be submitted in a form acceptable to and approved

by Molina and shall include all dental records pertaining to the Claim if requested by Molina or otherwise required by Molina's policies and procedures. Claims must be submitted by the Provider to Molina within 365 calendar days after the discharge for inpatient services or the date of service for outpatient services. If Molina is not the primary payer under the coordination of benefits or third-party liability, the Provider must submit Claims to Molina within 365 calendar days after final determination by the primary payer. Except as otherwise provided by law or provided by government program requirements, any Claims that are not submitted to Molina within these timelines shall not be eligible for payment, and the Provider hereby waives any right to payment.

Claim submission

Participating Providers are required to submit Claims to Molina with appropriate documentation. Providers must follow the appropriate state and CMS Provider billing guidelines as well as any criteria explicitly required in the Molina Dental Services Provider Dental Manual and any criteria explicitly required in the ADA claim form Providers must utilize electronic billing through a clearinghouse or the SKYGEN DENTAL HUB whenever possible and use current HIPAA-compliant American National Standards Institute (ANSI) X12N format (e.g., 837I for institutional Claims, 837P for professional Claims and 837D for dental Claims).

Providers must bill Molina for services with the most current ADA-approved procedural coding available as of the date the service was provided.

National Provider Identifier (NPI)

A valid NPI is required on all Claim submissions. Providers must report any changes in their NPI or subparts to Molina as soon as possible, not to exceed 30 calendar days from the change. Molina supports the CMS recommendations around NPPES data verification and encourages our Provider network to verify Provider data via nppes.cms.hhs.gov. Molina may validate that the NPI submitted in a Claim transaction is a valid NPI and is recognized as part of the NPPES data.

Required elements

Electronic submitters should use the Implementation Guide and Molina Companion Guide for format and code set information when submitting or receiving files directly with Molina. In addition to the Implementation Guide and Companion Guide, electronic submitters should use the appropriate state-specific Companion Guides and Provider Manuals. These documents are subject to change as new information is available. Please check the Molina website at MolinaHealthcare.com under EDI>Companion Guides for regularly updated information regarding Molina's companion guide requirements. Be sure to choose the appropriate state from the drop-down list on the top of the page. In addition to the Molina Companion Guide, it is also necessary to use the state health plan-specific companion guides, which are also available on our Molina website for your convenience (remember to choose the appropriate state from the drop-down list).

Electronic Claim submissions will adhere to specifications for submitting Dental Claim data in standardized Accredited Standards Committee (ASC) X12N 837 formats. Electronic Claims are validated for compliance with Strategic National Implementation Process (SNIP) levels 1-5.

The following information must be included on every Claim, whether electronic or paper:

- Member name, date of birth and Molina Member ID number
- Member's gender
- Member's address
- Date(s) of service
- Valid CDT for services or items provided
- Valid Diagnosis Pointers (if required)
- Total billed charges
- Place and type of service code
- Days or units as applicable (anesthesia Claims require minutes)
- Provider tax identification number (TIN)
- 10-digit National Provider Identifier (NPI) or Atypical Provider Identifier (API)
- Rendering Provider information when different than billing
- Billing/Pay-to-Provider name and billing address
- Place of service and type (for facilities)
- Disclosure of any other health benefit plans
- E-signature
- Service facility location information
- Any other state-required data

Provider and Member data will be verified for accuracy and active status. Be sure to validate this data in advance of Claim submission. This validation will apply to all Provider data submitted and also applies to atypical and out-of-state Providers.

Inaccurate, incomplete, or untimely submissions and re-submissions may result in denial of the Claim.

EDI (clearinghouse) submission

Corrected Claim information submitted via EDI submission are required to follow electronic Claim standardized ASC X12N 837 formats. Electronic Claims are validated for compliance with SNIP levels 1-5. The 837 Claim format allows you to submit changes to Claims that were not included on the original adjudication.

The 837 Implementation Guides refer to the National Uniform Billing Data Element Specifications Loop 2300 CLM05-3 for explanation and usage. In the 837 formats, the codes are called "Claim frequency codes." Using the appropriate code, you can indicate that the Claim is an adjustment of a previously submitted finalized Claim. Use the below frequency codes for Claims that were previously adjudicated.

Claim frequency code	Description	Action
7	Use to replace an entire Claim.	Molina will adjust the original Claim. The corrections submitted represent a complete replacement of the previously processed Claim.
8	Use to eliminate a previously submitted Claim.	Molina will void the original Claim from the records based on the request.

When submitting Claims noted with Claim frequency code 7 or 8, the original Claim number must be submitted in Loop 2300 REF02 – Payer Claim Control Number with qualifier F8 in REF01. The original Claim number can be obtained from the 835 ERA. Without the original Claim number, adjustment requests will generate a compliance error, and the Claim will be rejected.

Claim corrections submitted without the appropriate frequency code will deny as a duplicate and the original Claim number will not be adjusted.

Paper Claim Submission

Participating Providers should submit Claims electronically. If electronic Claim submission is not possible, please submit paper Claims to the following address:

Molina Healthcare of Ohio Medicare and Molina Dual Options MyCare Ohio
PO Box 22664
Long Beach, CA 90801

Molina Healthcare of Ohio, Molina MyCare Ohio Medicaid
PO Box 22712
Long Beach, CA 90801

When submitting paper Claims:

- Paper Claim submissions are not considered to be "accepted" until received at the appropriate Claims PO Box; Claims received outside of the designated PO Box will be returned for appropriate submission.
- Paper Claims are required to be submitted on an ADA claim form.
- Paper Claims not submitted on the required forms will be rejected and returned. This includes black and white forms, copied forms, and any alterations to include Claims with handwriting.
- Claims must be typed with either 10 or 12-point Times New Roman font, using black ink.

Corrected Claim Process

Providers may correct any necessary fields of the ADA claim form.

Molina strongly encourages participating Providers to submit Corrected Claims electronically via EDI or the SKYGEN DENTAL HUB.

All corrected Claims:

- Must be free of handwritten or stamped verbiage (paper Claims).
- Must be submitted on a standard ADA claim form (paper Claims).
- The Original Claim number must be inserted in field 35 of the ADA paper claim.

Corrected Claims must be sent within 365 calendar days of the date of service or the most recent adjudicated date> of the Claim.

Corrected Claim submission options:

- Submit Corrected Claims directly to Molina via the SKYGEN DENTAL HUB
- Submit corrected Claims to Molina via your regular EDI clearinghouse

Coordination of benefits (COB) and third-party liability (TPL)

Third-party liability refers to any other health insurance plan or carrier (e.g., individual, group, employer-related, self-insured, self-funded or commercial carrier, automobile insurance and worker's compensation) or program that is or may be liable to pay all or part of the health care expenses of the Member.

Medicaid is always the payer of last resort, and Providers shall make reasonable efforts to determine the legal liability of third parties to pay for services furnished to Molina Members. If third-party liability can be established, Providers must bill the primary payer and submit a primary explanation of benefits (EOB) to Molina for secondary Claim processing. In the event that coordination of benefits occurs, the Provider shall be reimbursed based on the state regulatory COB methodology. Primary carrier payment information is required with the Claim submission. Providers can submit Claims with attachments, including EOB and other required documents. Molina will pay Claims for prenatal care and EPSDT and then seek reimbursement from third parties. If services and payment have been rendered prior to establishing third-party liability, an overpayment notification letter will be sent to the Provider requesting a refund, including third-party policy information required for billing.

Subrogation – Molina retains the right to recover benefits paid for a Member's health care services when a third party is responsible for the Member's injury or illness to the extent permitted under state and federal law and the Member's benefit plan. If third-party liability is suspected or known, please refer pertinent case information to Molina's vendor at submitreferrals@optum.com.

General coding requirements

Correct coding is required to properly process Claims. Molina requires that all Claims be coded in accordance with the HIPAA transaction code set guidelines and follow the guidelines within each code set.

CDT codes

Codes must be submitted in accordance with the chapter and code-specific guidelines set forth in the current/applicable version of the ADA CDT codebooks. To ensure proper and timely reimbursement, codes must be effective on the date of service for which the procedure or service was rendered, not the date of submission.

Place of service (POS) codes

POS codes are two (2) digit codes placed on health care professional Claims (ADA claim form) to indicate the setting in which a service was provided. CMS maintains POS codes used throughout the health care industry. The POS code should indicate where that specific procedure/service was rendered. If billing multiple lines, each line should indicate the POS code for the procedure/service on that line.

Claim auditing

Molina shall use established industry claims adjudication and/or clinical practices, state and federal guidelines, and/or Molina's policies and data to determine the appropriateness of the billing, coding, and payment.

The Provider acknowledges Molina's right to conduct pre- and post-payment billing audits. The Provider shall cooperate with Molina's SIU and audits of Claims and payments by providing access at reasonable times to requested Claims information, the Provider's charging policies, and other related data as deemed relevant to support the transactions billed. Additionally, Providers are required, by contract and in accordance with the Provider Manual, to submit all supporting dental records/documentation as requested. Failure to do so in a timely manner may result in an audit failure and/or denial, resulting in an overpayment.

In reviewing dental records for a procedure, Molina reserves the right and where unprohibited by regulation, to select a statistically valid random sample or smaller subset of the statistically valid random sample. This gives an estimate of the proportion of Claims Molina paid in error. The estimated proportion or error rate may be extrapolated across all Claims to determine the amount of overpayment.

Provider audits may be telephonic, an on-site visit, internal claims review, client-directed/regulatory investigation and/or compliance reviews and may be vendor-assisted. Molina asks that you provide Molina or Molina's designee, during normal business hours, access to examine, audit, scan, and copy any and all records necessary to determine compliance and accuracy of billing.

If Molina's Special Investigations Unit suspects that there is fraudulent or abusive activity, Molina may conduct an on-site audit without notice. Should you refuse to allow access to your facilities, Molina reserves the right to recover the full amount paid or due to you.

Timely Claim processing

Claim processing will be completed for contracted Providers in accordance with the timeliness provisions set forth in the Provider Agreement with Molina. Unless the Provider and Molina have agreed in writing to an alternate schedule, Molina will process the claim for service within:

- 90% of all submitted "clean" claims are to be adjudicated within 30 calendar days of receipt.
- 99% of all submitted "clean" claims are to be adjudicated within 90 calendar days of receipt.
  days after receipt of Clean Claims.

The receipt date of a Claim is the date Molina receives notice of the Claim.

Electronic Claim payment

Participating Providers are required to enroll for EFT and ERA. Providers who enroll in EFT payments will automatically receive ERAs as well. EFT/ERA services allow Providers to reduce paperwork, provide searchable ERAs, and receive payment and ERA access faster than the paper check and RA processes. There is no cost to the Provider for EFT enrollment, and Providers are not required to be in-network to enroll. Molina uses a vendor to facilitate the HIPAA-compliant EFT payment and ERA delivery. Additional information about EFT/ERA is available at MolinaHealthcare.com or by contacting the Molina Provider Contact Center.

Overpayments and incorrect payments refund requests

Molina requires network Providers to report to Molina when they have received an overpayment.

If, after retroactively reviewing Claim payments, Molina determines that it has overpaid a Provider for services rendered to a Member, it will recoup the funds on a future remit.

Claim disputes/reconsiderations/appeals

Information on Claim disputes/reconsiderations/appeals is located in the **Complaints, Grievance, and Appeals Process** section of this Provider Manual.

Fraud, waste, and abuse

Failure to report instances of suspected fraud, waste, and abuse is a violation of the law and is subject to the penalties provided by law. For additional information, please refer to the **Compliance** section of this Provider Manual.

10. Appeals and Grievances

Definitions

The Ohio Administrative Code defines a grievance (complaint) as an expression of dissatisfaction with any aspect of Molina's or a participating Provider's operations, provision of health care services, activities, or behaviors. Examples of a grievance include but are not limited to the quality of care, aspects of interpersonal relationships such as rudeness of a Provider or Molina employee, waiting times for an appointment, cleanliness of contracted Provider facilities, failure of the Plan or a contracted Provider to respect the Member's rights under the Plan, Plan benefit design, or the coverage decision or Appeals process, the Plan formulary, or the availability of contracted Providers.

An Adverse Benefit Determination includes, among other things, the denial or limited authorization of a requested service, including determinations based on the type or level of service, requirements for Medical Necessity, appropriateness, setting, or effectiveness of a Covered Service; the reduction, suspension, or termination of a previously authorized service, or the denial, in whole or in part, of payment for a service.

An appeal is the request for a review of an adverse benefit determination. The Member or their authorized representative has the right to appeal Molina's decision to deny a service.
The Beneficiary and Family Centered Quality Improvement Organization (BFCC-QIO or QIO) is a Medicare organization comprised of practicing doctors and other health care experts under contract to the federal government to monitor and improve the care given to Medicare enrollees. The BFCC-QIOs review beneficiary complaints about the quality of care provided by physicians, inpatient hospitals, hospital outpatient departments, hospital emergency rooms, skilled nursing facilities (SNFs), home health agencies (HHAs), Medicare managed care organizations, Medicare Part D prescription drug plans, and ambulatory surgical centers. The BFCC-QIOs also review Medicare continued stay denials in acute inpatient hospital facilities as well as coverage terminations in SNFs, HHAs, and comprehensive outpatient rehabilitation facilities (CORFs). In some cases, the BFCC-QIO can provide informal dispute resolution between the health care Provider (e.g., physician, hospital, etc.) and the beneficiary. This definition is relevant for Members enrolled in the Molina Dual Options MyCare Ohio Medicare-Medicaid Plan.

Member grievance process

Members may file an appeal or grievance at any time by calling Molina's Member Services Department at:

Molina Dual Options MyCare Ohio Medicare-Medicaid Plan: (855) 665-4623 (TTY 711), Monday through Friday from 8 a.m. to 8 p.m.
Molina Dual Options MyCare Ohio Medicaid Only: (855) 687-7862 (TTY 711), Monday through Friday from 8 a.m. to 8 p.m.

Members may also submit a Molina Dual Options MyCare Ohio Medicaid (opt-out) grievance or appeal at any time in writing to:

Molina Healthcare of Ohio, Inc.
Attn: Provider Appeals and Grievance Department
PO Box 182273
Chattanooga, TN 37422
Fax: (866) 713-1891

Members may also submit a Molina Dual Options MyCare Ohio Medicare-Medicaid Plan grievance or appeal in writing to:

Molina Healthcare
Attn: Provider Appeals and Grievance
PO Box 22816
Long Beach, CA 90801-9977
Fax: (562) 499-0610

Members may authorize a designated representative to act on their behalf (hereafter referred to as "representative") with written consent. The representative can be a friend, a family member, a health care Provider, or an attorney.

For Medicaid, a Grievance/Appeal Request Form can be found on Molina's Member and Provider Websites at MolinaHealthcare.com.

For Molina Dual Options MyCare Ohio Medicare-Medicaid Plan, the Member may be required to provide a CMS Appointment of Representative Form (CMS1696) or documentation of legal surrogacy (e.g., through a Power of Attorney or guardianship).

Grievance timelines

Molina will investigate, resolve, and notify the Member or their authorized representative of the findings. Every attempt will be made to resolve a grievance at the time of a call. However, if a grievance is unable to be resolved immediately, it will be resolved as expeditiously as possible, but no later than the following time frames:

- Two working days of receipt of a grievance related to accessing Medically Necessary Covered Services in the Molina Dual Options MyCare Ohio line of business (unless an extension is requested from and approved by ODM).

Grievances are typically responded to within 30 days. Under certain circumstances, the plan may also be allowed to take an extension.

Member appeal process

Expedited appeal process and timeline

For Member appeals represented by the Provider, Molina must have written consent from the Member authorizing someone else to represent them. An appeal will not be reviewed until the Member's authorization is received. A

Grievance/Appeal Request Form can be found on Molina's Member website at MolinaHealthcare.com.

Providers can request expedited or standard pre-service Appeals on behalf of their Members who are enrolled in the Molina Dual Options MyCare Ohio Medicare-Medicaid Plan. However, if not requested specifically by a treating physician, a CMS Appointment of Representative Form may be required. The Appointment of Representative Form can be found online and downloaded at www.cms.hhs.gov/cmsforms/downloads/cms1696.com.

An appeal can be filed verbally or in writing within 60 days from the date of the denial notice. Molina will send a written acknowledgment in response to written appeal requests received. Molina will respond to the Member or representative in writing with a decision within 15 calendar days (unless an extension is granted to Molina by ODM).

When submitting an Appeal for a Member, provide all medical records and/or documentation to support the Appeal at that time. Please note that if additional information must be requested, processing of the Appeal may be delayed. Members should include their name, contact information, Member ID number, health plan name, reason for appealing, and any evidence the Member wishes to attach. Members may send in supporting medical records, documentation or other information that explains why Molina should provide or pay for the item or service.

Standard appeal process and timeline

Molina has an expedited process for reviewing Member appeals when the standard resolution time frame could seriously jeopardize the Member's life, health, or ability to attain, maintain, or regain maximum function.

Expedited Member appeals may be requested by the Member or their authorized representative orally or in writing. Molina will make the determination within one business day as to whether to expedite the appeal resolution. Molina will make reasonable efforts to provide prompt oral notification to the member or representative of the decision to expedite or not expedite the appeal resolution. Molina will resolve the appeal as expeditiously as the member's health condition requires, but the resolution time frame shall not exceed seventy-two hours from the date Molina received.

The Member or representative will be notified. No punitive action will be taken against a Member, Member's representative, or Provider for filing an expedited

Member appeal or against any Provider who supports a Member's request for an expedited appeal. If Molina denies the request for expedited appeal resolution, the appeal will be treated as a standard appeal and resolved within 15 calendar days from the receipt date (unless an extension was granted). Additional timeframes apply for Medicare-related Appeals for Members in the Molina Dual Options MyCare Ohio Medicare-Medicaid Plan:

Expedited Pre-Service Part B drug	72 hours
Expedited Pre-Service Part D drug	72 hours
Standard Pre-Service Part B drug	7 calendar days
Standard Pre-Service Part D drug	7 calendar days
Standard Post-Service Part D drug	14 calendar days

Extensions are not allowed for Appeals involving Part B and Part D drugs. Molina's Pharmacy Department manages all Part D Appeals.

External or Administrative Law Judge Reviews and State Fair Hearings

If the appeal resolution affirms the denial, reduction, suspension, or termination of a Medicaid-covered service or permits the billing of a Member due to Molina's denial of payment for that service, Molina will notify the Member of their right to request a state hearing.

A Member has the right to request a state hearing from the Bureau of State Hearings 90 days from the appeal resolution notice if there is dissatisfaction with Molina's decision. The Member or representative is required to file an appeal with Molina prior to requesting a state hearing.
Members are notified of their right to a state hearing in all the following situations:

- A service denial (in whole or in part).
- Reduction, suspension, or termination of a previously authorized service.
- A health care Provider may act as the Member's authorized representative or as a witness for the Member at the hearing.

Appeal decisions not wholly resolved in the Member's favor will include information on how to request a state hearing, the member's right to request a continuation of benefits during an appeal or state hearing, and the specification that at the discretion of ODM, the member may be liable for the cost of any such continued benefits.

If the state hearing upholds Molina's decision and continued benefits are requested in the interim, the Medicaid Member may be responsible for payment. The provider has the right to participate in these processes on behalf of the provider's patients and to challenge the MCE's failure to cover a specific service.

For Members in the Molina Dual Options MyCare Ohio Medicare-Medicaid Plan, the Member may have the right to pursue a State Fair Hearing when the item or service is or could be covered by Medicaid or both Medicare and Medicaid (overlap). In these cases, when the decision is partially or completely adverse to the Member, the Member is provided with their State Fair Hearing rights and any instructions for continuation of benefits pending State Fair Hearing. Additional levels of Appeal follow applicable State rules and requirements. When the item or service is or could be covered by Medicare or both Medicare and Medicaid (overlap) and the decision is partially or completely adverse to the Member, the Appeal will be forwarded to an Independent Review Entity (IRE). (For Part D upholds, the Member must request review by the IRE.) The IRE is a CMS contractor independent of Molina. If the IRE upholds the initial adverse determination and the amount in controversy requirements are met, the Member may continue to an additional level of Appeal with an Administrative Law Judge (ALJ) or attorney adjudicator. Additional levels of Appeal are available to the Member if the amount in controversy requirements are met, including appeal to the Medicare Appeals Council (MAC) and federal court. Members may pursue both the Medicare and the Medicaid additional levels of Appeal when applicable.

Provider Claim dispute (adjustment request)

Providers disputing a Claim previously adjudicated must request such action within 120 calendar days of Molina's original remittance advice date. Regardless of the type of denial/dispute (service denied, incorrect payment, administrative, etc.), all Claim disputes must be submitted on the Molina Claims Request for Reconsideration Form (CRRF) found on the Provider Website and the SKYGEN Dental Hub. The form must be filled out completely in order to be processed.

Additionally, the item(s) being resubmitted should be clearly marked as a reconsideration and must include the following:

- Any documentation to support the adjustment and a copy of the Authorization form (if applicable) must accompany the reconsideration request.
- The Claim number is clearly marked on all supporting documents.

Requests for Claims Disputes/Reconsiderations should be sent via the following methods:

- SKYGEN Dental Hub.
- Call Provider Relations at (855) 322-4079.

By mail to:

Molina Healthcare Provider Disputes
P.O. Box 649
Milwaukee, WI 53201

The provider will be notified of Molina's decision in writing within 60 days of receipt of the Claims Dispute/Adjustment request.

Reporting

Grievance and appeal trends are reported to the Quality Improvement and Health Equity Transformation Committee quarterly. This trend report includes a quantitative review of trends, qualitative or barriers analysis and identification of interventions that address key drivers. An annual evaluation of grievance and appeal analysis is then completed and presented to the Quality Improvement and Health Equity Transformation Committee for evaluation. If required by the state or CMS, reporting is submitted to the appropriate agency as needed.

11. Credentialing and recredentialing

ODM is responsible for credentialing all Medicaid managed care providers. The credentialing and recredentialing processes are paired with enrollment and revalidation, respectively, in the Provider Network Management (PNM) system. This process adheres to National Committee for Quality Assurance (NCQA) and CMS federal guidelines for both processes and the types of providers who are subject to the credentialing process.

Please note, you are not able to render services to Medicaid members until you are fully screened, enrolled, and credentialed (if required) by Ohio Medicaid. For a complete list of provider types that require credentialing, please refer to Ohio Administrative Code (OAC) rule 5160-1-42.

For individual providers, the general guidance is that licensed providers who can practice independently under state law are required to go through this process. Medical students, residents, fellows, and providers who practice strictly in an

inpatient setting are exempt from credentialing. It is recommended that you begin the contracting process with each managed care organization (MCO) you wish to participate with while you are enrolling and being credentialed at ODM, in order to be able to render services as of your effective date. While the credentialing process is being centralized at the state Medicaid level, you are still required to contract with the MCOs. Providers will only be included in the MCO contract during the period credentialed or approved by ODM.

When you submit your initial application to be an Ohio Medicaid provider, you can designate a managed care organization interest in the PNM system. Once your application is submitted, demographic data for your provider is transmitted automatically to the MCOs so they can start contracting with you.

Please direct any credentialing inquiries to ODM at Credentialing@medicaid.ohio.gov or visit the website: managedcare.medicaid.ohio.gov/managed-care/centralized-credentialing.

Note: All recredentialing activities transitioned to ODM on Feb. 1, 2023.

Non-discriminatory credentialing and recredentialing

Molina does not make credentialing and recredentialing decisions based on an applicant's race, ethnic/national identity, gender, gender identity, age, sexual orientation, ancestry, religion, marital status, health status, or patient types (e.g., Medicaid) in which the practitioner specializes. This does not preclude Molina from including in its network practitioners who meet certain demographic or specialty needs; for example, to meet the cultural needs of Members.

Criteria for participation in the Molina network

Molina has established criteria and the sources used to verify these criteria for evaluating and selecting practitioners for participation in the Molina network. These criteria have been designed to assess a Practitioner's ability to deliver care. This policy defines the criteria that are applied to applicants for initial participation, credentialing, and ongoing participation in the Molina network. To remain eligible for participation, Practitioners must continue to satisfy all applicable requirements for participation as stated herein and in all other documentation provided by Molina.

Molina reserves the right to exercise discretion in applying any criteria and to exclude Practitioners who do not meet the criteria. Molina may, after considering the recommendations of the Professional Review Committee, waive any of the requirements for network participation established pursuant to these

policies for good cause if it is determined that such waiver is necessary to meet the needs of Molina and the community it serves. Molina's refusal to waive any requirement shall not entitle any Practitioner to a hearing or any other rights of review.

Providers shall not be eligible to see Molina Members as Participating Providers until notified of their effective date from Molina.

Additionally, Providers shall not be eligible to treat Members as a Participating Provider at a location until both notified of credentialing completion and added to the Health Plan systems. The Provider will receive a welcome notice from Molina with the effective date of participation, along with a copy of the fully executed agreement for new contract execution (if applicable).

Practitioners must meet the following criteria to be eligible to participate in the Molina network. The Practitioner shall have the burden of producing adequate information to prove they meet all criteria for initial participation and continued participation in the Molina network. If the Practitioner does not provide this information, the credentialing application will be deemed incomplete, and it will result in an administrative denial or administrative termination from the Molina network. Practitioners who fail to provide this burden of proof do not have the right to submit an appeal.

- **Application** – Practitioners must submit to Molina a complete credentialing application either from CAQH ProView or other state-mandated practitioner application. The attestation must be signed within 120 days. Application must include all required attachments.
- **License, certification, or registration** – Practitioners must hold a current and valid license, certification, or registration to practice in their specialty in every state in which they will provide care and/or render services for Molina Members. Telemedicine Practitioners are required to be licensed in the state where they are located and the state the Member is located.
- **Drug Enforcement Agency (DEA) certificate** – Practitioners must hold a current, valid, unrestricted DEA certificate. Practitioners must have a DEA certificate in every state where the Practitioner provides care to Molina Members. If a Practitioner has a pending DEA certificate and never had any disciplinary action taken related to their DEA certificate or chooses not to have a DEA certificate, the Practitioner must then provide a documented process that allows another Practitioner with a valid DEA certificate to write all prescriptions requiring a DEA number.
- **Controlled Dangerous Substances (CDS) certificate** – Practitioners must hold a current, valid Ohio CDS certificate. Practitioners with locations in contiguous states must meet CDS requirements in those states.

- **Specialty** – Practitioners must only be credentialed in the specialty in which they have adequate education and training. Practitioners must confine their practice to their credentialed area of practice when providing services to Molina Members.
- **Education** – Practitioners must have graduated from an accredited school with a degree required to practice in their designated specialty.
- **Residency training** – Practitioners must have satisfactorily completed residency training from an accredited training program in the specialties in which they are practicing. Molina only recognizes programs that have been accredited by the Accreditation Council of Graduate Dental Education (ACGME) and the American Osteopathic Association (AOA) in the United States or by the College of Family Physicians of Canada (CFPC), the Royal College of Physicians and Surgeons of Canada. Oral Surgeons must complete a training program in Oral and Maxillofacial Surgery accredited by the Commission on Dental Accreditation (CODA). Training must be successfully completed prior to completing the verification. It is not acceptable to verify completion prior to graduation from the program. As of July 2013, Podiatric residencies are required to be three (3) years in length. If the podiatrist has not completed a three (3)-year residency or is not board certified, the podiatrist must have five (5) years of work history practicing podiatry.
- **General dentist** – Practitioners who are not board certified and have not completed training from an accredited program are only eligible to be considered for participation as a General Dentist in the Molina network.
- **Work history** – Practitioners must supply the most recent five (5)-years of relevant work history on the application or curriculum vitae. Relevant work history includes work as a health professional. If a gap in employment exceeds six (6) months, the Practitioner must clarify the gap verbally or in writing. The organization will document verbal clarification in the Practitioner's credentialing file. If the gap in employment exceeds one (1) year, the Practitioner must clarify the gap in writing.
- **Malpractice history** – Practitioners must supply a history of malpractice and professional liability claims and settlement history in accordance with the application. Documentation of malpractice and professional liability claims and settlement history is requested from the Practitioner on the credentialing application. If there is an affirmative response to the related disclosure questions on the application, a detailed response is required from the Practitioner.
- **State sanctions, restrictions on licensure or limitations on scope of practice** – Practitioners must disclose a full history of all license/certification/registration actions including denials, revocations, terminations, suspension, restrictions, reductions, limitations, sanctions,

probations, and non-renewals. Practitioners must also disclose any history of voluntarily or involuntarily relinquishing, withdrawing or failure to proceed with an application to avoid an adverse action or to preclude an investigation or while under investigation relating to professional competence or conduct. If there is an affirmative response to the related disclosure questions on the application, a detailed response is required from the Practitioner. At the time of initial application, the Practitioner must not have any pending or open investigations from any state or governmental professional disciplinary body[3]. This would include a Statement of Charges, Notice of Proposed Disciplinary Action, or the equivalent.

- **Medicare, Medicaid and other sanctions and exclusions** – Practitioners must not be currently sanctioned, excluded, expelled, or suspended from any state or federally funded program including but not limited to the Medicare or Medicaid programs. Practitioners must disclose all Medicare and Medicaid sanctions. If there is an affirmative response to the related disclosure questions on the application, a detailed response is required from the Practitioner. Practitioners must disclose all debarments, suspensions, proposals for debarments, exclusions, or disqualifications under the non-procurement common rule or when otherwise declared ineligible to receive federal contracts, certain subcontracts, and certain federal assistance and benefits. If there is an affirmative response to the related disclosure questions on the application, a detailed response is required from the Practitioner.
- **Medicare Opt-Out** – Practitioners currently listed on the Medicare Opt-Out Report may not participate in the Molina network for any Medicare or Duals (Medicare/Medicaid) lines of business.
- **Social Security Administration Death Master File** – Practitioners must provide their Social Security number. That Social Security number should not be listed on the Social Security Administration Death Master File.
- **Medicare Preclusion List** – Practitioners currently listed on the Preclusion List may not participate in the Molina network for any Medicare or Duals (Medicare/Medicaid) lines of business.
- **Professional liability insurance** – Practitioners must have and maintain professional malpractice liability insurance with limits that meet Molina's

[3]If a practitioner's application is denied solely because a practitioner has a pending Statement of Charges, Notice of Proposed Disciplinary Action, Notice of Agency Action or the equivalent from any state or governmental professional disciplinary body, the practitioner may reapply as soon as practitioner is able to demonstrate that any pending Statement of Charges, Notice of Proposed Disciplinary Action, Notice of Agency Action or the equivalent from any state or governmental professional disciplinary body is resolved, even if the application is received less than one year from the date of original denial.

criteria. This coverage shall extend to Molina Members and the Practitioners' activities on Molina's behalf. Practitioners maintaining coverage under Federal tort or self-insured policies are not required to include amounts of coverage on their application for professional or dental malpractice insurance.

- **Inability to perform** – Practitioners must disclose any inability to perform essential functions of a Practitioner in their area of practice, with or without reasonable accommodation. If there is an affirmative response to the related disclosure questions on the application, a detailed response is required from the Practitioner.
- **Lack of present illegal drug use** – Practitioners must disclose if they are currently using any illegal drugs/substances.
- **Criminal convictions** – Practitioners must disclose if they have ever had any of the following:
  - Criminal convictions, including any convictions, guilty pleas or adjudicated pretrial diversions for crimes against person such as murder, rape, assault, and other similar crimes.
  - Financial crimes such as extortion, embezzlement, income tax evasion, insurance fraud, and other similar crimes.
  - Any crime that places the Medicaid or Medicare program or its beneficiaries at immediate risk, such as a malpractice suit that results in a conviction of criminal neglect or misconduct.
  - Any crime that would result in mandatory exclusion under section 1128 of the Social Security Act.
  - Any crime related to fraud, kickbacks, health care fraud, claims for excessive charges, unnecessary services, or services which fail to meet professionally recognized standards of health care, patient abuse or neglect, controlled substances, or similar crimes.

  At the time of initial credentialing, practitioners must not have any pending criminal charges in the categories listed above.
- **Loss or limitations of clinical privileges** – At initial credentialing, Practitioners must disclose all past and present issues regarding loss or limitation of clinical privileges at all facilities or organizations with which the Practitioner has had privileges. If there is an affirmative response to the related disclosure questions on the application, a detailed response is required from the Practitioner. At recredentialing, Practitioners must disclose past and present issues regarding loss or limitation of clinical privileges at all facilities or organizations with which the Practitioner has had privileges since the previous credentialing cycle.
- **National Provider Identifier (NPI)** – Practitioners must have an NPI issued by CMS.

Notification of discrepancies in credentialing information and Practitioner's right to correct

Molina will notify the Practitioner immediately in writing if credentialing information obtained from other sources varies substantially from that provided by the Practitioner. Examples include but are not limited to actions on a license, malpractice claims history, board certification actions, sanctions, or exclusions. Molina is not required to reveal the source of information if the information is obtained to meet organization credentialing verification requirements or if disclosure is prohibited by law.

Practitioners have the right to correct erroneous information in their credentials file. Practitioner rights are published on the Molina website and are included in this Provider Manual.

The notification sent to the Practitioner will detail the information in question and will include instructions to the Practitioner indicating:

- Their requirement to submit a written response within ten (10) calendar days of receiving notification from Molina.
- In their response, the Practitioner must explain the discrepancy, may correct any erroneous information, and may provide any proof that is available.
- The Practitioner's response must be sent to:

  Molina Healthcare, Inc.
  Attention: Credentialing Director
  PO Box 2470
  Spokane, WA 99210

Upon receipt of notification from the Practitioner, Molina will document receipt of the information in the Practitioner's credentials file. Molina will then re-verify the primary source information in dispute. If the primary source information has changed, correction will be made immediately to the Practitioner's credentials file. The Practitioner will be notified in writing that the correction has been made to their credentials file. If the primary source information remains inconsistent with the Practitioner's information, the Credentialing department will notify the Practitioner.

If the Practitioner does not respond within ten (10) calendar days, their application processing will be discontinued, and network participation will be administratively denied or terminated.

Practitioner's right to review information submitted with their credentialing application

Practitioners have the right to review their credentials file at any time. Practitioner rights are published on the Molina website and are included in this Provider Manual.

The Practitioner must notify the Credentialing department and request an appointment time to review their file. Allow up to seven (7) calendar days to coordinate schedules. A Dental Director, a Director responsible for Credentialing, or the Quality Improvement Director will be present. The Practitioner has the right to review all information in the credentials file except peer references or recommendations protected by Law from disclosure.

The only items in the file that the Practitioner may copy are documents that the Practitioner sent to Molina (e.g., the application and any other attachments submitted with the application from the Practitioner). Practitioners may not copy any other documents from the credentialing file.

Practitioner's right to be informed of application status

Practitioners have the right, upon request, to be informed of the status of their application by telephone, email, or mail. Practitioner rights are published on the Molina website and are included in this Provider Manual. Molina will respond to the request within two (2) working days. Molina will share with the Practitioner where the application is in the credentialing process and note any missing information or information not yet verified.

Professional Review Committee (PRC)

Molina designates a PRC to make recommendations regarding credentialing decisions using a peer review process. Molina works with the PRC to ensure that network Practitioners are competent and qualified to provide continuous quality care to Molina members. The PRC reports to the Quality Improvement Committee (QIC). Molina utilizes information such as, but not limited to, credentialing verifications, QOCs, and member complaints to determine continued participation in Molina's network or if any adverse actions will be taken. Certain PRC decisions may be appealed. To utilize this process, providers should request a fair hearing as outlined below and in Molina's policy. Please contact Molina Provider Relations representatives for additional information about fair hearings.

Notification of credentialing decisions

Initial credentialing decisions are communicated to Practitioners via letter or email. The Molina Dental Director typically sends this notification within two (2) weeks of the decision. Under no circumstances will notification letters be sent to the Practitioners later than 60 calendar days from the decision. Notification of credentialing approvals is not required.

Excluded providers

Excluded Provider means an individual Provider, an entity with an officer, director, agent, manager, or individual who owns or has a controlling interest in the entity who has been convicted of crimes as specified in section 1128 of the SSA, excluded from participation in the Medicare or Medicaid program, assessed a civil penalty under the provisions of section 1128 or has a contractual relationship with an entity convicted of a crime specified in section 1128.

Pursuant to section 1128 of the SSA, Molina and its Subcontractors may not subcontract with an Excluded Provider/person. Molina and its Subcontractors shall terminate subcontracts immediately when Molina and its Subcontractors become aware of such excluded Provider/person or when Molina and its Subcontractors receive notice. Molina and its Subcontractors certify that neither it nor its Provider is presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from participation in this transaction by any federal department or agency. Where Molina and its Subcontractors are unable to certify any of the statements in this certification, Molina and its Subcontractors shall attach a written explanation to this Agreement.

Ongoing monitoring of sanctions and exclusions

Molina monitors the following agencies for Practitioner sanctions and exclusions between recredentialing cycles for all Practitioner types and takes appropriate action against Providers when instances of poor quality are identified. If a Molina Practitioner is found to be sanctioned or excluded, the Provider's contract will be immediately terminated, effective the same date as the sanction or exclusion was implemented.

- **The United States Department of Health & Human Services (HHS), Office of Inspector General (OIG) Fraud Prevention and Detection Exclusions Program** – Monitor for individuals and entities that have been excluded from Medicare and Medicaid programs.
- **The OIG High Risk List**—Monitor for individuals or facilities that refused to enter a Corporate Integrity Agreement (CIA) with the federal government on or after October 1, 2018.

- **State Medicaid exclusions** – Monitor for state Medicaid exclusions through each state's specific Program Integrity Unit (or equivalent).
- **Medicare Exclusion Database (MED)** – Monitor for Medicare exclusions through the CMS MED online application site.
- **Medicare Preclusion List** – Monitor for individuals and entities that are reported on the Medicare Preclusion List.
- **National Practitioner Database (NPDB)** – Molina enrolls all credentialed practitioners with the NPDB Continuous Query service to monitor for adverse actions on license, DEA, hospital privileges and malpractice history between credentialing cycles.
- **System for Award Management (SAM)** – Monitor for Practitioners sanctioned by SAM.

Molina also monitors the following for all Practitioner types between the credentialing cycles.

- Member complaints/grievances
- Adverse events
- Medicare Opt Out
- Social Security Administration Death Master File

Provider appeal rights

In cases where the Professional Review Committee suspends or terminates a Practitioner's contract based on quality of care or professional conduct, a certified letter is sent to the Practitioner describing the adverse action taken and the reason for the action, including notification to the Practitioner of the right to a fair hearing when required pursuant to laws or regulations.

12. Delegation

Delegation is a process that gives another entity the ability to perform specific functions on behalf of Molina. Molina may delegate:

1. Utilization management
2. Credentialing and recredentialing
3. Claims
4. Complex case management
5. CMS Preclusion List monitoring
6. Other clinical and administrative functions

When Molina delegates any clinical or administrative functions, Molina remains responsible to external regulatory agencies and other entities for the

performance of the delegated activities, including functions that may be sub-delegated. To become a delegate, the vendor must be in compliance with Molina's established delegation criteria and standards. Molina's Delegation Oversight Committee (DOC) or other designated committee must approve all delegation and sub-delegation arrangements. To remain a delegate, the vendor must maintain compliance with Molina's standards and best practices.

Delegation of reporting requirements

Delegated entities contracted with Molina must submit monthly and quarterly reports. Such reports will be determined by the function(s) delegated and will be reviewed by Molina delegation oversight staff for compliance with performance expectations within the timeline indicated by Molina.

Corrective action plans and revocation of delegated activities

If it is determined that the delegate is out of compliance with Molina's guidelines or regulatory requirements, Molina may require the delegate to develop a corrective action plan designed to bring the delegate into compliance. Molina may also revoke delegated activities if it is determined that the delegate cannot achieve compliance or if Molina determines that is the best course of action.

If you have additional questions related to delegated functions, please contact your Molina Contract Manager.