2024 Dental Provider Appendix

Molina Healthcare of Mississippi, Inc.

MolinaHealthcare.com

Contents

Introduction

Thank you for your participation in the delivery of quality oral health care services to Molina Dental Services' MississippiCAN Members. We look forward to working with you. This Provider Manual shall serve as a supplement as referenced thereto and incorporated therein, to the Molina Dental Services Provider Services Agreement. We have partnered with SKYGEN formerly known as Scion Dental a nationwide leader in managed benefits administration, to administer the dental benefit for our Members. Throughout your ongoing relationship with Molina Dental Services, refer to this Provider Manual for answers and useful information, including how to contact us, how to submit claims and authorizations, and benefits offered to our Members.

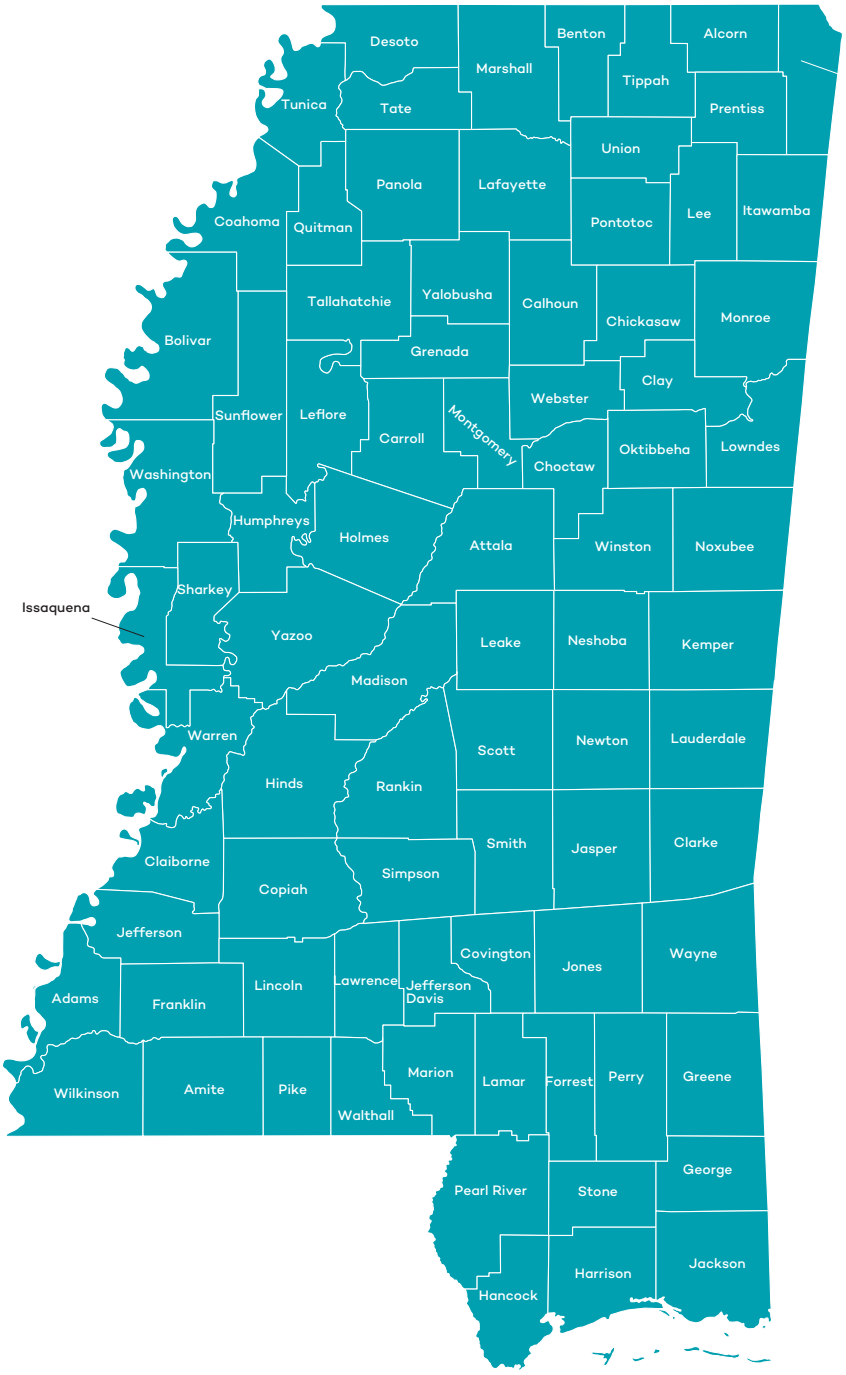
Molina Dental Services retains the right to add to, delete from, and otherwise modify this Provider Manual. Contracted providers must acknowledge this Provider Manual and any other written materials provided by Molina Dental Services as proprietary and confidential. For additional information, please see the Molina Healthcare of Mississippi Provider Manual located on the Molina Healthcare Public website at: molinahealthcare.com/providers/ms/medicaid/manual/medical.aspx.

This Provider Manual is designed to provide you with assistance in all areas of your practice, from making referrals to receiving payment for your services. In some cases, you may have developed internal procedures that meet the standards set out in this Provider Manual. In these instances, you do not need to change your procedures as long as they adhere to the standards outlined in this Provider Manual.

From time to time, this Provider Manual will be revised as policies or regulatory requirements change. All changes and updates will be updated and posted to the Molina Healthcare website as they occur.

Molina Dental Services operates Monday through Friday, 8:00 a.m. - 5:00 p.m. CST excluding the state approved holidays.

Molina Healthcare of Mississippi, Inc. Service Area



Corporate Office

Molina Healthcare of Mississippi, Inc.
188 East Capitol Street, Suite 700
Jackson, MS 39201

Molina Dental Services

The information contained within this appendix is proprietary. The information is not to be copied in whole or in part; nor is the information to be distributed without the express written consent of Molina.

The dedicated Molina Dental Provider Services Team is available M-F 8:00am-5:00PM CST at:

General inquiries and questions

- (844) 862-4564
- MDVSPROVIDERSERVICES@MOLINAHEALTHCARE.COM

Practice Changes/Updates/Credentialing

- MDVSPIM@Molinahealthcare.com
- Fax: (844) 891-2865

Contracting Questions

- Denta.Visiondevelopment@molinahealthcare.com
- Fax: (844) 584-3686

The dental appendix is a reference tool that contains eligibility, benefits, contact information, and policies/procedures for services that the Molina Healthcare of Mississippi specifically provides and administers on behalf of Molina Members.

Molina is committed to improving our Members' health and making a difference in the communities we serve by overseeing:

- Primary and Specialty Care Dental Network
- Dental Network Management
- Quality Improvement
- Compliance Program (including fraud, waste, and abuse)

The SKYGEN Provider Web Portal pwp.skygenusasystems.com/PWP/Landing is delegated and the exclusive dental provider platform for the Molina Healthcare of Mississippi Dental Network. The SKYGEN Provider Web Portal (PWP) combines powerful new enhancements with current features and functionality to provide the best experience for you and your practice.

Once contracted, a Payer ID is assigned by TIN and required for full access to the Hub. The dental provider's office will create a single sign-on to access the pwp.skygenusasystems.com/PWP/Landing. The features and functions of the SKYGEN Provider Web Portal are outlined below:

- Provider and Member services call center (SKYGEN)
- Immediate access to Member and benefit information, claim and authorization history, and payment records at any time, 24 hours a day, 7 days a week.

- Submit Claims and authorizations using pre-populated electronic forms and data entry shortcuts.
- Attach and securely send supporting documents, such as digital X-rays, EOBs, and treatment plans, at no extra charge.
- Reduce costs, increase revenue, and improve patient experiences.
- Check the real-time status of in-process claims and authorizations and review historical payment records and much more.

For help getting started with the SKYGEN Provider Web Portal Contact SKYGEN Provider Web Portal Support at (844) 621-4587 from 8:00 am – 4:30 pm CST.

Skygen Contact Information

This section includes important telephone and fax numbers available to your office. When calling Molina, please have the following information available:

- NPI (National Provider Identifier) number
- Tax ID Number (TIN) number
- Member's ID number or Medicaid ID number

Provider Services Phone: (844) 809-8438 from 7:30 a.m. to 8:00 p.m. CST, Monday through Friday, excluding state holidays which are:

- New Year's Day
- Martin Luther King Jr. Holiday
- Memorial Day Holiday
- Independence Day
- Labor Day
- Thanksgiving Day
- Day after Thanksgiving
- Christmas Eve Day- Open 7 a.m. until Noon
- Christmas Day
- New Year's Eve Day- Open 7 a.m. until Noon

A holiday that falls on a Saturday is observed on the Friday before the holiday. A holiday that falls on a Sunday is observed on the Monday after the holiday.

Delegation

Delegation is a process that gives another entity the ability to perform specific functions on behalf of Molina. Molina has delegated the below to SKYGEN USA:

- Call Center
- Utilization Management

- Claims
- CMS Preclusion List Monitoring
- 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 Provider/Accountable Care Organization (ACO)/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 Provider/ACO/vendor must maintain compliance with Molina's standards and best practices.

Delegation 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.

SKYGEN Provider Services Department

The Provider Services department conducts Provider trainings and handles inquiries from Providers, including policy and procedure questions, claims issues, and contracting questions.

SKYGEN Provider Web Portal: pwp.skygenusasystems.com/PWP/Landing .

Provider Services Phone: (844) 809-8438 from 7:30 a.m. to 8:00 p.m. CST, Monday through Friday. TTY: 711

In addition to the SKYGEN Provider Web Portal, the public website is MolinaHealthcare.com features our Provider Online Directory, Preventative & Clinical Care Guidelines, Dental Provider Appendix, Web Portal, Prior Authorization Look-up Tool, Advanced Directives, Behavioral Health Toolkit, Claims Information, Pharmacy Information, HIPAA, Fraud Waste & Abuse Information, Frequently Used Forms, Communications and Newsletters as well as Contact Information.

Practice Changes/Updates

Molina Dental Services encourages providers to report changes to your Practice within 35 days to ensure accurate updates to our Provider Online Directory. Changes are required to be submitted in writing by completing a Provider Information Form (PIF) provider-information-update-form.pdf. In addition, all forms can be found on the SKYGEN's Provider Web Portal and Molina's Healthcare Website.

The changes required to be reported include:

- Immediate notification to changes in license status, board actions, address or name changes, DBA or Tax ID
- Adding a new dentist to your practice (must be credentialed PRIOR to rendering treatment); Roster required for group practice(s)
- Notice of 120 days to terminate participation in writing to allow time for continuity of care issues and to notify Members

Forms may be submitted via email at:

Provider Information Management (PIM) at mdvspim@MolinaHealthcare.com.

Provider Credentialing and Recredentialing

Please note you must be enrolled as a Mississippi Medicaid Provider and have an active Medicaid ID and a National Provider Identifier Standard (NPI).

Once the Tax ID is contracted, each provider will be required to complete credentialing through Gainwell.

A Gainwell ID is required for providers to access their MESA Account. If you do not have an existing Gainwell ID, you will need to create one to access MESA.

1. Access the MESA portal by clicking here.
2. Click on the "Register Now" link.
3. If you need assistance or experience technical issues, contact the DOM Integrated Help Desk at (800) 884-3222 or ms_provider.inquiry@mygainwell.onmicrosoft.com.

Criteria for Participation in the Molina Network

Molina has established criteria and the sources used to verify these criteria for the evaluation and selection of 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, 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 documentations 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 such waiver is necessary to meet the needs of Molina and the community it serves. The refusal of Molina to waive any requirement shall not entitle any Practitioner to a hearing or any other rights of review.

Excluded Providers

Excluded Provider means an individual Provider, or 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 who refused to enter into 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 Centers for Medicare and Medicaid Services (CMS) MED online application site.
- Medicare Preclusion List – Monitor for individuals and entities that are reported on the Medicare Preclusion List.
- National Practitioner Database – 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 recredentialing 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 denies initial participation in the network, the Practitioner is sent a certified letter describing the reason for denial and is provided an opportunity to formally request a reconsideration.

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.

Member Eligibility

Medicaid Programs

Mississippi DHHS 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:

- 24 hours a day/7 days a week/365 days electronically on the SKYGEN Provider Web Portal pwp.skygenusasystems.com/PWP/Landing.
- If the above options do not sufficiently verify Member eligibility, Providers may speak to a representative at: (844) 826-4335 from 7:30 a.m. to 8:00 p.m. CST, Monday through Friday.

Possession of a Molina 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

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

Disenrollment

Voluntary Disenrollment

A Member may initiate a request for disenrollment from Molina without cause as follows:

- Once a year during the Member's annual enrollment choice period;
- Upon automatic re-enrollment under 42 CFR § 438.56(g) if a temporary loss of Medicaid eligibility caused the Member to miss the annual enrollment choice opportunity; or

A Member may initiate a request for disenrollment from Molina for cause, at any time, under any one of the following circumstances:

- Molina does not, because of moral or religious objections, cover the service the Member seeks;
- The Member needs related services to be performed at the same time, and not all of the related services are available with Molina, and the Member's PCP or another

Provider determines that receiving the services separately would subject the Member to unnecessary risk;

- Lack of access to Molina covered benefits and services;
- Other reasons including but not limited to, poor quality-of-care, or lack of access to Providers experienced in dealing with the Member's health care needs.

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

Involuntary Disenrollment

Molina may not request disenrollment because of a Member's health diagnosis; adverse change in health status; utilization of dental services; diminished medical capacity; pre-existing dental condition; refusal of dental care or diagnostic testing; uncooperative or disruptive behavior resulting from their special needs, unless it seriously impairs Molina's ability to furnish services to the Member or other Molina Members; or the Member attempts to exercise their rights under Molina's grievance system.

The following are the only reasons for which Molina may request disenrollment of a Member:

- Molina has sufficient documentation to establish fraud, forgery, or evidence of unauthorized use/abuse of services by the Member, including circumstances in which the Member misuses or loans the Member's ID card to another person to obtain services. If this occurs, Molina must report it to DOM; or
- The Member's behavior is disruptive, unruly, abusive, or uncooperative to the extent that enrollment in Molina seriously impairs our ability to furnish services either to the Member or other Members.

Mississippi DHHS may disenroll a Member for the following reasons:

- Member is no longer Medicaid eligible;
- Member's death;
- Member's intentional submission of fraudulent information;
- Member becomes an inmate in a public institution;
- Member moves out-of-state; and/or
- A disenrollment decision is made by a hearing officer or court of law.

When a Member is disenrolled, the effective date of the disenrollment will be the first day of the following month, given adequate and timely notice can be provided.

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 (hard copy or electronic) and that necessary information is readily available in the dental record in accordance with Molina Healthcare of Mississippi's policies and procedures. All entries will be indelibly added

to the Member's record. A Member's dental record is the property of the provider who generates the record. Dental Providers should maintain the following dental record components that include but are not limited to:

- Dental record confidentiality and release of dental records within medical and behavioral health care records.
  - Each Member is entitled to a copy of their dental record at no cost.
  - Upon notification of a Member transferring providers, Molina will ensure their dental records or copies of dental records are forwarded to the new Dental Provider within ten (10) business days from receipt of the request for transfer of the dental records.
  - Managed Long Term Care (MLTC) is not required to obtain written approval from a Member before requesting the Member's dental record from the Dental Provider or any other organization or agency.
- Molina Healthcare of Mississippi must afford DOM access to all Members' dental records, whether electronic or paper, within twenty (20) business days of receipt of the request or more quickly, if necessary, in DOM's sole determination.
- Dental record content and documentation standards include legibility, accuracy, and plan of care that comply with applicable law and Molina written standards.
- Storage maintenance and disposal processes.
- Process for archiving dental records and implementing improvement activities.
- If care has not been established, information may be kept temporarily in an appropriately labeled file, in lieu of a permanent dental record.
- The temporary file must be associated with the Member's dental record as soon as one is established.
- Information related to fraud and abuse may be released. However, Human Immunodeficiency Virus (HIV)-related information may not be disclosed except as provided in state statute, and substance use disorder information shall only be disclosed consistent with Federal and State law including, but not limited to 42 CFR § 2.1 et seq.

Dental Record Keeping Practices

Below is a list of the minimum items that are necessary in the maintenance of the Member's Medical records:

- Each patient has a separate record.
- Records are stored away from patient areas and preferably locked.
- Records are available at 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 thickness of the record dictates.
- If electronic, all those with access have individual passwords.
- Record keeping is monitored for Quality and HIPAA compliance.

- Storage maintenance for the determined timeline and disposal per record management processes.
- Process for archiving dental records and implementing improvement activities.
- Records are kept confidential and there is a process for release of dental records.

Content

Providers must remain consistent in their practices with Molina's dental record documentation guidelines. Medical records are maintained and should include the following information:

- Each page in the record contains the patient's name or ID number.
- Member name, date of birth, gender, legal guardianship (if applicable), marital status, address, employer, home and work telephone numbers, and emergency contact.
- Primary language spoken by the Member and any translation needs.
- Legible signatures and credentials of Provider and other staff members within a paper chart.
- All Providers who participate in the Member's care.
- The primary care dentist is responsible for documenting all services provided directly by the Dental Provider. This includes all ancillary and diagnostic services ordered by the Dental Provider, and all diagnostic and therapeutic services for which the member was referred by the Dental Provider. At a minimum, each dental record must contain the following:

1. Member demographics: Member name, member ID number, date of birth, gender, marital status, address, employer, home and work telephone numbers, emergency contact information, primary language and translation needs;
2. Legible signature and credentials of provider and other staff members if a paper dental record; after each entry into progress notes. Process notes should include:
    i. Review of medical history;
    ii. Exam findings and diagnosis
    iii. Verbal or written informed consent;
    iv. Date of Service
    v. Services performed including:
        a. tooth number;
        b. arch;
        c. Surfaces;
        d. Quadrant;
    vi. Summary of the appointment and discussions with the member
    vii. Review treatment for the next visit as applicable
3. Presenting complaints, diagnoses, and treatment plans, including follow-up visits and referrals to other providers;
4. Prescribed medications, including dosages and dates of initial or refill prescriptions;
5. Allergies and adverse reactions (or notation that none are known);

6. Treatment plans are consistent with diagnosis;
7. A working diagnosis is recorded with the clinical findings;
8. Progress notes clearly and thoroughly state the intent for all ordered services and treatments;
9. There are notations regarding follow-up care, calls or visits, including the next preventative care visit when appropriate;
10. Notes from consultants are in the record if applicable;
    a. All staff and provider notes are signed physically or electronically with either name or initials;
    b. All entries are dated;
    c. All ancillary services reports;

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 retrieval of information.
- A release document for each Member authorizing Molina to release dental information for facilitation of dental care.

Retrieval

- The dental record is available to 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 at no cost.
- 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 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.
- Medical 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.

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 Dental Provider Appendix

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 Dental 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 Types	Standard
Emergent	Immediate upon Member contact 24-hours a day, 7 days per week
Urgent	Within 48-hours of Member contact
After Hours Dental Care	24-hours a day, 7 days per week
Routine, asymptomatic/symptomatic	Within 45 days of Member contact

Office Wait Time

For scheduled appointments, the wait time in offices should not exceed 45 minutes. All Dental Providers are required to monitor waiting times and adhere to this standard.

After Hours

All Providers must have back-up (on call) coverage after hours or during the Provider's absence or unavailability. Molina requires Providers to maintain a 24-hour telephone service, seven 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

Access to care standards is reviewed, revised as necessary, and approved by the Quality Improvement Committee 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 appointment 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 analysis are reported to the Quality Improvement 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 Committee.

Quality Improvement Activities and Programs

Molina maintains an active Quality Improvement Program. The Quality Improvement Program provides structure and key processes to carry out our ongoing commitment to improvement of care and service. The goals identified are based on an evaluation of programs and services; regulatory, contractual and accreditation requirements; and strategic planning initiatives.

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. Clinical Practice Guidelines are reviewed at least annually, and more frequently as needed when clinical evidence changes, and approved by the Quality Improvement Committee.

Molina Clinical Practice Guidelines include the following:

- The adopted CPGs are distributed to the appropriate Providers, Provider groups, staff model facilities, delegates and Members by the Quality, Provider Services, Health Education and Member Services departments. The guidelines are disseminated through Provider newsletters, electronic Provider Bulletins and other media and are available on the Molina website. Individual Providers or Members may request copies from your local Molina Quality department.

Molina Dental Services Utilization Management Criteria uses components of dental standards from the American Academy of Pediatric Dentistry (aapd.org) and the American Dental Association (ada.org). Molina Dental Services criteria are changed and enhanced as needed.

The procedure codes used by Molina Dental Services are described in the American Dental Association's Code Manual. Requests for documentation of these codes are determined by community accepted dental standards for authorization including but not limited to treatment plans, narratives, radiographs, and periodontal charting.

These criteria are approved and annually reviewed by Molina Dental Services Utilization Management Committee. They are designed as guidelines for authorization and payment decisions and are not intended to be absolute. Please refer to the section of this appendix titled, "Covered Services," for a list of all codes covered under the program and additional limitations and requirements for coverage.

Guidelines for X-Rays

- Must be of diagnostic quality
- Must be marked right and left and indicate tooth ID
- Must have the patient's name
- Must have the date x-rays were taken

Guidelines for Crowns

Criteria for crowns will be met only for permanent teeth needing multi-surface restorations where other restorative materials have a poor prognosis.

Permanent molar teeth must have pathologic destruction to the tooth by caries or trauma and should involve four (4) or more surfaces and two (2) or more cusps.

Permanent bicuspid teeth must have pathologic destruction to the tooth by caries or trauma and should involve three (3) or more surfaces and at least one (1) cusp.

Permanent anterior teeth must have pathologic destruction to the tooth by caries or trauma and must involve four (4) or more surfaces and at least 50% of the incisal edge.

Note: To meet criteria, a crown must be opposed to a tooth or denture in the opposite arch or be an abutment for a partial denture.

Crowns will not meet criteria if:

- A lesser invasive restoration is possible
- Tooth has subosseous and/or furcation caries
- Tooth has advanced periodontal disease
- Crowns are being planned to alter vertical dimension

Guidelines for Crowns following Root Canal Therapy

The tooth should be filled sufficiently close to the radiological apex to ensure that an apical seal

is achieved, unless there is a curvature or calcification of the canal that limits the provider's ability to fill the canal to the apex. The filling must be properly condensed/obturated. Filling material should not extend excessively beyond the apex. The permanent tooth must be at least 50% supported in bone and cannot have mobility grades +2 or +3.

Guidelines for Endodontics

- The tooth is infected and/or abscessed.
- There has been trauma or a fracture that damages the pulp.
- The pulp of the primary tooth is infected, and the exfoliation of the deciduous tooth is not anticipated within six (6) months (for pulpotomy or pulpectomy only)
- The tooth must demonstrate at least 50% bone support and cannot have mobility grades +2 or +3.
- Root canal therapy not completed in anticipation of placement of an overdenture.

Retreatment of Root Canal

- Overfilled canal
- Underfilled canal
- Broken instrument in canal, that is not retrievable
- Root canal filling material lying free in periapical tissues and acting as an irritant
- Perforation of the root in the apical one-third of the canal (therefore this will cause a denial for a retreatment)
- Fractured root tip is not reachable (therefore this will cause a denial for a retreatment)

Other Considerations

- Root canal therapy for permanent teeth includes diagnosis, extirpation of the pulp, shaping and enlarging the canals, temporary fillings, filling and obliteration of root canal(s), and progress radiographs, including a final root canal fill radiograph.
- In cases where the root canal filling does not meet Molina Dental Services treatment standards, Molina Dental Services can require the procedure to be redone at no additional cost. Any reimbursement already made for an inadequate service may be recouped after Molina Dental Services reviews the circumstances.

Criteria for Apexification

- Apex of the root is not closed and needs to be treated so closure can be achieved (usually after trauma)

Criteria for Apicoectomy and Retrograde Filling

- Apex of the tooth needs to be removed because the surrounding area is infected and/or has an abscess;
- Requires a filling to be placed in the apical part of the tooth to seal that part of the root canal;

- Perforation of the root in the apical one-third of the canal

Guidelines for Periodontal Treatment

- Periodontal charting indicates abnormal pocket depths in multiple sites. Probing depths must be 4mm or greater.
- Radiographic evidence of root surface calculus.
- Radiographic evidence of noticeable loss of bone support. Attachment loss with the appearance of reduction of the alveolar crest beyond 1-1 1/2mm proximity to the cement-enamel junction (CEJ) exclusive of gingival recession.

Criteria for Gingivectomy

- Presence of diseased malformed or excess gingival tissue due to systemic disease or pharmacologically induced gingival hyperplasia.
- Must interfere with mastication.

Criteria for Full Mouth Debridement

- Presence of significant gingival inflammation and/or supragingival calculus

Documentation Required for Authorization of Scaling and Root Planing and Pre-payment Review of Gingivectomy and/or Gingivoplasty

- Scaling and Root planing:
- Submit appropriate radiographs with authorization request: bitewings or periapical preferred.
- Complete periodontal charting
- Narrative
- Gingivectomy and/or Gingivoplasty:
- Pre-operative color photographs
- Narrative

Guidelines for Oral Surgery

- Uncomplicated extractions, removal of soft tissue impactions or minor surgical procedures are considered basic services and are the responsibility of the general dentist or pediatric specialist. The member may be referred to a contracted Molina oral surgeon when it is beyond the scope of the general dentist or pediatric specialist.
- Any extractions that do not clearly meet these criteria should be submitted for preauthorization review.
- Covered for pain or infection.
- Extractions to reduce crowding without a Molina-approved orthodontic case, must demonstrate clear evidence of impaction or the severe deflection of the unerupted permanent tooth. Prior authorization, panoramic x-ray, and narrative are required.
- Over-retention of a primary tooth where the succedaneous permanent is ectopically

erupting into the arch and the primary tooth is not mobile.

- Irregular root resorption interfering with path of permanent tooth progression.
- Extraction of primary tooth to prevent potential impaction of permanent canines when canine is mesially progressing and is overlapping the root of the lateral incisor.
- Removal of 3rd molars prior to orthognathic surgery
- Supernumerary tooth.
- Radiographic pathology (cyst, abscess)
- Orthodontic extractions (requires approval of the orthodontic case)
- Carious lesion or fracture making tooth non-restorable.
- No extractions of third molars if roots are not substantially formed.
- Recurrent pericoronitis
- Untreatable periodontal disease
- Recoupment of restorative fees may be necessary if tooth is extracted within 6 months of restorative treatment.
- Extractions are not payable for deciduous teeth when normal loss is imminent.
- There is no benefit for the extraction of asymptomatic teeth.

Guidelines for Orthodontia

Medicaid covers prior authorized orthodontic treatment for clients who are age 20 or younger and have a handicapping malocclusion. For auditing purposes, Medicaid may request end of treatment diagnostic models and x-rays. Payment for the end of treatment records will be included in the dollar amount prior authorized. Medicaid uses the HLD form to determine whether coverage is appropriate based on a handicapping malocclusion. A score of 28 or greater being necessary to qualify for Medicaid coverage of orthodontic treatment. The HLD form must be used to pre-screen orthodontic cases. To be eligible for orthodontic treatment, a client must be age 20 or younger when treatment is authorized, and have a handicapping malocclusion, which includes one or more of the following five documented conditions:

- HLD form
- Accident causing a severe malocclusion;
- Injury causing a severe malocclusion;
- Condition that was present at birth causing a severe malocclusion;
- Medical condition causing a severe malocclusion; and (e) Facial skeletal condition causing a severe malocclusion.

Authorization

Treatment is prior authorized and paid on a single procedure code. In order for Medicaid clients to receive timely treatment, the request for approval will constitute the providers acceptance of the Medicaid fee, and a commitment to complete care.

Documentation Requirements

The following documentation must be submitted with the prior authorization request:

- A pre-treatment request form that outlines treatment and the HLD form;
- Diagnostic records including: (i) Diagnostic casts and oral or facial photographic images; (ii) Full mouth radiographs and panoramic x-ray; and (iii) Cephalometric x-ray;
- A narrative description of the diagnosis, and prognosis;
- On surgical cases, include a description of the procedure to be completed. Following completed surgery, a surgical letter of documentation is required accompanying an additional prior authorization request for the added surgical fee.

Interceptive Orthodontic Treatment of Transitional Dentition

The interceptive orthodontic treatment of transitional dentition is covered if it is the cost-effective method to lessen the severity of a malformation such that extensive treatment is not required.

Continuation of Care

A continuation of care form, along with required clinical documentation must be submitted as a prior authorization for code D8999 and all applicable orthodontic codes.

The case will be reviewed by Molina Healthcare and approved or denied for the continuation of care. If approved, an approved reimbursement amount will be determined as well.

Required Documentation

- Continuation of Care Form (all forms can be found on the SKYGEN's Provider Web Portal and Molina's Healthcare Website).
- Completed 2019 ADA Dental Claim Form listing.
- D8999 and all applicable orthodontic codes.

Narrative that includes reason for leaving previous treating Provider, previous Provider contact information, additional treatment needed, and the approximate amount of additional time needed for treatment.

Guidelines for Non-Intravenous and IV Sedation

Requirements

- Dentists providing sedation or anesthesia services must have the appropriate certification from the
- Mississippi State Board of Dentistry for the level of sedation or anesthesia provided.
- Molina Dental Services must have on file a copy of the certification prior to rendering sedation services.

Acceptable conditions include, but are not limited to, one or more of the following:

- There is documented local anesthesia toxicity.
- Patient displays severe cognitive impairment or developmental disability.
- Patient displays severe physical disability.
- Patient displays uncontrolled behavior management problem.
- Treatment plan requires extensive or complicated surgical procedures.
- Local anesthesia fails.
- There are documented medical complications.
- Patient presents with acute infection(s).

Criteria for Medical Immobilization Including Papoose Boards

The provider must obtain a written informed consent from the legal guardian. Written informed consent must be documented in the patient's treatment record prior to medical immobilization. The patient's treatment record should include:

- Informed consent
- Type of immobilization used
- Indication for immobilization
- The duration of application

Goals of behavior management:

- Establish communication
- Alleviate fear and anxiety
- Deliver quality dental care
- Build a trusting relationship between dentist and child
- Promote the child's positive attitude toward oral/dental health

Guidelines for Dental Services Rendered in an Outpatient or Ambulatory Service Center (ASC)

Molina requires the following information to be submitted with prior authorization requests for dental therapeutic services and other procedures to be performed at a hospital outpatient or ambulatory surgical center:

- A completed Molina ASC Scorecard Molina ASC Scorecard fillable.pdf. In addition, all forms can be found on the SKYGEN's Provider Web Portal and Molina's Healthcare Website.
- A complete written treatment plan (electronic ADA form, 2019 ADA, or newer, claim form).
- Narrative of medical necessity for the need to have the requested services performed at a hospital outpatient or ambulatory surgical center.

The location where the procedures will be performed (hospital or ambulatory surgical center).

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

- Healthcare Effectiveness Data and Information Set (HEDIS®)
- Consumer Assessment of Healthcare Providers and Systems (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's or facility's contract. 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) and/or 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.

Healthcare Effectiveness Data and Information Set (HEDIS®)

Molina utilizes the 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, dental services, and cardiovascular disease.

HEDIS® results are used in a variety of ways. The results are the measurement standard for many of Molina's clinical quality activities and health improvement programs. The standards are based on established clinical guidelines and protocols, providing a firm foundation to measure the success of these programs.

Selected HEDIS® results are provided to regulatory and accreditation agencies as part of our contracts with these agencies. The data are also used to compare to established health plan performance benchmarks.

Consumer Assessment of Healthcare Providers and Systems (CAHPS®)

CAHPS® is the tool used by Molina to summarize Member satisfaction with the 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. 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 assessment of clinical and service improvements on an ongoing basis. Results of these measurements guide activities for the 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 is properly coding all services provided.
- Be sure patients understand what they need to do.

Molina has additional resources to assist Providers and their patients. For access to tools that can assist, please visit the SKYGEN Provider Web Portal. There are a variety of resources, including HEDIS® CDT/CMS-approved diagnostic and procedural code sheets. To obtain a current list of HEDIS® and CAHPS®/Qualified Health Plan Enrollee Experience Survey Star Ratings measures, contact your local Molina Quality department.

HEDIS® and CAHPS® are registered trademarks of the National Committee for Quality Assurance (NCQA).

Provider Rights and Responsibilities

Molina expects that its contracted Provider 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)

As a provider, you have the right and responsibility to:

- Communicate openly and freely with Molina.
- Communicate openly and freely with members.
- Suggest dental treatment options to members.
- Recommend non-covered services to members.
- Manage the dental health care needs of members to assure that all necessary services are made available in a timely manner.
- Maintain the confidentiality of members' personal health information, including medical records and histories, and adhere to state and federal laws and regulations regarding confidentiality, privacy, and security
- Obtain written parental or guardian consent for treatment to be rendered to
- members who have not yet reached the age of majority or who have been determined to require guardianship, in accordance with state dental board rules or ADA guidelines.
- Ensure disclosure form is signed for non-covered services by all parties prior to rendering service.
- Obtain information regarding the status of claims.
- Inform a member of appeal status.
- Receive prompt payments from SKYGEN for clean claims.
- Resubmit a claim with additional information
- Make a complaint or file an appeal with Molina on behalf of a member with the member's consent
- Question policies and/or procedures that Molina has implemented.
- Request a prior authorization for services identified as requiring authorization.
- Refer members to participating specialists for treatment that is outside your normal scope of practice.
- Abide by the rules and regulations set forth under applicable provisions of state or federal law
- Inform SKYGEN in writing within two business days of any revocation, suspension, and/or limitation of your practice, certification(s), and/or DEA license by any licensing or certification authority or additional information on providers rights and responsibilities, please see the Molina Healthcare of Mississippi Provider Manual located on the Molina. 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 outcomes of the programs.
- 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 Healthcare Services department.

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 of 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 the office site. 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 availability of exam tables in exam rooms.

Administration & Confidentiality of Facilities

Facilities contracted with Molina must demonstrate an 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 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 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.
- At least one CPR certified employee is available.
- Yearly OSHA training (Fire, Safety, Blood-borne 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. Signatures on fee slips, separate forms, stickers, or labels are possible alternative methods.
- 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.
- Medical 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 is restricted.
- System in place to ensure expired sample medications are not dispensed and injectables and emergency medication are checked monthly for outdates.
- Drug refrigerator temperatures are documented daily.

EPSDT Services to Enrollees Under 21 Years of Age

Molina maintains systematic and robust monitoring mechanisms to ensure all required Early and Periodic Screening Diagnostic and Treatment (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 Services 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 the Provider submit a written corrective action plan to Molina within 30 calendar days. Molina will 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 Providers 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.

Nondiscrimination 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 Dental Provider Appendix.

Additionally, Molina requires Providers to deliver services to Molina Members without regard to source of payment. Specifically, Providers may not refuse to serve Molina Members because they receive assistance with cost sharing from a government-funded program.

Section 1557 Investigations

All Molina Providers shall disclose all complaints of discrimination in violation of Section 1557 of the Patient Protection and Affordable Care Act to Molina's Civil Rights Coordinator.

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

Toll Free: (866) 606-3889
TTY/TDD: 711

Online: MolinaHealthcare.AlertLine.com
Email: civil.rights@MolinaHealthcare.com

Should you or a Molina Member need more information, you can refer to the Health and Human Services website at federalregister.gov/documents/2020/06/19/2020-11758/nondiscrimination-in-health-and-health-education-programs-or-activities-delegation-of-authority.

Facilities, Equipment and Personnel

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

It is important for Providers to 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, as well as 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 your Provider Agreement, Providers must notify Molina of any changes, as soon as possible, but at a minimum 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
- 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.

Please visit our Provider Online Directory to validate your information. Providers can make updates through the CAQH portal, or you may submit a full roster that includes the required information above for each health care Provider and/or health care facility in your practice. Providers unable to make updates through the CAQH portal, or roster process, should contact their Provider Services representative for assistance.

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 Dental Provider Appendix.

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 Network of Providers through various methods, such as letters, phone campaigns, face-to-face contact, fax, and fax-back verification, etc. 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.

National Plan and Provider Enumeration System (NPPES) Data Verification

In addition to the above verification requirements, CMS recommends that Providers routinely verify and attest to the accuracy of their National Plan and Provider Enumeration System (NPPES) data.

NPPES allows Providers to attest to the accuracy of their data. If the data is correct, the Provider is able to attest and NPPES will reflect the attestation date. If the information is not correct, the Provider is able to 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. Additional information regarding the use of NPPES is available in the Frequently Asked Questions (FAQ) document published at the following link: cms.gov/Medicare/Health-Plans/ManagedCareMarketing/index.

Molina Electronic Solutions Requirements

Molina requires Providers to utilize electronic solutions and tools whenever possible, which include, but are not limited to, electronic submission of prior authorization requests, prior authorization status inquiries, health plan access to electronic medical records (EMR), electronic Claims submission, electronic fund transfers (EFT), electronic remittance advice (ERA), electronic Claims appeal and registration for and use of the SKYGEN Provider Web Portal.

Electronic Claims include Claims submitted via a clearinghouse using the EDI process and Claims submitted through the SKYGEN Provider Web Portal. To receive EFT, please complete and return this form: EFT Form. The form is also available on the SKYGEN Provider Web Portal and on Molina's website at MolinaHealthcare.com.

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 Provider Web Portal 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 a National Provider Identifier (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 Claims Submission Options
- Electronic Payment: EFT with ERA
- SKYGEN Provider Web Portal

Electronic Claims Submission Requirement

Molina strongly encourages Participating Providers to submit Claims electronically whenever possible. Molina offers the following electronic Claims submission options:

- Submit Claims directly to Molina via the SKYGEN Provider Web Portal.
- Submit Claims to Molina through your EDI clearinghouse using Payer ID SKYGN, refer to the SKYGEN Provider Web Portal for additional information.

For more information on EDI Claims submission, see the Claims and Compensation section of this Dental Provider Appendix.

Electronic Payment Requirement

Participating Providers are encouraged to enroll in Electronic Funds Transfer (EFT) and Electronic Remittance Advice (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.

SKYGEN Provider Web Portal

Providers and third-party billers can use the no cost SKYGEN Provider Web Portal 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, and Covered Services
- Claims:
    - Submit Claims with attached files
    - Correct/Void Claims
    - Add attachments to previously submitted Claims
    - Check Claims status
    - View Electronic Remittance Advice (ERA) and Explanation of Payment (EOP)
    - Create and submit a Claim Appeal with attached files
- Prior Authorizations/Service Requests
    - Create and submit Prior Authorization/Service Requests
    - Check status of Authorization/Service Requests
- Download forms and documents

Balance Billing

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

Providers agree that under no circumstance shall a Member be liable to the Provider for any sums that are the legal obligation of Molina to the Provider. As described in your Agreement with Molina Healthcare of Mississippi, balance billing a Member for Covered Services is prohibited, except for the Member's applicable copayment, coinsurance, and deductible amounts.

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.

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 Provider and Members regarding Medically Necessary or appropriate patient care, regardless of covered benefits limitations. Providers are free to communicate any and 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 Members may take to promote their own health.

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 childcare givers.

- 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

Report suspected abuse or neglect to the Child Abuse and Neglect Hotline at:

- (800) 222-8000
- reportabuse.mdcps.ms.gov

Adult Abuse

Adult Protective Services (APS) meets the needs of vulnerable adults and helps protect them from abuse, neglect, and exploitation.

Report suspected abuse or neglect of a vulnerable adult to Adult Protective Services at Adult:

- (844) 437-6282

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 website. The Member Handbook that is provided to Members annually is hereby incorporated into this Dental Provider Appendix. The most current Member Rights and Responsibilities can be accessed via the following link: molinahealthcare.com/members/ms/en-US/mem/medicaid/overvw/coverd/coverd.aspx.

Member Handbooks are available on Molina's Member Website. Member Rights and Responsibilities are outlined under the heading "Your Rights and Responsibilities" within the Member Handbook document.

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 Provider's or health care facility's right to expect certain behavior on the part of the Members.

- For additional information, please contact Provider Services at: (844) 826-4335 from 7:30 a.m. to 8:00 p.m. CST, Monday through Friday. TTY/TDD users, please call 711.

Member Health Education Materials

Members can access our easy-to-read evidenced-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 Member Portal, direct mail as requested, email, and the My Molina mobile App.

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 by 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-year period. The list of disclosures does not need to include disclosures made for treatment, payment, or health care operations or made prior to April 14, 2003.

Member Newsletters

Member Newsletters are posted on the MolinaHealthcare.com website at least twice a year. The articles are about topics asked by Members. The tips are aimed to help Members stay healthy.

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 Molina Member Services to find out how to get a second opinion. Molina will coordinate the second opinion with an in-network Provider. If a qualified specialty care provider is not available within the network, Molina will coordinate and authorize the second opinion with an out-of-network Provider.

Participation in Quality Programs

Providers are expected to participate in Molina's Quality 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 Dental Provider Appendix.

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 Dental Provider Appendix.

Participation in Grievance and Appeals Programs

Providers are required to participate in Molina's Grievance Program and cooperate with Molina in identifying, processing, and promptly resolving all Member complaints, grievances, or appeals. If a Member has a grievance 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 investigation until such time that the review or investigation is complete.

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

Eligibility, Enrollment, and Disenrollment

Member Eligibility Verification

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

Medicaid and CHIP eligibility renewals are conducted annually.

1. The State of Mississippi makes all eligibility determinations.
2. The Molina Healthcare Member ID is NOT proof of eligibility.
3. Providers are responsible for verifying member eligibility and benefit coverage before providing services.

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

- 24 hours a day/7 days a week/365 days via the Mississippi Medicaid Eligibility System (NMES) via medicaid.ms.gov/programs/managed-care/ or toll free at 800-421-2408
- 24 hours a day/7 days a week/365 days electronically on SKYGEN Provider Web Portal pwp.skygenusasystems.com/PWP/Landing

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

Enrollment in Medicaid Programs

The Mississippi Department of Health and Human Services (DHHS) administers and manages eligibility for Medicaid programs. Details on how individuals can apply for benefits are available on the medicaid.ms.gov/mesa-portal-for-members/. Medicaid and CHIP eligibility renewals are conducted annually.

No eligible Member shall be refused enrollment or re-enrollment, have their enrollment terminated, or be discriminated against in any way because of their health status, or pre-existing physical or mental condition, including pregnancy, hospitalization, or the need for frequent or high-cost care.

Effective Date of Enrollment

The effective date of enrollment with Molina is typically the first day of the month of the Member's eligibility for Medicaid. In some cases, an individual may be retroactively eligible for Medicaid, in such cases the first day of eligibility is the date of the Member's eligibility effective date with DHHS.

Cultural Competency and Linguistic Services

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), Office of Minority Health (OMH) guide the activities to deliver culturally competent services. Molina complies with Section 1557 of the Patient Protection and Affordable Care Act, prohibiting discrimination in health programs and activities receiving federal financial assistance on the basis of race, color, 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 your local Provider Services representative and by calling Provider Services at: (844) 826-4335from 7:30 a.m. to 8:00 p.m. CST, Monday through Friday.

Nondiscrimination 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 medical (physical or mental) condition or the expectation for the need of frequent or high-cost care.
2. You **MUST** post in a conspicuous location in your office, a Nondiscrimination Notice. A sample of the Nondiscrimination Notice that you will post 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, which 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 limited English proficiency ("LEP"). You can find resources on meeting your LEP obligations at hhs.gov/civil-rights/for-individuals/special-topics/limited-english-proficiency/index.html. See also, hhs.gov/civil-rights/for-providers/clearance-medicare-providers/technical-assistance/limited-english-proficiency/index.html.
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.jsf Complaint Form: hhs.gov/ocr/complaints/index.html

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 Services 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 nondiscrimination of service delivery into Provider communications.

Integrated Quality Improvement – Ensuring Access

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 Member materials in alternate languages and formats (i.e., 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.

Key Member information, including appeal and Grievance forms, are also available in threshold languages on the Molina Member website.

Access to Interpreter Services

Providers may request interpreters for Members whose primary language is other than English by calling Translation Services at 844-826-4335. If Provider Services helpline 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.

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

Molina provides a TTY/TDD connection accessible by dialing 711. This connection provides access to Member Services, 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 a 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. Requests should be made at least three (3) business days in advance of an appointment to ensure availability of the service. In most cases, Members will have made this request via Molina Member Services.

Nurse Advice Line

Molina provides Nurse Advice Services for Members 24 hours per day, 7 days per week. The Nurse Advice Line provides access to 24-hour interpretive services. Members may call Molina's Nurse Advice Line directly: (844) 782-2721 or TTY/TDD 711. The Nurse Advice Line telephone numbers are also printed on membership 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 culturally 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 CAHPS®/Qualified Health Plan Enrollee Experience survey results for potential cultural and linguistic disparities that prevent Members from obtaining the recommended key chronic and preventive services.

Benefits and Covered Services

This section provides an overview of the dental benefits and Covered Services for Molina Members. Some benefits may have limitations which may not all be outlined in the summary table below. If there are questions as to whether a service is covered or requires prior authorization, please reference the prior authorization tools located at on the Molina website and the SKYGEN Provider Web Portal. You may also contact Provider Services at (844) 826-4335 from 7:30 a.m. to 8:00 p.m. CST, Monday through Friday.

Services Covered by Molina

Molina covers, at a minimum, core benefits and services specified in our Agreement with Mississippi DHHS and defined in the Mississippi Medicaid administrative rules, and Department policies and procedure handbook. Please refer to the Mississippi Medicaid website for additional information at medicaid.ms.gov/programs/managed-care/

If there are questions as to whether a service is covered or requires prior authorization, please reference the prior authorization tools located at on the Molina website and the SKYGEN Provider Web Portal. You may also contact Provider Services at (844) 826-4335, 7:30 a.m. – 8:00 p.m. CST Monday – Friday, excluding state holidays.

Corrected or Voided Claims

A corrected claim should ONLY be submitted when an original claim or service was PAID based upon incorrect information. A Corrected Claim must be resubmitted within 90 days in order for the original claim to be adjusted with the correct information. As part of this process, the original claim will be recouped, and a new claim processed in its place with any necessary changes. If a claim or service originally denied due to incorrect or missing information, or was not previously processed for payment, DO NOT submit a corrected claim. Denied services have no impact on member tooth history or service accumulators, and, as such, do not require reprocessing. To void a claim, please void on the SKYGEN Provider Web Portal.

MS CAN Medicaid Program Covered Service

Proper dental care has proven to be one of the first lines of defense in identifying health issues. The MississippiCAN Medicaid Program provides dental services to Adults ages 21 and older MississippiCAN Medicaid Program provides dental services to Children ages 0-20

Dental Coverage Includes:

- Diagnostic and Preventive Services
- Restorative services
- Extractions
- Dentures and partials

For a complete list of covered services, please refer to the Molina Healthcare of Mississippi Dental Provider Manual.

MS CHIP Medicaid Program Covered Service

Proper dental care has proven to be one of the first lines of defense in identifying health issues. Mississippi CHIP Medicaid Program provides dental services to Children ages 0-19

Dental Coverage Includes:

- Diagnostic and Preventive Services
- Restorative services
- Extractions
- Orthodontics

For a complete list of covered services, please refer to the Molina Healthcare of Mississippi Dental Provider Manual.

Dental Benefits Mississippi CAN

Code	Description	Age	Tooth/Quad/ Arch	Limitations	Auth	Documentation Required
D0120	Periodic Oral Exam	0-999		Two D0120 per calendar year, limit to one (1) every five (5 months, not on the same DOS as D0120, D0145, D0150	NO	
D0140	Limited Oral Evaluation- Problem Focused	0-999		Limit to four (4) D0140 per patient, per year	NO	
D0145	Oral Evaluation, Patient Under Three	0-2		Limit to two (2) D0145 per patient per year every five months. Not on the same DOS as D0120, D0145, D0150	NO	
D0150	Comprehensive Oral Evaluation - New Or Established Patient	0-999		Limit to two (2) D0150 every five months every three (3) years per patient, per provider or group, Not on the same DOS as D0120, D0145, D0150	NO	
D0210	Intraoral - Complete Series of Radiographic Images	0-999		Limit to one (1) D0210 per patient, per provider every two years. Not on the same DOS as D0210, D0330	NO	All radiographic images must be of diagnostic quality, properly exposed and mounted, clearly focused and readable, (if applicable) and free from defect for the relevant area of the mouth.
D0220	Intraoral - Periapical First Radiographic Image	0-999			NO	All radiographic images must be of diagnostic quality, properly exposed and mounted, clearly focused and readable, (if applicable) and free from defect for the relevant area of the mouth.

Code	Description	Age	Tooth/Quad/ Arch	Limitations	Auth	Documentation Required
D0230	Intraoral - Periapical Each Additional Image	0-999		Limit to six (6) D0230 per patient per year Not on the same DOS as D0210, D0330	NO	All radiographic images must be of diagnostic quality, properly exposed and mounted, clearly focused and readable, (if applicable) and free from defect for the relevant area of the mouth.
D0270	Bitewing - Single Radiographic Image	0-999		Limit to one (1) D0270 per patient, per day. Not on the same DOS as D0270, D0272, D0273, or D0274	NO	All radiographic images must be of diagnostic quality, properly exposed and mounted, clearly focused and readable, (if applicable) and free from defect for the relevant area of the mouth.
D0272	Bitewings - Two Radiographic Images	0-999		Limit to one (1) D0272 per patient, per day. Not on the same DOS as D0270, D0272, D0273, or D0274	NO	All radiographic images must be of diagnostic quality, properly exposed and mounted, clearly focused and readable, (if applicable) and free from defect for the relevant area of the mouth.
D0273	Bitewings - Three Radiographic Images	0-999		Limit to one (1) D0273 per patient, per day. Not on the same DOS as D0270, D0272, D0273, or D0274	NO	All radiographic images must be of diagnostic quality, properly exposed and mounted, clearly focused and readable, (if applicable) and free from defect for the relevant area of the mouth.
D0274	Bitewings - Four Radiographic Images	0-999		Limit to one (1) D0274 per patient, per day. Not on the same DOS as D0270, D0272, D0273, or D0274	NO	All radiographic images must be of diagnostic quality, properly exposed and mounted, clearly focused and readable, (if applicable) and free from defect for the relevant area of the mouth.
D0321	Other emporomandibular Joint Radiographic Images, By Report	0-999			Yes - Priced by PA	All radiographic images must be of diagnostic quality, properly exposed and mounted, clearly focused and readable, (if applicable) and free from defect for the relevant area of the mouth.

Code	Description	Age	Tooth/Quad/ Arch	Limitations	Auth	Documentation Required
D0330	Panoramic Radiographic Image	0-999		Limit to one (1) D0330 every two (2) years per patient, per provider	NO	All radiographic images must be of diagnostic quality, properly exposed and mounted, clearly focused and readable, (if applicable) and free from defect for the relevant area of the mouth.
D0340	2D Cephalometric Radiographic Image	0-20			NO	All radiographic images must be of diagnostic quality, properly exposed and mounted, clearly focused and readable, (if applicable) and free from defect for the relevant area of the mouth.
D0350	Oral/Facial Photographic Images	0-20			NO	All oral and facial images must be of diagnostic quality, properly exposed and mounted, clearly focused and readable, (if applicable) and free from defect for the relevant area of the mouth.
D0999	Unspecified Diagnostic Procedures, By Report	0-999			Yes - Priced by PA	
D1110	Prophylaxis - Adult	0-999	**COVERED ON ALT CODE D1120**		NO	
D1120	Prophylaxis - Child	0-20		Limit to one (1) D1120 every five (5) months, per patient, two (2) per year	NO	
D1206	Topical Application of Fluoride Varnish	0-20		Limit to one (1) D1206 every five months per patient, two (2) per year	NO	
D1208	Topical Application of Fluoride	0-20		Limit to one (1) D1208 every five (5) months per patient, two (2) per year	NO	

Code	Description	Age	Tooth/Quad/ Arch	Limitations	Auth	Documentation Required
D1351	Sealant - Per Tooth	0-20	Tooth: 02-05, 12-15, 18-21, 28-31, A-B, I-L, S-T		NO	
D1510	space maintainer – fixed, unilateral - per quadrant	0-13	Quadrant: LL, LR, UL, UR		NO	
D1516	Space Maintainer - Fixed - Bilateral, maxillary	0-13			NO	
D1517	Space Maintainer - Fixed - Bilateral, mandibular	0-13			NO	
D1520	space maintainer – removable, unilateral - per quadrant	0-13	Quadrant: LL, LR, UL, UR		NO	
D1526	Space Maintainer - Removable - Bilateral, maxillary	0-13			NO	
D1527	Space Maintainer - Removable - Bilateral, mandinular	0-13			NO	
D1551	Re-Cement Or Re-Bond Bilateral Space Maintainer - maxillary	0-20			NO	
D1552	Re-Cement Or Re-Bond Bilateral Space Maintainer - mandibular	0-20			NO	
D1553	Re-Cement Or Re-Bond Unilateral Space Maintainer - Per quadrant	0-20	Quadrant: LL, LR, UL, UR		NO	
D1556	Removal Of Fixed Unilateral Space Maintainer - Per quadrant	0-20	Quadrant: LL, LR, UL, UR		NO	
D1557	Removal Of Fixed Bilateral Space Maintainer - maxillary	0-20			NO	
D1558	Removal Of Fixed Bilateral Space Maintainer - mandibular	0-20			NO	
D2140	Amalgam - One Surface, Primary Or Permanent	0-20	Tooth: 01-32, A-T		NO	

Code	Description	Age	Tooth/Quad/ Arch	Limitations	Auth	Documentation Required
D2150	Amalgam - Two Surfaces, Primary Or Permanent	0-20	Tooth: 01-32, A-T		NO	
D2160	Amalgam - Three Surfaces, Primary Or Permanent	0-20	Tooth: 01-32, A-T		NO	
D2161	Amalgam - Four Or More Surfaces, Primary Or Permanent	0-20	Tooth: 01-32, A-T		NO	
D2330	Resin-Based Composite - One Surface, Anterior	0-20	Tooth: 06-11, 22-27, C-H, M-R		NO	
D2331	Resin-Based Composite - Two Surfaces, Anterior	0-20	Tooth: 06-11, 22-27, C-H, M-R		NO	
D2332	Resin-Based Composite - Three Surfaces, Anterior	0-20	Tooth: 06-11, 22-27, C-H, M-R		NO	
D2335	Resin-Based Composite - Four Or More Surfaces Or Involving Incisal Angle	0-20	Tooth: 06-11, 22-27, C-H, M-R		NO	
D2390	Resin-Based Composite Crown, Anterior	0-20	Tooth: 06-11, 22-27, C-H, M-R		NO	
D2391	Resin-Based Composite - One Surface, Posterior	0-20	Tooth: 01-05, 12-21, 28-32, A-B, I-L, S-T		NO	
D2392	Resin-Based Composite - Two Surfaces, Posterior	0-20	Tooth: 01-05, 12-21, 28-32, A-B, I-L, S-T		NO	
D2393	Resin-Based Composite - Three Surfaces, Posterior	0-20	Tooth: 01-05, 12-21, 28-32, A-B, I-L, S-T		NO	
D2394	Resin-Based Composite - Four Or More Surfaces, Posterior	0-20	Tooth: 01-05, 12-21, 28-32, A-B, I-L, S-T		NO	
D2750	Crown - Porcelain Fused To High Noble Metal	0-20	Tooth: 01-32		YES	
D2751	Crown - Porcelain Fused To Predominantly Base Metal	0-20	Tooth: 01-32		YES	
D2752	Crown - Porcelain Fused To Noble Metal	0-20	Tooth: 01-32		YES	

Code	Description	Age	Tooth/Quad/ Arch	Limitations	Auth	Documentation Required
D2930	Prefabricated Stainless Steel Crown - Primary Tooth	0-20	Tooth: A-T		NO	
D2931	Prefabricated Stainless Steel Crown - Permanent Tooth	0-20	Tooth: 01-32		NO	
D2933	Prefabricated Stainless Steel Crown With Resin Window	0-20	Tooth: 06-11, 22-27, C-H, M-R		NO	
D2934	Prefabricated Esthetic Coated Stainless Steel Crown - Primary Tooth	0-20	Tooth: A-T		NO	
D2940	Protective Restoration	0-20	Tooth: 01-32		YES	
D2952	Post And Core In Addition To Crown, Indirectly Fabricated	0-20	Tooth: 06-11, 22-27		YES	
D2999	Unspecified Restorative Procedure, By Report	0-20			Yes - Priced by PA	
D3220	Therapeutic Pulpotomy	0-20	Tooth: 01-32, A-T		NO	
D3222	Partial Pulpotomy For Apexogenesis - Permanent Tooth	0-20	Tooth: 01-32		NO	
D3310	Endodontic Therapy, Anterior Tooth (Excluding Final Restoration)	0-20	Tooth: 06-11, 22-27		NO	
D3320	Endodontic Therapy, Premolar Tooth (Excluding Final Restoration)	0-20	Tooth: 04-05, 12-13, 20-21, 28-29		NO	
D3330	Endodontic Therapy, Molar Tooth (Excluding Final Restoration)	0-20	Tooth: 01-03, 14-19, 30-32		NO	
D3346	Retreatment Of Previous Root Canal Therapy - Anterior	0-20	Tooth: 06-11, 22-27		YES	

Code	Description	Age	Tooth/Quad/ Arch	Limitations	Auth	Documentation Required
D3347	Retreatment Of Previous Root Canal Therapy - Premolar	0-20	Tooth: 04-05, 12-13, 20-21, 28-29		YES	
D3348	Retreatment of Previous Root Canal Therapy - Molar	0-20	Tooth: 01-03, 14-19, 30-32		YES	
D3999	Unspecified Endodontic Procedure, By Report	0-20	Tooth: 01-32, A-T		Yes - Priced by PA	
D4210	Gingivectomy Or Gingivoplasty - Four Or More Contiguous Teeth	0-999	Quadrant: LL, LR, UL, UR		NO	
D4211	Gingivectomy Or Gingivoplasty - One To Three Contiguous Teeth	0-999	Quadrant: LL, LR, UL, UR		NO	
D4240	Gingival Flap Procedure, Including Root Planing - Four Or More Contiguous Teeth	0-999	Quadrant: LL, LR, UL, UR		NO	
D4241	Gingival Flap Procedure, Including Root Planing - One To Three Contiguous Teeth	0-999	Quadrant: LL, LR, UL, UR		NO	
D4260	Osseous Surgery (Including Flap And Closure) - Four Or More Teeth	0-999	Quadrant: LL, LR, UL, UR		NO	
D4261	Osseous Surgery (Including Flap And Closure) - One To Three Teeth	0-999	Quadrant: LL, LR, UL, UR		NO	
D4341	Periodontal Scaling And Root Planing - Four Or More Teeth Per Quadrant	0-999	Quadrant: LL, LR, UL, UR		NO	
D4342	Periodontal Scaling And Root Planing - One To Three Teeth Per Quadrant	0-999	Quadrant: LL, LR, UL, UR		NO	
D5110	Complete Denture - Maxillary	0-20			YES	

Code	Description	Age	Tooth/Quad/ Arch	Limitations	Auth	Documentation Required
D5120	Complete Denture - Mandibular	0-20			YES	
D5211	Maxillary Partial Denture - Resin Base	0-20			YES	
D5212	Mandibular Partial Denture - Resin Base	0-20			YES	
D5221	immediate maxillary partial denture – resin base	0-20			YES	
D5222	immediate mandibular partial denture – resin base	0-20			YES	
D5955	Palatal Lift Prosthesis, Definitive	0-20			YES	
D6999	Unspecified Fixed Prosthodontic Procedure, By Report	0-20	Tooth: 01-32		Yes - Priced by PA	
D7140	Extraction, Erupted Tooth Or Exposed Root	0-999	Tooth: 01-32, A-T		NO	
D7210	Extraction, Erupted Tooth	0-999	Tooth: 01-32, A-T		NO	
D7220	Removal Of Impacted Tooth - Soft Tissue	0-999	Tooth: 01-32		NO	
D7230	Removal Of Impacted Tooth - Partially Bony	0-999	Tooth: 01-32		NO	
D7240	Removal Of Impacted Tooth - Completely Bony	0-999	Tooth: 01-32, A-T		NO	
D7241	Removal Of Impacted Tooth - Completely Bony, Unusual Surgical Complications	0-999	Tooth: 01-32, A-T		NO	
D7250	Removal Of Residual Tooth (Cutting Procedure)	0-999	Tooth: 01-32, A-T		NO	
D7251	Coronectomy - Intentional Partial Tooth Removal	0-999	Tooth: 01-32		YES	
D7260	Oroantral Fistula Closure	0-999			NO	

Code	Description	Age	Tooth/Quad/ Arch	Limitations	Auth	Documentation Required
D7270	Reimplantation And/Or Stabilization Of Accidentally Evulsed / Displaced Tooth	0-20	Tooth: 01-32		NO	
D7272	Tooth Transplantation (Includes Reimplantation)	0-20	Tooth: 01-32		YES	
D7280	Exposure of an Unerupted Tooth	0-999	Tooth: 02-15, 18-31		YES	
D7285	Incisional Biopsy Of Oral Tissue - Hard (Bone, Tooth)	0-999			NO	
D7286	Incisional Biopsy Of Oral Tissue - Soft	0-999			NO	
D7288	Brush Biopsy - Transepithelial Sample Collection	0-999			YES	
D7290	Surgical Repositioning Of Teeth	0-999	Tooth: 01-32		NO	
D7296	Corticotomy - One To Three Teeth Or Tooth Spaces, Per Quadrant	0-999	Quadrant: LL, LR, UL, UR		NO	
D7297	Corticotomy - Four Or More Teeth Or Tooth Spaces, Per Quadrant	0-999	Quadrant: LL, LR, UL, UR		NO	
D7310	Alveoloplasty In Conjunction With Extractions - Four Or More Teeth	0-999	Quadrant: LL, LR, UL, UR		NO	
D7311	Alveoloplasty In Conjunction With Extractions - One To Three Teeth	0-999	Quadrant: LL, LR, UL, UR		NO	
D7320	Alveoloplasty Not In Conjunction With Extractions - Four Or More Teeth	0-999	Quadrant: LL, LR, UL, UR		NO	
D7321	Alveoloplasty Not In Conjunction With Extractions - One To Three Teeth	0-999	Quadrant: LL, LR, UL, UR		NO	

Code	Description	Age	Tooth/Quad/ Arch	Limitations	Auth	Documentation Required
D7340	Vestibuloplasty - Ridge Extension (Secondary Epithelialization)	0-999	Quadrant: LL, LR, UL, UR		NO	
D7350	Vesibuloplasty - Ridge Extension (Including Soft Tissue Grafts)	0-999	Quadrant: LL, LR, UL, UR		NO	
D7410	Excision Of Benign Lesion Up To 1.25 Cm	0-999			NO	
D7411	Excision Of Benign Lesion Greater Than 1.25 Cm	0-999			NO	
D7413	Excision Of Malignant Lesion Up To 1.25 Cm	0-999			NO	
D7414	Excision Of Malignant Lesion Greater Than 1.25 Cm	0-999			NO	
D7440	Excision Of Malignant Tumor - Lesion Diameter Up To 1.25 Cm	0-999			NO	
D7441	Excision Of Malignant Tumor - Lesion Diameter Greater Than 1.25 Cm	0-999			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	

Code	Description	Age	Tooth/Quad/ Arch	Limitations	Auth	Documentation Required
D7465	Destruction Of Lesion(S) By Physical Or Chemical Method, By Report	0-999			NO	
D7471	Removal Of Lateral Exostosis (Maxilla Or Mandible)	0-999	Arch: LA, UA		NO	
D7490	Radical Resection Of Maxilla Or Mandible	0-999			YES	
D7510	Incision And Drainage Of Abscess - Intraoral Soft Tissue	0-999			NO	
D7520	Incision And Drainage Of Abscess - Extraoral Soft Tissue	0-999			NO	
D7530	Removal Of Foreign Body From Mucosa	0-999			NO	
D7540	Removal Of Reaction Producing Foreign Bodies	0-999			NO	
D7550	Partial Ostectomy/ Sequestrectomy For Removal Of Non-Vital Bone	0-999	Quadrant: LL, LR, UL, UR		NO	
D7560	Maxillary Sinusotomy For Removal Of Tooth Fragment Or Foreign Body	0-999			NO	
D7610	Maxilla - Open Reduction (Teeth Immobilized, If Present)	0-999			NO	
D7620	Maxilla - Closed Reduction (Teeth Immobilized, If Present)	0-999			NO	
D7630	Mandible - Open Reduction (Teeth Immobilized, If Present)	0-999			NO	
D7640	Mandible - Closed Reduction (Teeth Immobilized, If Present)	0-999			NO	

Code	Description	Age	Tooth/Quad/ Arch	Limitations	Auth	Documentation Required
D7650	Malar And/Or Zygomatic Arch - Open Reduction	0-999			NO	
D7660	Malar And/Or Zygomatic Arch - Closed Reduction	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			NO	
D7680	Facial Bones - Complicated Reduction With Fixation And Multiple Surgical	0-999			NO	
D7710	Maxilla - Open Reduction	0-999			NO	
D7720	Maxilla - Closed Reduction	0-999			NO	
D7730	Mandible - Open Reduction	0-999			NO	
D7740	Mandible - Closed Reduction	0-999			NO	
D7750	Malar And/Or Zygomatic Arch - Open Reduction	0-999			NO	
D7760	Malar And/Or Zygomatic Arch - Closed Reduction	0-999			NO	
D7770	Alveolus - Open Reduction Stabilization Of Teeth	0-999			NO	
D7780	Facial Bones - Complicated Reduction With Fixation And Multiple Approaches	0-999			NO	
D7810	Open Reduction Of Dislocation	0-999			NO	
D7820	Closed Reduction Of Dislocation	0-999			NO	

Code	Description	Age	Tooth/Quad/ Arch	Limitations	Auth	Documentation Required
D7830	Manipulation Under Anesthesia	0-999			NO	
D7840	Condylectomy	0-999			NO	
D7850	Surgical Discetomy, With/Without Implant	0-999			NO	
D7860	Arthrotomy	0-999			YES	
D7870	Arthrocentesis	0-999			NO	
D7910	Suture Of Recent Small Wounds Up To 5 Cm	0-999			NO	
D7911	Complicated Suture - Up To 5 Cm	0-999			NO	
D7912	Complicated Suture - Greater Than 5 Cm	0-999			YES	
D7920	Skin Graft (Identify Defect Covered, Location And Type Of Graft)	0-999			NO	
D7940	Osteoplasty - For Orthognathic Deformities	0-999			Yes - Priced by PA	
D7941	Osteotomy - Mandibular Rami	0-999			YES	
D7943	Osteotomy - Mandibular Rami With Bone Graft: Includes Obtaining The Graft	0-999			YES	
D7944	Osteotomy - Segmented Or Subapical	0-999	Quadrant: LL, LR, UL, UR		YES	
D7945	Osteotomy - Body Of Mandible	0-999			YES	
D7946	Lefort I - (Maxilla - Total)	0-999			YES	
D7947	Lefort I - (Maxilla - Segmented)	0-999			YES	
D7948	Lefort Ii Or Lefort Iii (Osteoplasty Of Facial Bones) - Without Bone Graft	0-999			YES	
D7949	Lefort Ii Or Lefort Iii - With Bone Graft	0-999			YES	

Code	Description	Age	Tooth/Quad/ Arch	Limitations	Auth	Documentation Required
D7950	Osseous, Osteoperiosteal, Or Cartilage Graft Of The Mandible Or Maxilla	0-999			Yes - Priced by PA	
D7955	Repair Of Maxillofacial Soft And/Or Hard Tissue Defect	0-999			YES	
D7961	buccal / labial frenectomy (frenulectomy)	0-999			NO	
D7962	lingual frenectomy (frenulectomy)	0-999			NO	
D7970	Excision Of Hyperplastic Tissue - Per Arch	0-999	Arch: LA, UA		NO	
D7979	Non-Surgical Sialolithotomy	0-999			NO	
D7980	Surgical Sialolithotomy	0-999			NO	
D7981	Excision Of Salivary Gland, By Report	0-999			Yes - Priced by PA	
D7982	Sialodochoplasty	0-999			NO	
D7983	Closure Of Salivary Fistula	0-999			YES	
D7990	Emergency Tracheotomy	0-999			NO	
D7991	Coronoidectomy	0-999			YES	
D7999	Unspecified Oral Surgery Procedure, By Report	0-999			Yes - Priced by PA	
D8060	Interceptive Orthodontic Treatment Of The Transitional Dentition	Ages 0-20			YES	
D8080	Comprehensive Orthodontic Treatment Of The Adolescent Dentition	Ages 0-20			YES	
D8670	Periodic Orthodontic Treatment Visit	Ages 0-20			YES	
D8703	Replacement Of Lost Or Broken Retainer - Maxillary	Ages 0-20			YES	

Code	Description	Age	Tooth/Quad/ Arch	Limitations	Auth	Documentation Required
D8704	Replacement Of Lost Or Broken Retainer - Mandibular	Ages 0-20			YES	
D8999	Unspecified Orthodontic Procedure, By Report	0-999			Yes - Priced by PA	
D9110	Palliative (Emergency) Treatment Of Dental Pain - Minor Procedure	0-999			YES	
D9222	Deep Sedation/ General Anesthesia - First 15 Minutes	0-999			YES	
D9223	Deep Sedation / General Anesthesia - Each Subsequent 15 Minute Increment	0-999			YES	
D9230	Inhalation Of Nitrous/Analgesia, Anxiolysis	0-999			YES	
D9239	Intravenous Moderate (Conscious) Sedation/ Analgesia - First 15 Minutes	0-999			YES	
D9243	Intravenous Moderate (Conscious) Sedation/Analgesia - Each Subsequent 15 Minute	0-999			YES	
D9248	Non-Intravenous Conscious Sedation	0-999			YES	
D9310	Consultation - Diagnostic Service Provided By Dentist Or Physician	0-999			NO	
D9944	Occlusal Guard	Ages 0-20			YES	
D9945	Occlusal Guard	Ages 0-20			YES	
D9946	Occlusal Guard	Ages 0-20			YES	

Code	Description	Age	Tooth/Quad/ Arch	Limitations	Auth	Documentation Required
D9999	Unspecified Adjunctive Procedure, By Report	0-999			YES	

Dental Benefits Mississippi CHIP

Code	Description	Age	Tooth/Quad/ Arch	Limitations	Auth	Documentation Required
Code	Description	Age	Surface	Limitations	Auth	Documentation Required
D0120	Periodic Oral Exam	Ages 0-19			NO	
D0140	Limited Oral Evaluation - Problem Focused	Ages 0-19		1 per code every Day per Patient per Payee	NO	
D0145	Oral Evaluation, Patient Under Three	Ages 0-2			NO	
D0150	Comprehensive Oral Evaluation - New Or Established Patient	Ages 0-19			NO	
D0210	Intraoral - Comprehensive Series of Radiographic Images	Ages 0-19			NO	All radiographic images must be of diagnostic quality, properly exposed and mounted, clearly focused and readable, (if applicable) and free from defect for the relevant area of the mouth.
D0220	Intraoral - Periapical First Radiographic Image	Ages 0-19		1 per code every Day Per Patient	NO	All radiographic images must be of diagnostic quality, properly exposed and mounted, clearly focused and readable, (if applicable) and free from defect for the relevant area of the mouth.
D0230	Intraoral - Periapical Each Additional Image	Ages 0-19			NO	All radiographic images must be of diagnostic quality, properly exposed and mounted, clearly focused and readable, (if applicable) and free from defect for the relevant area of the mouth.
D0240	Intraoral - Occlusal Radiographic Image	Ages 0-19		1 per code every Day per Patient per Payee	NO	

Code	Description	Age	Tooth/Quad/ Arch	Limitations	Auth	Documentation Required
D0270	Bitewing - Single Radiographic Image	Ages 0-19			NO	All radiographic images must be of diagnostic quality, properly exposed and mounted, clearly focused and readable, (if applicable) and free from defect for the relevant area of the mouth.
D0272	Bitewings - Two Radiographic Images	Ages 0-19			NO	All radiographic images must be of diagnostic quality, properly exposed and mounted, clearly focused and readable, (if applicable) and free from defect for the relevant area of the mouth.
D0273	Bitewings - Three Radiographic Images	Ages 0-19			NO	All radiographic images must be of diagnostic quality, properly exposed and mounted, clearly focused and readable, (if applicable) and free from defect for the relevant area of the mouth.
D0274	Bitewings - Four Radiographic Images	Ages 0-19			NO	All radiographic images must be of diagnostic quality, properly exposed and mounted, clearly focused and readable, (if applicable) and free from defect for the relevant area of the mouth.
D0320	Temporomandibular Joint Arthrogram, Including Injection	Ages 0-19		1 per code every Day per Patient per Payee	YES	
D0321	Other Temporomandibular Joint Radiographic Images, By Report	Ages 0-19		1 per code every Year per Patient per Payee	YES	All radiographic images must be of diagnostic quality, properly exposed and mounted, clearly focused and readable, (if applicable) and free from defect for the relevant area of the mouth.
D0330	Panoramic Radiographic Image	Ages 0-19			NO	All radiographic images must be of diagnostic quality, properly exposed and mounted, clearly focused and readable, (if applicable) and free from defect for the relevant area of the mouth.

Code	Description	Age	Tooth/Quad/ Arch	Limitations	Auth	Documentation Required
D1110	Prophylaxis - Adult	Ages 0-13	**COVERED ON ALT CODE D1120**		NO	
D1110	Prophylaxis - Adult	Ages 14-19		1 per code every 6 Months Per Patient	NO	
D1120	Prophylaxis - Child	Ages 0-13		1 per code every 6 Months Per Patient	NO	
D1120	Prophylaxis - Child	Ages 14-19	**COVERED ON ALT CODE D1110**		NO	
D1206	Topical Application Of Fluoride Varnish	Ages 0-19			NO	
D1208	Topical Application of Fluoride	Ages 0-19			NO	
D1351	Sealant - Per Tooth	Ages 0-14	Tooth: 02-05, 12-15, 18-21, 28-31, A-B, I-L, S-T	1 per code per tooth every 36 Months Per Patient	NO	
D1510	space maintainer – fixed, unilateral - per quadrant	Ages 0-15	Quadrant: LL, LR, UL, UR		NO	
D1516	Space Maintainer - Fixed - Bilateral, maxillary	Ages 0-15			NO	
D1517	Space Maintainer - Fixed - Bilateral, mandibular	Ages 0-15			NO	
D1520	space maintainer – removable, unilateral - per quadrant	Ages 0-15	Quadrant: LL, LR, UL, UR		NO	
D1526	Space Maintainer - Removable - Bilateral, maxillary	Ages 0-15			NO	
D1527	Space Maintainer - Removable - Bilateral, mandinular	Ages 0-15			NO	
D1551	Re-Cement Or Re-Bond Bilateral Space Maintainer - maxillary	Ages 0-15		1 per code every Year Per Patient	NO	

Code	Description	Age	Tooth/Quad/ Arch	Limitations	Auth	Documentation Required
D1552	Re-Cement Or Re-Bond Bilateral Space Maintainer - mandibular	Ages 0-15		1 per code every Year Per Patient	NO	
D1553	Re-Cement Or Re-Bond Unilateral Space Maintainer - Per quadrant	Ages 0-15	Quadrant: LL, LR, UL, UR	1 per code per quadrant every Year Per Patient	NO	
D1556	Removal Of Fixed Unilateral Space Maintainer - Per quadrant	Ages 0-15	Quadrant: LL, LR, UL, UR		NO	
D1557	Removal Of Fixed Bilateral Space Maintainer - maxillary	Ages 0-15			NO	
D1558	Removal Of Fixed Bilateral Space Maintainer - mandibular	Ages 0-15			NO	
D2140	Amalgam - One Surface, Primary Or Permanent	Ages 0-19	Tooth: 01-32, A-T		NO	
D2150	Amalgam - Two Surfaces, Primary Or Permanent	Ages 0-19	Tooth: 01-32, A-T		NO	
D2160	Amalgam - Three Surfaces, Primary Or Permanent	Ages 0-19	Tooth: 01-32, A-T		NO	
D2161	Amalgam - Four Or More Surfaces, Primary Or Permanent	Ages 0-19	Tooth: 01-32, A-T		NO	
D2330	Resin-Based Composite - One Surface, Anterior	Ages 0-19	Tooth: 06-11, 22-27, C-H, M-R		NO	
D2331	Resin-Based Composite - Two Surfaces, Anterior	Ages 0-19	Tooth: 06-11, 22-27, C-H, M-R		NO	
D2332	Resin-Based Composite - Three Surfaces, Anterior	Ages 0-19	Tooth: 06-11, 22-27, C-H, M-R		NO	
D2335	Resin-Based Composite - Four Or More Surfaces Or Involving Incisal Angle	Ages 0-19	Tooth: 06-11, 22-27, C-H, M-R		NO	
D2390	Resin-Based Composite Crown, Anterior	Ages 0-19	Tooth: 06-11, 22-27, C-H, M-R		NO	

Code	Description	Age	Tooth/Quad/ Arch	Limitations	Auth	Documentation Required
D2391	Resin-Based Composite - One Surface, Posterior	Ages 0-19	Tooth: 01-05, 12-21, 28-32, A-B, I-L, S-T		NO	
D2392	Resin-Based Composite - Two Surfaces, Posterior	Ages 0-19	Tooth: 01-05, 12-21, 28-32, A-B, I-L, S-T		NO	
D2393	Resin-Based Composite - Three Surfaces, Posterior	Ages 0-19	Tooth: 01-05, 12-21, 28-32, A-B, I-L, S-T		NO	
D2394	Resin-Based Composite - Four Or More Surfaces, Posterior	Ages 0-19	Tooth: 01-05, 12-21, 28-32, A-B, I-L, S-T		NO	
D2751	Crown - Porcelain Fused To Predominantly Base Metal	Ages 0-19	Tooth: 06-11, 22-27		YES	
D2930	Prefabricated Stainless Steel Crown - Primary Tooth	Ages 0-19	Tooth: A-T	1 per code per tooth every Day Per Patient per Payee	NO	
D2931	Prefabricated Stainless Steel Crown - Permanent Tooth	Ages 0-19	Tooth: 01-32		NO	
D2933	Prefabricated Stainless Steel Crown With Resin Window	Ages 0-19	Tooth: 06-11, 22-27, C-H, M-R		NO	
D2940	Protective Restoration	Ages 0-19	Tooth: 01-32	1 per code per tooth every Day Per Patient per Payee	YES	
D2952	Post And Core In Addition To Crown, Indirectly Fabricated	Ages 0-19	Tooth: 06-11, 22-27, C-H, M-R		YES	
D2954	Prefabricated Post And Core In Addition To Crown	Ages 0-19	Tooth: 01-32	1 per code per tooth every Day Per Patient per Payee	NO	
D3220	Therapeutic Pulpotomy	Ages 0-19	Tooth: A-T		NO	
D3230	Pulpal Therapy (Resorbable Filling) - Anterior, Primary Tooth	Ages 0-6	Tooth: C-H, M-R		NO	

Code	Description	Age	Tooth/Quad/ Arch	Limitations	Auth	Documentation Required
D3240	Pulpal Therapy (Resorbable Filling) - Posterior, Primary Tooth	Ages 0-10	Tooth: A-B, I-L, S-T		NO	
D3310	Endodontic Therapy, Anterior Tooth (Excluding Final Restoration)	Ages 0-19	Tooth: 06-11, 22-27	1 per code per tooth every Lifetime Per Patient	NO	
D3320	Endodontic Therapy, Premolar Tooth (Excluding Final Restoration)	Ages 0-19	Tooth: 04-05, 12-13, 20-21, 28-29	1 per code per tooth every Lifetime Per Patient	NO	
D3330	Endodontic Therapy, Molar Tooth (Excluding Final Restoration)	Ages 0-19	Tooth: 01-03, 14-19, 30-32	1 per code per tooth every Lifetime Per Patient	NO	
D4210	Gingivectomy Or Gingivoplasty - Four Or More Contiguous Teeth	Ages 0-19	Quadrant: LL, LR, UL, UR		NO	
D4211	Gingivectomy Or Gingivoplasty - One To Three Contiguous Teeth	Ages 0-19	Quadrant: LL, LR, UL, UR		NO	
D4341	Periodontal Scaling And Root Planing - Four Or More Teeth Per Quadrant	Ages 10-19	Quadrant: LL, LR, UL, UR		NO	
D4342	Periodontal Scaling And Root Planing - One To Three Teeth Per Quadrant	Ages 10-19	Quadrant: LL, LR, UL, UR		NO	
D5110	Complete Denture - Maxillary	Ages 0-19			YES	
D5120	Complete Denture - Mandibular	Ages 0-19			YES	
D5211	Maxillary Partial Denture - Resin Base	Ages 0-19			YES	
D5212	Mandibular Partial Denture - Resin Base	Ages 0-19			YES	
D5213	maxillary partial denture - cast metal framework with resin denture bases	Ages 0-19			YES	

Code	Description	Age	Tooth/Quad/ Arch	Limitations	Auth	Documentation Required
D5214	mandibular partial denture - cast metal framework with resin denture bases	Ages 0-19			YES	
D7140	Extraction, Erupted Tooth Or Exposed Root	Ages 0-19	Tooth: 01-32, A-T	1 per code per tooth every Lifetime Per Patient	NO	
D7210	Extraction, Erupted Tooth	Ages 0-19	Tooth: 01-32, A-T	1 per code per tooth every Lifetime Per Patient	NO	
D7220	Removal Of Impacted Tooth - Soft Tissue	Ages 0-19	Tooth: 01-32	1 per code per tooth every Lifetime Per Patient	NO	
D7230	Removal Of Impacted Tooth - Partially Bony	Ages 0-19	Tooth: 01-32	1 per code per tooth every Lifetime Per Patient	NO	
D7240	Removal Of Impacted Tooth - Completely Bony	Ages 0-19	Tooth: 01-32, A-T	1 per code per tooth every Lifetime Per Patient	NO	
D7241	Removal Of Impacted Tooth - Completely Bony, Unusual Surgical Complications	Ages 0-19	Tooth: 01-32, A-T	1 per code per tooth every Lifetime Per Patient	NO	
D7250	Removal Of Residual Tooth (Cutting Procedure)	Ages 0-19	Tooth: 01-32, A-T	1 per code per tooth every Lifetime Per Patient	NO	
D7270	Reimplantation And/Or Stabilization Of Accidentally Evulsed / Displaced Tooth	Ages 0-19	Tooth: 01-32		NO	
D7780	Facial Bones - Complicated Reduction With Fixation And Multiple Approaches	Ages 0-19			NO	
D7810	Open Reduction Of Dislocation	Ages 0-19			NO	
D7820	Closed Reduction Of Dislocation	Ages 0-19			NO	
D7830	Manipulation Under Anesthesia	Ages 0-19			NO	

Code	Description	Age	Tooth/Quad/ Arch	Limitations	Auth	Documentation Required
D7840	Condylectomy	Ages 0-19			NO	
D7850	Surgical Discetomy, With/Without Implant	Ages 0-19			NO	
D7860	Arthrotomy	Ages 0-19			YES	
D7870	Arthrocentesis	Ages 0-19			NO	
D8080	Comprehensive Orthodontic Treatment Of The Adolescent Dentition	Ages 0-19		1 per code every Lifetime Per Patient	YES	
D8670	Periodic Orthodontic Treatment Visit	Ages 0-19		1 per code every 20 Days Per Patient	YES	
D9110	Palliative (Emergency) Treatment Of Dental Pain - Per Visit	Ages 0-19			YES	
D9222	Deep Sedation/ General Anesthesia - First 15 Minutes	Ages 0-19		1 per code every Day Per Patient per Payee	YES	
D9223	Deep Sedation / General Anesthesia - Each Subsequent 15 Minute Increment	Ages 0-19		1 per code every Day Per Patient per Payee	YES	
D9230	Inhalation Of Nitrous/Analgesia, Anxiolysis	Ages 0-7			YES	
D9310	Consultation - Diagnostic Service Provided By Dentist Or Physician	Ages 0-19			NO	
D9951	Occlusal Adjustment - Limited	Ages 0-19			NO	
D9952	Occlusal Adjustment - Complete	Ages 0-19			NO	
D9999	Unspecified Adjunctive Procedure, By Report	Ages 0-19			YES	
T1013	Sign language or oral interpretive services	All			NO	
T1015	FQHC Encounter Payment-ADA	All			NO	

Services Not Covered by Molina

Per Molina-MLTC contract section V.E.30 Excluded Services, a provider may bill a Member for non-covered services if the provider obtains a Non-Covered Services Agreement form from the Member prior to rendering such services. The agreement must include:

- Services to be provided.
- Explanation of all other treatment options that are a covered benefit. Molina Dental Services will not pay for or be liable for these services; the Member will be financially liable for such services.

The Non-Covered Services agreement can be found on the SKYGEN's Provider Web Portal and Molina's Healthcare Website.

Emergency Services

Emergency Services means: Covered inpatient and outpatient services that are as follows:

- Furnished by a Provider that is qualified to furnish these services under Title 42 CFR.
- Needed to evaluate or stabilize an Emergency Medical Condition.

Emergency medical condition: A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) 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 the following: (1) placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; (2) serious impairment to bodily functions; or (3) serious dysfunction of any bodily organ or part.

Emergent Services are covered by Molina without prior authorization. This includes non-contracted Providers inside or outside of Molina's service area. Molina will reimburse non-contracted Providers for emergency dental services at no less than the Mississippi Medicaid FFS (Fee For Service) rate in effect on the Date of Service. Molina will not deny payment for treatment obtained when a Member has an Emergency Medical Condition as defined in 42 CFR § 438.114(a) and/or 42 CFR § 438.114(c)(1)(ii)(A), or when a representative of Molina instructs the Member to seek Emergency Services. Molina will not limit what constitutes an Emergency Medical Condition based on diagnoses or symptoms. A Member who has an Emergency Medical Condition may not be held liable for payment of subsequent screening and treatment needed to stabilize and diagnose the specific condition.

Molina will not refuse to cover Emergency Services based on the emergency department Provider, hospital, or fiscal agent failing to notify the Member's primary care Provider, Molina, or applicable state entity of the Member's screening and treatment within 10 calendar days of presentation for Emergency Services. Emergency dental services and post stabilization services are reimbursed at 100% of the current Medicaid FFS rate on the date of service.

A Member who has an Emergency Medical Condition may not be held liable for payment of subsequent screening and treatment needed to stabilize and diagnose the specific condition.

Post-Stabilization

Molina will provide coverage under the medical plan for post-stabilization care services as specified in 42 CFR § 438.114(e) and 42 CFR § 422.113(c)(2)(i), (ii) and (iii), regardless of whether the Provider who furnishes the services is contracted or non-contracted Providers inside or outside of Molina's service area.

Molina covers post-stabilization care services if they are:

- Pre-approved by a network Provider or other Molina representative; or
- Not pre-approved by a network Provider or other Molina representative, but:
  - Administered to maintain the Member's stabilized condition within one hour of a request to Molina for prior authorization of further post-stabilization care services, or
  - Administered to maintain, improve, or resolve the Member's stabilized condition, and:
    - Molina did not respond to a request for prior authorization within one hour;
    - Molina cannot be reached; or
    - Molina representative and the treating physician cannot reach an agreement regarding the Member's care and a network physician is not available for consultation. In this situation, Molina will give the treating physician the opportunity to consult with a network physician and the treating physician may continue with care of the patient until a network physician is reached or one of the criteria of 42 CFR § 422.133(c)(3) is met.
- Molina's financial responsibility for post-stabilization care services that have not been pre-approved ends when:
  - A contracted Provider with privileges at the treating hospital assumes responsibility for the Member's care;
  - A contracted Provider assumes responsibility for the Member's care through transfer to another place of service;
  - A Molina representative and the treating physician reach an agreement concerning the Member's care; or
  - The Member is discharged.

Prior Authorization

Molina requires prior authorization for specified services if it complies with Federal or State regulations and the Molina Hospital or Provider Services Agreement. The list of services that require prior authorization is available in narrative form, along with a more detailed list by CDT codes. Molina prior authorization documents are customarily updated quarterly, but may be updated more frequently as appropriate, and are posted on the Molina website at MolinaHealthcare.com.

Providers are encouraged to use the Molina prior authorization form provided on the Molina web site. If using a different form, the prior authorization request must include the following information:

- Member demographic information (name, date of birth, Molina 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 service will be performed.
- Clinical information sufficient to document the Medical Necessity of the requested service is required including:
    - Pertinent medical history (include treatment, diagnostic tests, examination data).
    - Requested length of stay (for inpatient requests).
    - 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. Prior Authorization is not a guarantee of payment. Payment is contingent upon medical necessity and Member eligibility at the time of service. 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 Newborn Mothers Health Protection Act.

Molina 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 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.

For expedited organization determinations/pre-service authorization request, Molina will make a determination as promptly as the Member's health requires and no later than contractual and regulatory requirements after we receive the initial request for service in the event a Provider indicates; or, if we determine that a standard authorization decision timeframe could jeopardize a Member's life or health. For a standard authorization request, Molina makes the determination and provides notification no later than contractual requirements.

Request Type	Notification Timeframe
Prior Authorization - **Standard**	14 Calendar days
Prior Authorization - **Urgent**	72 hours

Providers who request prior authorization approval for patient services and/or procedures may request to review the criteria used to make the final decision. Molina has a full-time Dental

Director available to discuss Medical Necessity decisions with the requesting Provider at (844) 826-4335 from 7:30 a.m. to 8:00 p.m. CST, Monday through Friday.

Upon approval, the requestor will receive an authorization number. The number may be provided by telephone or fax. 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.

Requesting Prior Authorization

Participating Providers are encouraged to use the SKYGEN Provider Web Portal for prior authorization submissions whenever possible. Instructions for how to submit a prior authorization request are available on the SKYGEN Provider Web Portal.

Managing prior authorizations/service requests electronically provides many benefits to Providers, such as:

- Reduced cost associated with fax and telephonic interactions
- Easy to access 24/7 online submission and status checks
- Ensures HIPAA compliance
- Ability to receive real-time authorization status
- Ability to upload dental records
- Increased efficiency through reduced telephonic interactions

Molina offers the following electronic prior authorizations/service requests submission options:

- SKYGEN Provider Web Portal
- Electronic submission via clearinghouse
    - Change Healthcare
    - DentalXChange
    - Payer ID: SKYGN
- 2019 or newer ADA claim form

Approved authorization does not guarantee payment. The Member and benefit must be eligible at the time services are rendered. Prior authorizations will be honored for 180 days from the date they are issued.

Prior authorizations can be initiated by contacting Provider Services at (844) 826-4335 from 7:30 a.m. to 8:00 p.m. CST, Monday through Friday. It may be necessary to submit additional documentation before the authorization can be processed.

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

Post Service Review

Failure to obtain authorization when required will result in denial of payment for those services. The only possible exception for payment as a result of post-service review is if information is received within 10 business days indicating the Provider did not know nor reasonably could have known that patient was a Molina Member or there was a Molina error, a Medical Necessity review will be performed. Decisions, in this circumstance, will be based on dental need, appropriateness of care guidelines defined by UM policies and criteria, regulation, guidance and evidence-based criteria sets.

Specific Federal or State requirements or Provider contracts that prohibit administrative denials supersede this policy.

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.

Emergency dental services, post stabilization services and emergency ancillary services are reimbursed at 100% of the current Medicaid FFS rate on the date of service. Emergency ancillary services are defined as those services provided in a hospital include, but are not limited to, radiology, laboratory, emergency medicine, and anesthesiology due to an emergent episode.

All out of network services except in the case of emergency, family planning or Indian Health protected services require prior authorization. Reimbursement to out of network providers, except when required by law or policy, will be reimbursed at 90% of the current Medicaid FFS rate. Please see the Molina Mississippi Out-of-Network Policy available on our website.

Peer-to-Peer Review

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

A "peer" is considered a Dentist who is directly providing care to a Molina Member and can request a peer-to-peer telephone communication with a Molina Dental Director by calling Provider Services at (844) 826-4335 from 7:30 a.m. to 8:00 p.m. CST, Monday through Friday.

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

- Member name and ID number.
- Auth ID number.
- Requesting Provider name and contact number, and best times to call.

Primary Care Dental Providers

Molina provides a panel of Dental Providers to care for its Members.

Specialty Providers

Molina maintains a network of specialty Providers to care for its Members. Some specialty care Providers may require a referral for a Member to receive specialty services; however, no prior authorization is required.

Molina will help to arrange specialty care outside the network when Providers are unavailable, or the network is inadequate to meet a Member's dental needs. To obtain such assistance contact Provider Services at (844) 826-4335 from 7:30 a.m. to 8:00 p.m. CST, Monday through Friday. Referrals to specialty care outside the network require prior authorization from Molina.

Claims and Compensation

Payor ID	SKYGN
SKYGEN Provider Web Portal	pwp.skygenusasystems.com/PWP/Landing
Clean Claim Timely filling	180 calendar days from the Date of Service

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. Providers must utilize electronic billing though a clearinghouse or the SKYGEN Provider Web Portal whenever possible and use current HIPAA compliant ANSI X 12N format (e.g., 837D for dental Claims).

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

Molina Dental Services accepts claims submitted in any of the following formats:

- SKYGEN Provider Web Portal
- Electronic submission via clearinghouse, Payer ID: SKYGN HIPAA-compliant 837D file
- Paper 2019 ADA Dental Claim Form, available from American Dental Association

Please note that when submitting a dental claim to SKYGEN, via the provider portal, clearing house or ADA claim form, a valid ICD-10 dental diagnosis code is required.

Claims, Billing, and Payment

Providers are to use approved ADA dental codes, as published in the current CDT book to identify all services. Include all quadrants, tooth numbers, and surfaces for dental codes which require identification (extractions, root canals, amalgams, and resin fillings). SKYGEN recognizes tooth letters A through T for primary teeth and tooth numbers 1 to 32 for permanent teeth. Designate supernumerary teeth with codes AS through TS or 51 through 82. Designation of the tooth can be determined by using the nearest erupted tooth. If the tooth closest to the supernumerary tooth is #1, then chart the supernumerary tooth as #51. Likewise, if the nearest tooth is A chart the supernumerary tooth as AS. Missing, incorrect, or illegible information could result in the claim being returned to the submitting provider's office, causing a delay in payment.

Clean Claims

A clean claim is considered a 2019 ADA claim form with appropriate ICD-10 and CDT codes for the services rendered.

Timely Filing

Provider shall promptly submit claims to SKYGEN for Covered Services rendered to Members. All Claims shall be submitted on an approved ADA claim form 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 Provider to SKYGEN within 180 calendar days after the Date of Service. If Molina is not the primary payer under coordination of benefits or third-party liability, Provider must submit Claims to SKYGEN 60 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 SKYGEN within these timelines shall not be eligible for payment and Provider hereby waives any right to payment.

Claims Payment

The SKYGEN benefits administration software system imports claim and authorization data, evaluates and edits the data for completeness and correctness, analyzes the data for clinical appropriateness and coding correctness, audits against plan and benefit limits, calculates the appropriate payment amounts, and generates payments and remittance summaries. The system also evaluates and automatically matches claims and services that require prior authorizations and matches the claims and services to the appropriate member record for efficient and accurate claims processing.

As soon as the system prices and pays claims, checks and electronic payments are generated, and remittance summaries are posted and available for online review from the Provider Web Portal SKYGEN Provider Web Portal.

To appeal a reimbursement decision, submit the appeal in writing along with any necessary documentation to:

Molina Dental Services Dispute/Appeals and Complaints
P.O. Box 649
Milwaukee, WI. 53201

Lesser of Biller Charges or Fee Schedule

SKYGEN pays a provider the lesser of the provider's billed charge or the amount on the appropriate fee schedule.

Electronic Funds Payment (EFT)

To receive claims payments through the EFT program: Complete the online form on the Provider Web Portal: pwp.skygenusasystems.com

Allow up to six weeks for the EFT program to be implemented after we receive your completed paperwork. Once you are enrolled in the EFT program, you will no longer receive paper remittance statements through postal mail. Instead, your Remittance Reports will be posted online and made available from the Provider Web Portal as soon as your claims are paid. (Navigate to the Provider Web Portal SKYGEN Provider Web Portal)

Once you are enrolled in the EFT Program, notify Molina Dental Services of any changes to bank accounts, including changes in Routing Number or Account Number, or switching to a different bank. Submit all changes via the EFT Authorization Form. Allow up to three weeks for changes to be implemented after we receive your change request. Molina Dental Services is not responsible for delays in payment if providers do not properly notify Molina Healthcare in writing of banking changes.

Explanation of Payment (EOP)

When you enroll in the EFT Program, your Remittance Reports will be made available automatically from the Provider Web Portal. For help registering for the portal or accessing your Remittance Reports, call the SKYGEN Provider Web Portal Team:

- (844) 621-4587

Receiving Payment

Molina Dental Services offers all providers the option of Electronic Funds Transfer. {EFT) for claims payments. With EFT, we can pay claims more efficiently - and you can receive payments faster - because funds are deposited directly into payee bank accounts, eliminating the steps of printing, and mailing paper checks.

Overpayment

If, as a result of retroactive review of coverage decisions or payment levels, Molina determines that it has made an Overpayment to a Provider for services rendered to a Member, it will make a claim for such Overpayment. A Provider shall pay a Claim for an Overpayment made by Molina which the Provider does not contest or dispute within the specified number of days on the refund request letter mailed to the Provider. If a provider does not repay or dispute the overpaid amount within the timeframe allowed Molina may offset the overpayment amount(s) against future payments made to the provider. Payment of a Claim for Overpayment is considered made on the date payment was received or electronically transferred or otherwise delivered to Molina, or the date that the Provider receives a payment from Molina that reduces or deducts the Overpayment. Recoupment/refund checks should be sent to:

Molina Healthcare Claims
PO Box 2136
Milwaukee, WI. 53201

Member Billing

Providers contracted with Molina Dental Services cannot bill the member for any covered benefits. The Provider is responsible for verifying eligibility and obtaining approval for those services that require prior authorization. Providers agree that under no circumstance shall a Member be liable to the Provider for any sums owed by Molina Dental Services to the Provider. Provider agrees to accept payment from Molina as payment in full or bill the appropriate responsible party.

Coordination of Benefits

Medicaid is the payer of last resort. Commercial, private, and governmental carriers must be billed prior to billing Molina Dental Services. Molina Dental Services will make every effort to determine the appropriate Third-Party Payer for services rendered. Molina Dental Services may deny Claims when Third Party has been established and will process Claims for Covered Services when probable Third-Party Liability {TPL) has not been established or third-party benefits are not available to pay a claim. Molina Dental Services will attempt to recover any third-party resource available to Members and shall maintain records pertaining to TPL collections on behalf of Members for audit and review. When a participant arrives for an appointment, always ask if they have other dental insurance coverage or is entitled to payment by a third party under any other insurance plan of any type. Provider shall immediately notify Molina Dental Services of said entitlement. When Molina Dental Services is the secondary insurance carrier, a copy of the primary carrier's Explanation of Benefits {EOB) must be submitted with the claim within 180 days from the date of the primary carrier's explanation/denial of payment. For electronic claim submissions, the payment or denial made by the primary carrier must be indicated in the appropriate Coordination of Benefits (COB) field. When a primary carrier's payment meets or exceeds a provider's contracted rate or fee schedule, Molina Dental Services will consider the claim paid in full and no further payment will be made on the claim. If Molina Dental Services reimburses a provider and then discovers other coverage is primary, Molina Dental Services will recover the amount paid by Molina Dental Services.

Electronic Claims Submission

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

- Helps to reduce operation costs associated with paper Claims (printing, postage, etc.).
- Increases 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 Claims submission options:

- Submit Claims directly to Molina via the SKYGEN Provider Web Portal
- Submit Claims to Molina via your regular EDI clearinghouse

The SKYGEN Provider Web Portal is a no cost online platform that offers a number of Claims processing features:

- Submit Claims with attached files.
- Correct/Void Claims.
- Add attachments to previously submitted Claims.
- Check Claims status.
- View Electronic Remittance Advice (ERA) and Explanation of Payment (EOP).
- Create and submit a Claim appeal with attached files.

EDI (Clearinghouse) Submission

Molina uses SSI as its gateway clearinghouse. SSI has relationships with hundreds of other clearinghouses. Typically, Providers can continue to submit Claims to their usual clearinghouse.

If you do not have a clearinghouse, Molina offers additional electronic Claims submissions options as shown by logging on to the SKYGEN Provider Web Portal.

Molina accepts EDI transactions through our gateway clearinghouse for Claims via the 837D for Dental. It is important to track your electronic transmissions using your acknowledgement reports. The reports assure Claims are received for processing in a timely manner.

When your Claims are filed via a Clearinghouse:

- You should receive a 999 acknowledgement from your clearinghouse.
- You should also receive 277CA response file with initial status of the Claims from your clearinghouse.
- You should refer to the Molina Companion Guide for information on the response format and messages.
- You should contact your local clearinghouse representative if you experience any problems with your transmission.

Corrected Claim information submitted via EDI submission are required to follow electronic Claim standardized Accredited Standards Committee (ASC) X12N 837 formats. Electronic Claims are validated for Compliance SNIP levels 1 to 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 records based on 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 Electronic Remittance Advice (ERA). Without the original Claim number, adjustment requests will generate a compliance error and the Claim will reject.

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

Paper Claim Submissions

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

Molina Dental Services Claims
PO Box 2136
Milwaukee, WI 53201

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 2012 or newer ADA claim forms.
- Paper Claims not submitted on the required forms will be rejected and returned. This includes black and white forms, copied forms, and any altering to include Claims with handwriting.
- Claims must be typed with either 10- or 12-point Times New Roman font, using black ink.

EDI Claims Submission Issues

Providers who are experiencing EDI Submission issues should work with their clearinghouse to resolve this issue. If the Provider's clearinghouse is unable to resolve, the Provider should contact their Provider Services representative for additional support.

Timely Claim Processing

Claims processing will be completed for contracted Providers in accordance with the timeliness provisions set forth in the Provider's contract. Unless the Provider and Molina have agreed in

writing to an alternate schedule, Molina will process 90% the Claims for service within 30 days and 99% of Claims for service within 900 days after receipt of Clean Claims.

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

Claims Recovery

Molina's Claims Recovery department manages recovery for Overpayment and incorrect payment of Claims.

Provider Overpayment Disputes/ Refund checks	Molina Healthcare of Mississippi, Inc. Molina Refunds PO Box 641 Milwaukee, WI 53201
Phone:	(844) 826-4335
SKYGEN Provider Web Portal	pwp.skygenusasystems.com/PWP/Landing

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.

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 Dental Provider Appendix. These documents are subject to change as new information is available. Please check the Molina website at 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 Claims data in standardized Accredited Standards Committee (ASC) X12N 837 formats. Electronic Claims are validated for Compliance SNIP levels 1 to 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 codes

- Valid ICD-10 dental diagnosis code
- Total billed charges
- Place and type of service code
- Days or units as applicable
- 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
- National Drug Code (NDC), unit of measure and quantity for medical injectables
- 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 Claims submission. This validation will apply to all Provider data submitted and also applies to atypical and out-of-state Providers. Provider information submitted on the claim must match the information on file with Mississippi Medicaid and CHIP in order for claim payment to be made. Changes to Provider information should be made to Gainwell's Provider Enrollment Platform prior to claim submission to Molina.

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

Corrected Claim Process

Providers may correct any necessary field of the ADA forms.

Molina strongly encourages Participating Providers to submit Corrected Claims electronically via EDI or the SKYGEN Provider Web Portal.

All corrected Claims:

- Must be free of handwritten or stamped verbiage (paper Claims).
- Must be submitted on a standard ADA form.

Corrected Claims must be sent within 180 calendar days of the Date of Service.

The mailing address to submit paper 2019 or newer ADA Dental Corrected Claim Forms is:

Molina Dental Services Corrected Claims
PO Box 641
Milwaukee, WI 53201

Manually Priced Codes

Manually priced codes are identified on the State of Mississippi Medicaid and CHIP Fee Schedules with an indicator as follows:

- BR – By Report

Manually priced codes follow the pricing methodology stated below in Table 1, unless noted with asterisk as an exception and further described.

Table 1 – Manually Priced Codes

Manually Priced Code Descriptor	No Rate on Medicaid Fee Schedule, defaults to:	No Rate on Medicare Fee Schedule, defaults to:
BR	CMS Medicare Fee Schedule	% of Billed Charge*

*CDT codes with a BR status without a rate on the CMS Medicare Fee Schedule shall pay as follows:

- Miscellaneous or unlisted codes (i.e., 45399, etc.) reimbursement will be based upon equal value of a like code.

Non-Covered Services

Molina Healthcare of Mississippi considers a non-covered service to mean a CDT code that is:

- Listed on the published fee schedule as Non-Covered, Obsolete or Non-Covered by Medicaid or other similar language; and,
- A code not found on a published State of Mississippi Medicaid and CHIP Fee Schedule.

Reimbursement Guidance and Payment Guidelines

Providers are responsible for submission of accurate 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.

Molina utilizes a Claims adjudication system that encompasses edits and audits that follow State and Federal requirements as well as administers payment rules based on generally accepted principles of correct coding. These payment rules include, but are not limited to, the following:

- Manuals published by the Centers for Medicare & Medicaid Services (CMS), including:
  - Current Code on Dental Procedures and Nomenclature (CDT Code) guidance published by the American Dental Association (ADA).
  - Current Code on the International Classification of Diagnosis (ICD) version ten (10)
  - State-specific Claims reimbursement guidance.
  - Other coding guidelines published by industry-recognized resources.

- Payment policies based on professional associations or other industry-recognized guidance for specific services. Such payment policies may be more stringent than State and Federal guidelines.
- Molina policies based on the appropriateness of health care and Medical Necessity.
- Payment policies published by Molina.

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, contains the Code on Dental Procedures and Nomenclature (CDT Code) codebooks. In order to ensure proper and timely reimbursement, codes must be effective on the Date of Service (DOS) for which the procedure or service was rendered and not the date of submission.

ICD-10 Codes

Dental ICD-10 Diagnosis Codes must be submitted in accordance with the chapter and code-specific guidelines set forth in the current/applicable version of the International Classification of Disease codebooks. In order to ensure proper and timely reimbursement, codes must be effective on the Date of Service (DOS) for which the procedure or service was rendered and not the date of submission.

Place of Service (POS) Codes

Place of Service Codes (POS) are two-digit codes placed on the ADA Claim to indicate the setting in which a service was provided. CMS maintains POS codes used throughout the health care industry. The POS should be indicative of where that specific procedure/service was rendered. If billing multiple lines, each line should indicate the POS 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.

Provider acknowledges Molina's right to conduct pre- and post-payment billing audits. Provider shall cooperate with Molina's Special Investigations Unit and audits of Claims and payments by providing access at reasonable times to requested Claims information, all supporting dental records, Provider's charging policies, and other related data as deemed relevant to support the transactions billed. Providers are required to submit, or provide access to, dental records upon

Molina's request. 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 may 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 projected 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.

Overpayments and Incorrect Payments Refund Requests

If, as a result of retroactive review of Claim payment, Molina determines that it has made an overpayment to a Provider for services rendered to a Member, it will make a Claim for such overpayment. Providers will receive an overpayment request letter if the Overpayment is identified in accordance with State and CMS guidelines. Providers will be given the option to either:

1. Submit a refund to satisfy Overpayment,
2. Submit a request to offset from future Claim payments, or
3. Dispute Overpayment findings.

Instructions will be provided on the overpayment notice and overpayments will be adjusted and reflected in your remittance advice. The letter timeframes are Molina standards and may vary depending on applicable state guidelines and contractual terms.

Overpayments related to TPL/COB will contain primary insurer information necessary for rebilling including the policy number, effective date, term date, and subscriber information. For Members with Commercial COB, Molina will provide notice within 270 days from the Claim's paid date if the primary insurer is a Commercial plan. For Members with Medicare COB, Molina will provide notice within 540 days from the Claim's paid date if the primary insurer is a Medicare plan. A Provider may resubmit the Claim with an attached primary EOB after submission to the primary payer for payment. Molina will adjudicate the Claim and pay or deny the Claim in accordance with Claim processing guidelines.

A Provider shall pay a Claim for an Overpayment made by Molina which the Provider does not contest or dispute within the specified number of days on the refund request letter mailed to the Provider. If a Provider does not repay or dispute the overpaid amount within the timeframe allowed Molina may offset the Overpayment amount(s) against future payments made to the Provider.

Payment of a Claim for Overpayment is considered paid on the date payment was received or electronically transferred or otherwise delivered to Molina, or the date that the Provider receives a payment from Molina that reduces or deducts the Overpayment.

Overpayment Disputes should be received within 30 days of Overpayment notification letter. Overpayment Disputes should be sent to the address listed on the Overpayment notification. Overpayment Disputes can also be submitted via the SKYGEN Provider Web Portal.

Balance Billing

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

Providers agree that under no circumstance shall a Member be liable to the Provider for any sums that are the legal obligation of Molina to the Provider. As described in your Agreement with Molina Healthcare of Mississippi, balance billing a Member for Covered Services is prohibited, except for the Member's applicable copayment, coinsurance, and deductible amounts.

Encounter Data

Each Provider, capitated Provider or organization delegated for Claims processing is required to submit Encounter data to Molina for all adjudicated Claims. The data is used for many purposes, such as regulatory reporting, rate setting and risk adjustment, hospital rate setting, the Quality Improvement program and HEDIS® reporting.

Encounter data must be submitted at least weekly, and within 30 days from the Date of Service to meet State and CMS encounter submission threshold and quality measures. Encounter data must be submitted via HIPAA compliant transactions, including the ANSI X12N 837I –837D – Dental. Data must be submitted with Claims level detail for all non-institutional services provided.

Molina has a comprehensive automated and integrated Encounter data system capable of Supporting all 837 file formats and proprietary formats if needed.

Providers must correct and resubmit any encounters which are rejected (non-HIPAA compliant) or denied by Molina. Encounters must be corrected and resubmitted within 15 days from the rejection/denial.

Molina created 837D Companion Guides with the specific submission requirements available to Providers.

When Encounters are filed electronically Providers should receive two types of responses:

- First, Molina will provide a 999 acknowledgement of the transmission.
- Second, Molina will provide a 277CA response file for each transaction.

Health Care Services

Health Care Services is 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 care management 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 utilization management program include pre-service authorization review and inpatient authorization management that includes pre-admission, admission and concurrent review, Medical Necessity review, and restrictions on the use of out-of-network 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 Member's care by:

- Managing available benefits effectively and efficiently while ensuring quality care.
- Evaluating the Medical 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 Medical Necessity decisions.

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 Medical Necessity need(s) and benefit plan
  - Verifying of current Physician/hospital contract status
- **Resource Management**
  - Prior authorization and referral management
  - Staff education on consistent application of UM functions
- **Quality Management**
  - Satisfaction survey analysis 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 at MolinaHealthcare.com or contact Provider Services at (844) 826-4335 from 7:30 a.m. to 8:00 p.m. CST, Monday through Friday.

UM Decisions

A decision is any determination made by Molina 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).
- Discontinuation of a payment or authorization for a service.

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 Providers from appropriate specialty areas are utilized to assist in making determinations of Medical Necessity, as appropriate. All utilization decisions are made in a timely manner to accommodate the clinical urgency of the situation, in accordance with Federal regulatory requirements and NCQA standards.

Requests for authorization not meeting criteria are reviewed by a designated Molina Medical Director or other appropriate clinical professional. Only a licensed physician, dentist, 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.

Providers can contact Provider Services at (844) 826-4335 from 7:30 a.m. to 8:00 p.m. CST, Monday through Friday to obtain Molina's UM Criteria.

Where applicable, Molina Corporate 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.

Delegated Utilization Management Functions

Molina may delegate UM functions to qualifying delegated entities. They 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 Dental Provider Appendix.

Medical Necessity

"Medically Necessary" or **"Medical Necessity"** means health care services and supplies that are medically appropriate and:

- Necessary to meet the basic health needs of the Member.
- Rendered in the most cost-efficient manner and type of setting appropriate for the delivery of the Covered Service.
- Consistent in type, frequency, and duration of treatment with scientifically based guidelines of national dental, research, or health care coverage organizations or governmental agencies.
- Consistent with the diagnosis of the condition.
- Required for means other than convenience of the client or their physician.
- No more intrusive or restrictive than necessary to provide a proper balance of safety, effectiveness, and efficiency.
- Of demonstrated value.
- No more intensive level of service than can be safely provided.

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, physician specialty society recommendations, the views of physicians 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, in 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, as part of the inpatient admission notification/concurrent review, or retrospectively. To determine Medical Necessity, in conjunction with independent professional dental judgment, Molina uses nationally recognized evidence-based guidelines, third party guidelines, CMS guidelines, state guidelines, guidelines from recognized professional societies, and advice from authoritative review articles and textbooks.

Complaints, Grievance, and Appeals Process

Member Grievance Process

A Grievance is a Member's expression of dissatisfaction with any matter other than an adverse benefit determination. Grievances may include, but are not limited to, the quality of care or services provided, and aspects of interpersonal relationships such as rudeness of a Provider or employee, or failure to respect the Member's rights regardless of whether remedial action is requested.

A Member or a Provider acting on behalf of a Member (with written consent) may file a grievance verbally or in writing anytime. Molina provides Members with reasonable assistance in completing forms and other procedural steps at no charge.

Grievance Timelines

Molina will acknowledge each grievance within 10 calendar days from the date Molina received the grievance. Molina will address each grievance, resolve, and provide notice as expeditiously as the Member's health condition requires, and under all circumstances within 90 days from the date Molina received the grievance.

Member Appeals Process

Appeal means a review by Molina of an Adverse Benefit Determination.

Members or a Provider acting on behalf of a Member (with written consent) may file an appeal verbally or in writing. Appeals must be filed within 60 calendar days from the date on the adverse benefit determination notice. Molina has only one level of member appeals. Molina will acknowledge each appeal within 10 calendar days from the date Molina received the appeal.

Standard Appeals Process and Timeline

Molina will resolve appeals and provide notice as expeditiously as the Member's health condition requires, and within 30 calendar days from the date Molina receives the appeal. Molina will provide written notice of the disposition of the appeal.

Molina may extend the timeframes by up to 14 calendar days if the Member request the extension or Molina shows that there is a need for additional information and the reason(s) why the delay is in the Member's interest.

Expedited Appeals Process and Timeline

Molina will resolve expedited appeals and provide notice as expeditiously as the Member's health condition requires, within seventy-two (72) hours after Molina receives the appeal. Molina will provide written notice of the disposition of the appeal.

Molina may extend the timeframes by up to five (5) calendar days if the Member requests the extension or the MCO shows that there is a need for additional information and the reason(s) why the delay is in the Member's interest. If the Plan denies a request for an expedited resolution of an appeal, it will transfer the appeal to the standard timeframe.

Appointment of Representative Process

Molina Members can file appeals and grievances on their own. They can also appoint someone else to file an appeal or grievance for them. This is called an "Authorized Representative." If a provider is submitting an appeal or grievance on behalf of a Member, written consent from the Member is required. You can use Molina's Appointment of Representative (AOR) Form to complete this requirement.

Submission of Member Appeals and Grievances

Providers shall submit a Member appeal or grievance at:

- Phone: (844) 782-2018
- Fax: (833) 635-2044
- Mail: Molina Healthcare of Mississippi, Inc.
  ATTN: Appeals and Grievance Department
  188 E. Capitol St., Suite 700
  Jackson, MS 39201

Continuation of Benefits During the Appeal or State Fair Hearing Process

Molina will continue the Member's benefits while Molina's internal appeals process is pending and while the State Fair Hearing is pending if all the following conditions exist:

- The Member files the request for an appeal timely in accordance with 42 CFR § 438.402(c)(1)(ii) and (c)(2)(ii)
- The appeal involves the termination, suspension, or reduction of previously authorized services;

- The services were ordered by an authorized Provider;
- The period covered by the original authorization has not expired; and
- The Member timely files for continuation of benefits. Timely files mean on or before the later of the following:
    - within ten Calendar Days of the Plan mailing the Notice of Adverse Benefit Determination; or,
    - the intended effective date of the Plan's proposed Adverse Benefit Determination;

Molina will provide benefits until one of the following occurs:

- The Member withdraws the appeal or request for State Fair Hearing;
- The Member fails to request a State Fair Hearing and continuation of benefits within ten calendar days after Molina send the notice of adverse resolution to the Member's appeal; or
- The State Fair Hearing office issues a hearing decision not in the Member's favor.

To ask for continuation of benefits during the appeal process, the Member may call us or can send their request in writing to:

- Fax: (833) 635-2044
- Mail: Molina Healthcare of Mississippi, Inc
  Appeals & Grievances Unit
  PO Box 182273
  Chattanooga, TN 37422

If the final appeal decision is not in the Member's favor, the Member may have to pay for the services they were getting while the appeal was being reviewed. If the final appeal decision is in the Member's favor and the services were not given to the Member while the appeal was being looked at, Molina will authorize the services for the Member as quickly as their health requires, but no later than 72 hours from the date of the approval.

Molina will ensure that punitive action is not taken against any Provider who requests an expedited resolution or supports an appeal.

State Fair Hearing

A Member may request a State Fair Hearing if Molina's appeal system has been exhausted, and the final decision was not wholly in the Member's favor. The request for a State Fair Hearing must be submitted in writing within 120 calendar days from the date of Molina's resolution of the appeal.

Provider Claim Appeal Request: A Provider Claim Appeal Request is not a Member appeal. Molina's Provider Claim Appeal process is detailed under the "Provider Complaints, Grievances, and Appeals, Process" heading.

Provider Complaints, Grievances, and Appeals Process

A Provider complaint is any verbal or written expression, originating from a Provider and delivered to Molina, voicing dissatisfaction with a policy, procedure, payment, or any other communication or action by Molina. Molina is committed to the timely resolution of all Provider complaints. Molina will not take any punitive actions against any Provider who files a Grievance or a Claim Appeal

Providers may request Molina's Provider Complaints policies and procedures by contacting Provider Services at (844) 826-4335 from 7:30 a.m. to 8:00 p.m. CST, Monday through Friday.

Provider Grievance Process and Timeline

A Provider complaint that is not related to a Claim is considered a Provider Grievance. Provider grievances may include, but are not limited to, dissatisfaction with a policy, procedure, the quality services provided, timeliness or processing of an authorization, and aspects of interpersonal relationships such as rudeness of an employee.

Provider grievances are accepted verbally, in-person, and in writing within 30 calendar days from the date the grievance occurred, or Provider becomes aware of the grievance occurring. Molina will acknowledge the Provider Grievance within 3 business days from receipt. Molina will address each Provider Grievance, resolve, and provide written notice within 30 calendar days.

Provider Appeal Process and Timeline

A Provider complaint that is related to a Claim, such as processing, payment, or non-payment of a Claim, is considered a Provider Appeal. Provider appeals are requests to investigate the outcome of a finalized Claim.

Provider Appeals are accepted electronically and in writing within 90 days from the date on the Explanation of Payment (EOP) or the Provider Remittance Advice (PRA). Molina will acknowledge Provider Appeals within 3 business days from receipt. Molina will address each Provider Appeal, resolve, and provide written notice within 30 calendar days. Molina will adjudicate each appealed claim to a paid or denied status within thirty (30) business days of receiving notice of a resolution.

Providers are encouraged to submit Provider Appeals electronically, using the SKYGEN Provider Web Portal. Alternatively, Provider Appeals may be submitted using the form located on the MolinaHealthcare.com website.

The item(s) being submitted should be clearly marked as a Provider Appeal and must include the following documentation:

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

Providers are encouraged to submit appeals via the SKYGEN Provider Web Portal or verbally.

- Call Provider Services toll free at (844) 826-4335 from 7:30 a.m. to 8:00 p.m. CST, Monday through Friday.

- SKYGEN Provider Web Portal: pwp.skygenusasystems.com/PWP/Landing

If you would like a hard copy of the Provider Complaint System Policies and Procedures, please contact your Provider Services representative, or reach out to the Provider Services helpline. You can also find a copy on our website at MolinaHealthcare.com.

Cost Recovery Disputes and Correspondence:

Molina Healthcare of Mississippi, Inc.
Molina MS Refunds
PO Box 641
Milwaukee, WI 53201

Provider Claims Inquiry Process

A Provider Claims Inquiry is a provider's initial request to adjust a claim that is not related to a clinical decision. Provider Claims Inquiries are accepted by phone within 90 days from the date on the Explanation of Payment (EOP) or the Provider Remittance Advice (PRA).

To request a Provider Claims Inquiry, please call our Provider Services Contact Center at (844) 826-4335 from 7:30 a.m. to 8:00 p.m. CST, Monday through Friday.

If you would like to (1) request adjustment of a claim that is related to a clinical decision, or (2) submit a formal request to adjust a claim, or (3) if you are dissatisfied with the outcome of your claim processing or initial claim adjustment, please use Molina's Provider Complaints, Grievances, Appeals Process found below.

Reporting

Grievance and appeal trends are reported to the Quality Improvement 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 Committee for evaluation. If required by the state or CMS, reporting is submitted to the appropriate Agency as needed.

Compliance

Fraud, Waste, and Abuse

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, which 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 and 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 reoccurring. 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 cost and to 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 falsity of information in the Claim;
- Acts in deliberate ignorance of the truth or falsity of the information in a Claim; or,
- 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

The Deficit Reduction Act (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 of Medicare/Medicaid funds either by 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.

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 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.

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 Anti-Kickback Statutes (AKS) statutes and regulations and Federal and State marketing regulations. Providers are prohibited from engaging in any activities covered under this statute.

What is AKS?

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.

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

Sarbanes-Oxley Act of 2022 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 cost 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 for 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 identification card.
- Failing to report a Member's forgery or alteration of a prescription or other medical 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 services 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 trying to identify 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 Claims payment system utilizes system edits and flags to validate those elements of Claims 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 Claims 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 Fraud, Waste, and Abuse Detection Activities

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

Molina has a pre-payment Claims 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, Centers for Medicare & Medicaid Services (CMS), Federal CMS guidelines, AMA, and published specialty specific coding rules. Code Edit Rules are based on information received from the National Physician Fee Schedule Relative File (NPFS), the Medically Unlikely Edit (MUE) table, the National Correct Coding Initiative (NCCI) files, Local Coverage Determination/ National Coverage Determination (LCD/NCD), and State-specific policy appendix and guidelines as specified by a defined set of indicators in the Medicare Physician Fee Schedule Data Base (MPFSDB).

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

Post-payment Recovery Activities

The terms expressed in this section of this Dental Provider Appendix are incorporated into the Provider Agreement, 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 or at Law or equity.

In the event of any inconsistency between the terms expressed here and any terms expressed in the Provider Agreement, the parties agree that Molina shall in its sole discretion exercise the terms that are expressed in the Provider Agreement, the terms that are expressed here, its rights under Law and equity, or some combination thereof.

Provider will provide Molina, governmental agencies and their representatives or agents, access to examine, audit, and copy any and all records deemed by Molina, at Molina's sole discretion, necessary to determine compliance with the terms of the Provider Agreement, including for the purpose of investigating potential fraud, waste, and abuse. Documents and records must be readily accessible at the location where Provider provides services to any Molina Members. Auditable documents and records include, but are not limited to, dental charts, patient 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, Provider agrees to repay funds or Molina may seek recoupment.

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

Provider acknowledges that HIPAA specifically permits a covered entity, such as Provider, to disclose protected health information for its own payment purposes (see 45 CFR 164.502 and 45 CFR 154.501). Provider further acknowledges that in order to receive payment from Molina, 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 Provider under HIPAA and other applicable privacy Laws.

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.

Provider acknowledges Molina's right to conduct pre- and post-payment billing audits. Provider shall cooperate with Molina's Special Investigations Unit and audits of Claims and payments by providing access at reasonable times to requested Claims information, all supporting dental

records, Provider's charging policies, and other related data as deemed relevant to support the transactions billed. Providers are required to submit, or provide access to, dental records upon Molina's request. 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 may select a statistically valid random sample, or smaller subset of the statistically valid random sample. This gives an estimate of the proportion of Claims that Molina paid in error. The estimated proportion, or error rate, may be projected 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.

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 corrective action plan (CAP) to Molina addressing the issues identified and how it will cure these issues moving forward.

Reporting Fraud, Waste, and Abuse

If you suspect cases of fraud, waste, or abuse, you must report it by contacting the Molina AlertLine. AlertLine is an external telephone and web-based reporting system hosted by NAVEX Global, a leading Provider of compliance and ethics hotline services. AlertLine telephone and web-based reporting is available 24 hours a day, seven days a week, 365 days a year. When you make a report, you can choose to remain confidential or anonymous. If you choose to call AlertLine, a trained professional at NAVEX Global will note your concerns and provide them to the Molina Compliance department for follow-up. If you elect to use the web-based reporting process, you will be asked a series of questions concluding with the submission of your report. Reports to AlertLine can be made from anywhere within the United States with telephone or internet access.

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

You may also report cases of fraud, waste, or abuse to Molina's Compliance department. You have the right to have your concerns reported anonymously without fear of retaliation.

Molina Healthcare of Mississippi, Inc.
Attn: Compliance
200 Oceangate Blvd. Suite 100
Long Beach, CA 90802

Remember to include the following information when reporting:

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

Suspected fraud and abuse may also be reported directly to the State at:

Suspected fraud or abuse by a Provider:

Fraud, Waste, and Abuse Alertline Confidential Compliance Official Molina Healthcare, Inc.
200 Oceangate, Suite 100
Long Beach, CA 90802 (866) 606-3889

Marketing Guidelines and Requirements

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, which 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 form 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.

HIPAA (health insurance portability and accountability act)

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 Member's protected health information (PHI).

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 medical - is a rapidly growing problem and that their patients trust their health care Providers to keep their most sensitive information private and confidential.

Medical identity theft is an emerging threat in the health care industry. Medical 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. Medical 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 "I'm a Health Care Professional."
2. Click the tab titled "HIPAA."
3. Click on the tab titled "HIPAA Transactions" or "HIPAA Code Sets."

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 privacy of health information, including, without limitation, the following:

1. **Federal Laws and Regulations**
   - HIPAA
   - The Health Information Technology for Economic and Clinical Health Act (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.

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 entity1. 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
   - Case 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

[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

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.

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.

National Provider Identifier (NPI)

Providers must comply with the National Provider Identifier (NPI) Rule promulgated under HIPAA. The Provider must obtain an NPI from the National Plan and Provider Enumeration System (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.

Additional Requirements for Delegated Providers

Providers that are delegated for Claims and Utilization Management activities are the "business associates" of Molina. Under HIPAA, Molina must obtain contractual assurances from all business associates that they will safeguard Member PHI. Delegated Providers must agree to various contractual provisions required under HIPAA's Privacy and Security Rules.

Reimbursement for Copies of PHI

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

- Utilization Management
- Care Coordination and/or Complex Medical Care Management Services
- Claims Review
- Resolution of an Appeal and/Grievance

- Anti-Fraud Program Review
- Quality of Care Issues
- Regulatory Audits
- Risk Adjustment
- Treatment, Payment and/or Operation Purposes
- Collection of HEDIS® dental records

Business Continuity Plan (BCP)

The Provider will have a documented Business Continuity Plan (BCP) to ensure continuation and recovery of services after a disruption occurs. The BCP will be updated at least annually and approved by the applicable designated representative.

The Provider Business Continuity Plan will include:

- Names and contact information for staff responsible for invoking and managing response and recovery.
- Molina notification names and contact information.
- Disaster declaration process.
- Details of how the services will be recovered and restored.
- Details of how the systems and applications supporting the services will be recovered and restored, including recovery of data.

The Provider will notify Molina of a disruption to the services or activation of business continuity plans within two hours of occurrence and will provide Molina with regular updates on the situation and actions taken to resolve the issue, until normal services have been resumed.

The Provider will ensure that its third parties needed to deliver the services have appropriate Business Continuity Plans in place to prevent significant disruption to the services.

The Provider will test the BCP at least annually and document the test results. Provider will make available to Molina, upon request, the results of the most recent test including lessons learned and remediation plans.

The Provider will participate in Molina annual tests upon notification and mutual agreement.

After disruption to services, once normal service has been resumed, the Provider will promptly complete a root cause analysis report and provide it to Molina.

Definitions

Business Continuity Plan: documented procedures that guide organizations to respond, recover, resume, and restore to a pre-defined level of operations following a disruption.

Disaster Recovery Plan: a document that defines the resources, actions, tasks, and data required to manage the technology recovery effort.

Disaster Declaration: criteria to declare a disaster and the staff authorized to invoke recovery plans to recover and restore services.

Cybersecurity Requirements

Note: This section (Cybersecurity Requirements) is only applicable to Providers who are delegated Providers and have been delegated by Molina to perform a health plan function.

1. Provider shall comply with the following requirements and permit Molina to audit such compliance as required by Law or any enforcement agency.
2. The following terms are defined as follows:
   I. "Consumer" means an individual who is a State resident, whose Nonpublic Information is in Molina's possession, custody or control and which Provider maintains, processes, stores or otherwise has access to such Nonpublic Information.
   II. "Cybersecurity Event" means any act or attempt, successful or, to the extent known by Provider, unsuccessful, to gain unauthorized access to, disrupt or misuse an Information System or Nonpublic Information stored on such Information System. The ongoing existence and occurrence of attempted but Unsuccessful Security Incidents shall not constitute a Cybersecurity Event under this definition. "Unsuccessful Security Incidents" 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, so long as no such incident results in unauthorized access, use or disclosure of Molina Nonpublic Information or sustained interruption of service obligations to Molina.
   III. "Information System" or "Information Systems" means a discrete set of electronic information resources organized for the collection, processing, maintenance, use, sharing, dissemination, or disposition of electronic Nonpublic Information, as well as any specialized system such as industrial or process controls systems, telephone switching and private branch exchange systems, and environmental control systems.
   IV. "Nonpublic Information" means information that is not publicly available information and is one of the following:
      (a) business related information of Molina the tampering with which, or unauthorized disclosure, access, or use of which, would cause a material adverse impact to the business, operations, or security of Molina;
      (b) any information concerning a Consumer that because of the name, number, personal mark, or other identifier contained in the information can be used to identify such Consumer, in combination with any one or more of the following data elements:
         (i) social security number;
         (ii) driver's license number, commercial driver's license, or state identification card number;
         (iii) account number, credit, or debit card number;
         (iv) security code, access code, or password that would permit access to a Consumer's financial account; or
         (v) biometric records;

(c) any information or data, except age or gender, in any form or medium created by or derived from a health care Provider or a consumer, which can be used to identify a particular consumer, and that relates to any of the following:

(i) the past, present, or future physical, mental, or behavioral health or condition of a consumer or a member of the consumer's family;

(ii) the provision of health care to a consumer; or

(iii) payment for the provision of health care to a consumer.

V. "State" means the State of Mississippi.

3. Provider shall implement appropriate administrative, technical, and physical measures to protect and secure the Information Systems and Nonpublic Information, as defined herein, that are accessible to, or held by, the Provider. Implementation of the foregoing measures shall incorporate guidance issued by the State Department of Insurance, as appropriate.
4. Provider agrees to comply with all applicable Laws governing Cybersecurity Events. Molina will decide on notification to affected Consumers or government entities, except where Provider is solely responsible and required to notify such Consumers or government entities by Law. Upon Molina's prior written request, Provider agrees to assume responsibility for informing all such Consumers in accordance with applicable Law.
5. In the event of a Cybersecurity Event, Provider shall notify Molina's Chief Information Security Officer of such Cybersecurity Event by telephone and email (as provided below) as promptly as possible, but in no event later than 24 hours from a determination that a Cybersecurity Event has occurred. In addition to the foregoing, Provider shall notify Molina's Chief Information Security Officer (by telephone and email) within 24 hours following payment of a ransom that involves or may involve Molina Nonpublic Information.

   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

   A follow-up notification shall be provided by mail at the address indicated below.

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

6. Upon Provider's notification to Molina of a determination of a Cybersecurity Event, Provider must promptly provide Molina any documentation required and requested by Molina to complete an investigation, or, upon written request by Molina, Provider shall complete an investigation pursuant to the following requirements:
   (a) determine whether a Cybersecurity Event occurred;
   (b) assess the nature and scope of the Cybersecurity Event;
   (c) identify Nonpublic Information that may have been involved in the Cybersecurity Event; an

(d) 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 the Nonpublic Information.

7. Provider shall maintain records concerning all Cybersecurity Events for a period of at least five years from the date of the Cybersecurity Event or such longer period as required by applicable Laws and produce those records upon request of Molina.
8. Provider must provide to Molina the following 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 in the initial and subsequent notices must include as much of following information known to Provider at the time of the notification:
   (a) the date of the Cybersecurity Event;
   (b) a description of how the information was exposed, lost, stolen, or breached, including the specific roles and responsibilities of Provider, if any;
   (c) how the Cybersecurity Event was discovered;
   (d) whether any lost, stolen, or breached information has been recovered and if so, how this was done;
   (e) the identity of the source of the Cybersecurity Event;
   (f) 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;
   (g) a description of the specific types of information 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;
   (h) the period during which the Information System was compromised by the Cybersecurity Event;
   (i) the number of total Consumers in the State affected by the Cybersecurity Event;
   (j) 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;
   (k) a description of efforts being undertaken to remediate the situation which permitted the Cybersecurity Event to occur;
   (l) a copy of Provider's privacy policy and if requested by Molina, the steps that Provider will take to notify Consumers affected by the Cybersecurity Event; and
   (m) the name of a contact person who is both familiar with the Cybersecurity Event and authorized to act on behalf of Provider.
9. 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.
10. Provider shall ensure that all workforce members are provided regular Cybersecurity awareness and training.

In the event provisions of this Section conflict with provisions of any other agreement between Molina and Provider, the stricter of the conflicting provisions will control.

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