DENTAL PROVIDER MANUAL

Molina Healthcare of Mississippi Inc.
(Molina Healthcare or Molina)

Mississippi CHIP

2021

The Provider Manual is customarily updated annually but may be updated more frequently as policies or regulatory requirements change. Providers can access the most current Provider Manual at www.MolinaHealthcare.com.

Last Updated: 08/2021

Welcome

Welcome to the Molina Dental Services Provider Network (Molina Healthcare)! At Molina, we are committed to providing our members the best possible care, keeping them healthy, stable, and independent – it's our reason for being here. We are pleased to welcome you to our team.

Thank you for your participation in the delivery of quality health care services to Molina Dental Services' Mississippi CHIP 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 USA, Inc. 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.

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. All contracted Providers will receive an updated Provider Manual annually, which will be made available at www.MolinaHealthcare.com. Thank you for your active participation in the delivery of quality health care services to Molina Healthcare members.

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• Contact Information

Molina Member Services Mississippi CHIP Members (844) 282-2419 TTY/TDD: 711 Relay Monday – Friday, 7:30 a.m. – 8:00 p.m. CST, excluding observed state holidays	**Dental Claims** Molina Dental Services Claims P.O. Box 2136 Milwaukee, WI. 53201 Electronic Payer ID: SKYGN
Corrected Claims Molina Dental Services Corrected Claims P.O. Box 641 Milwaukee, WI. 53201	**Provider Appeals** Molina Dental Services Provider Appeals and Complaints P.O. Box 649 Milwaukee, WI. 53201
Prior Authorizations Molina Dental Services Authorizations P.O. Box TBD Milwaukee, WI. 53201	**Provider Web Portal/ EFT** https://pwp.skygenusasystems.com/PWP/Landing (844) 261-4587 providerportal@skygenusa.com
Credentialing Department (855) 812-9211 credentialing@skygenusa.com	**Credentialing Portal** Application Submissions https://providercap.skygenusasystems.com/CAP
Molina Dental Provider Services (844)-826-4335 MDVSProviderServices@MolinaHealthcare.com	**Fraud, Waste, and Abuse Alertline** Confidential Compliance Official Molina Healthcare, Inc. 200 Oceangate, Suite 100 Long Beach, CA 90802 **(866) 606-3889** https://MolinaHealthcare.alertline.com
Corporate Office Molina Healthcare of Mississippi, Inc. 188 East Capitol Street, Suite 700 Jackson, MS 39201	**Report Suspected Abuse and/or Neglect** Child: **(800) 222-8000** https://reportabuse.mdcps.ms.gov Adult: **(844) 437-6282**

Molina Dental Services makes every effort to maintain the accuracy of information contained in the provider manual. To report any typographical errors or discrepancies please contact Molina Dental Provider Services at ***844-826-4335*** or email at MDVSProviderServices@MolinaHealthcare.com . Molina Healthcare is not liable for any damages, directly or indirectly, that may occur from the result of a typo.

• General Information

At Molina, we are committed to providing our members the best possible care, keeping them healthy, stable, and independent – it's our reason for being here. We are pleased to welcome you to our team.

Thank you for your participation in the delivery of quality dental services to Molina Dental Services' 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 USA, Inc. 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.

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

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 dependent 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. All contracted Providers will receive an updated Provider Manual annually, which will be made available at www.MolinaHealthcare.com.

• Provider Rights and Responsibilities

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
- 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
- Inform a member of appeal status
- 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
- Inquire about re-credentialing
- Update credentialing materials, including state licensure, DEA, and professional liability insurance
- 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

• Dental Appointment Times

Appointment Types	Standard
Routine Dental Care	Within 45 calendar days
Urgent Care	Within 48 hours
After Hours Care	24 hours/day; 7 day/week availability
Specialty Care	Within 45 calendar days

• Advanced Directives

Molina complies with the advance directive requirements of the States in which the organization provides services. Responsibilities include ensuring Members receive information regarding advance directives and that contracted Providers and facilities uphold executed documents.

Advance Directives are a written choice for health care. There are three types of Advance Directives:

- **Durable Power of Attorney for Health Care**: allows an agent to be appointed to carry out health care decisions.
- **Living Will**: allows choices about withholding or withdrawing life support and accepting or refusing nutrition and/or hydration.
- **Guardian Appointment**: allows one to nominate someone to be appointed as Guardian if a court determines that a guardian is necessary.

Providers must inform adult Molina Members, 18 years old and up, of their right to make health care decisions and execute Advance Directives. It is important that Members are informed about Advance Directives.

• Member Rights and Responsibilities

This section explains the rights and responsibilities of Molina Dental Services members as written in the Mississippi CHIP Member Handbook. Mississippi law requires that health care providers or health care facilities recognize member rights while they are receiving medical care and that members respect the health care provider's or health care facility's right to expect certain behavior on the part of patients.

Member Rights

Molina Dental Services members have the right and responsibility to:

- Communicate openly and freely with Molina and their dentists and other oral health providers without fear of retribution
- Expect privacy according to HIPAA (Health Insurance Portability and Accountability Act) and other state or federal guidelines
- Be treated with respect, courtesy, and dignity
- Be treated the same as all other patients in the practice
- Be treated without discrimination based on race, religion, color, sex, national origin, or disability
- Be informed of their oral health status and examination findings

- Participate in choosing treatment options for your child
- Receive information on treatment options in a manner that they can understand, including receiving materials translated into their primary language, upon request
- Know whether treatment is medically necessary
- Know whether the treatment is experimental and give his/her consent for your child
- Refuse any treatment, except as provided by law
- Be provided with a phone number in case of an emergency
- Obtain non-covered services only when a disclosure form is signed by all parties
- Submit a complaint against a provider, without fear of retribution
- Be informed of any appeals filed on their child's behalf
- Change providers
- File grievance issues with Molina
- Access their records to review and/or change
- Members shall, to the best of their ability:
- Choose providers who participate in the Molina network
- Be honest with the providers
- Provide accurate information to the providers
- Understand the medicines they take and know what they are, what they are for, and how to take them properly, and to provide their doctor with a correct list of medications at each visit
- Provide complete information about past or present complaints/illnesses, hospitalizations, surgical procedures, and allergies
- Respect the rights, property, and environment of all providers, employees, and other patients
- Behave in a respectful manner and not be disruptive to the office
- Understand the status of their child's oral health
- Choose a mutually agreed upon treatment plan with options they believe are in the best interest of their oral health
- Have the opportunity to ask about a fee associated with any non-covered service before the service is rendered
- Use best efforts to not miss or be late for an appointment

- Cancel scheduled appointment in advance, if unable to make it
- Provide emergency contact information
- Follow home care instructions
- Call the dentist of record in the event of an emergency
- Report suspected, fraud, waste, and abuse
- Inform caregivers about any changes to Advance Directive

• Standards of Participation

Molina Healthcare of Mississippi requires that all providers participating in our programs meet any applicable state and federal laws and regulations. The following specifications must be met by all providers for participation in the Mississippi CHIP dental program:

- Current licensure by the appropriate licensing board for your specialty
- Contracting and credentialing with SKYGEN
- NPI number issued through the National Plan and Provider Enumeration System (NPPES)
- Active Mississippi Medicaid Identification Number

• Standards of Care

Background Providers are required to practice within the scope of dental practice as established by the State Board of Dentistry and State Board of Medical Licensure, as applicable. Providers are also expected to be aware of any applicable state and federal laws that impact the role as an employer, a business owner, and a healthcare professional.

A dentist or dental specialist is expected to use all relevant training, knowledge, and expertise to provide the best care for the member.

• Standards for Member Dental Records

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

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

• Recordkeeping

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.
- Dental records are stored away from patient areas and preferably locked.
- Dental 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 medical records and implementing improvement activities.

Dental records are kept confidential and there is a process for release of medical records including behavioral health care records

• Confidentiality of Records

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 medical information is released only in accordance with applicable Federal or State Law in pursuant to court orders or subpoenas.
- Maintain records and information in an accurate and timely manner.

- Ensure timely access by Members to the records and information that pertain to them.
- Abide by all Federal and State Laws regarding confidentiality and disclosure of dental records or other health and enrollment information.
- Dental Records are protected from unauthorized access.
- Access to computerized confidential information is restricted.
- Precautions are taken to prevent inadvertent or unnecessary disclosure of protected health information.
- Education and training for all staff on handling and maintaining protected health care information.

Additional information on dental records is available from your local Molina Quality department toll free at 844-826-4335. For additional information regarding HIPAA please, refer to the Compliance section of this Provider Manual

• Records Audit

To ensure timely, accurate payment to each participating provider, SKYGEN USA audits claims for completeness as they are received. This audit validates member eligibility, procedure codes, and provider identification information. A Dental Reimbursement Analyst reviews any claim conditions that would result in nonpayment. When potential problems are identified, your office may be contacted and asked to assist in resolving the issue.

• Standards for Member Contact Information and Outreach

Each office shall maintain accurate contact information for each member and shall have appropriate contact numbers for parent(s) or legal guardian, if the member is under the age of majority.

Members shall be offered appointments within the period dictated by the state and/or the specific health plan. Emergency coverage shall be in keeping with the requirements established in the Dental Provider Service Agreement, by the member's specific dental plan, and as described within this manual. No charges shall be permitted for late or broken appointments.

• Standards for Member Appointments

Each new member must have thorough medical and dental health histories completed before any treatment begins. Each new member must have a complete clinical examination and oral cancer screening. Each member must have appropriate radiographs for diagnosis and treatment based upon age and dentition. Each member must have a written treatment plan in the member record that clearly explains all necessary treatments.

- **Missed Appointments**

Participating Providers are responsible for establishing a process for documenting missed appointments. When a Member does not keep a scheduled appointment, it is to be noted in the Member's record and the Provider is to assess if a visit is still medically indicated. All efforts to notify the Member must be documented in the medical record. If a second appointment is missed, the Provider should notify Molina Provider Services.

- **Standards for Infection Control**

The dental office shall follow all appropriate federal and state guidelines, including any from OSHA and the CDC that impact clinical dental practice. The office shall perform appropriate sterilization procedures on all instruments and dental hand pieces.

Appropriate disinfection procedures for all surfaces in the treatment areas shall be performed following each patient visit. Masks and gloves must be worn while treating any member. Protective eyewear should be available for all dental healthcare personnel and patients. Members shall always be protected from all chemical and biological hazards.

Failure to use appropriate infection control procedure may result in the immediate suspension of the provider. The suspension shall remain in place from the time of notice of suspension until the provider has satisfactorily demonstrated compliance with infection control procedures to a Molina dental consultant or National Dental Director.

- **Standards for Radiation Protection**

All healthcare personnel required to use radiograph technology must be trained on the proper use of this technology prior to its use. The dental office shall have radiograph machines that have been checked by the appropriate state authorities and were confirmed to be within the standards set by statute or regulation. Members shall be given proper shielding for all radiographs, and the processing shall be done according to manufacturer's specifications. For digital radiographs, the computer system shall have the appropriate storage and back-up protection. Radiation badges to monitor the levels of radiation in the dental office shall also be worn by all personnel, if required by state law

- **Standards for Treatment Planning**

All treatment plans must be recorded and presented to the member and, if the member is a minor, to the parent. The member must be given the opportunity to accept or reject the treatment recommendations, and the member's response must be recorded in the member's record.

• Molina Provider Network

High-quality dental providers are essential to the success of the Molina Dental Services dental network, and even more importantly, essential to the health of members enrolled in its CHIP benefit plans.

While Molina Dental Services has an open recruitment strategy that encourages all providers to participate, all dentists seeking acceptance into the network must undergo a qualification process, which includes a background check, licensing verification, and primary source verification of professional credentials. Molina Dental Services has partnered with SKYGEN USA to provide credentialing services for its provider network.

Dentists (DDS or DMD) who are interested in participating with the Molina Dental Services provider network are invited to apply and submit a credentialing application for review by SKYGEN USA's Credentialing Committee. We do not differentiate or discriminate in the treatment of providers seeking credentialing on the basis of race, ethnicity, gender, age, national origin, or religion.

Providers must be credentialed before participating in the Molina Dental Services network. Providers accepted into the Molina Healthcare are re-credentialed every 36 months.

Molina may not enter into a Provider agreement that prohibits the Provider from contracting with another Payer or that prohibits or penalizes Molina for contracting with other Providers. Molina may not require Providers who agree to participate in the MississippiCAN Program to contract with Molina's other lines of business.

• Quality

To ensure that the highest quality services are consistently provided to our members and that providers continue to perform only those services that are necessary for the welfare of the members, Molina maintains an approach to quality that includes three components:

- Quality standards
- Quality assurance
- Utilization review

We welcome participation from you and other network providers who seek to review and/or contribute to either of these efforts.

Participating network providers are expected to agree, respond to, and/or otherwise comply with Molina Quality Assurance Program as it relates to quality assurance, utilization review, and member grievances. Network providers may also be subject to the quality assurance, utilization review, and grievance programs of the health plan for which SKYGEN provides benefit administration

• Quality Assurance Program

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.

• National Dental Director

The Molina National Dental Director is your local contact as a dental professional. Your National Dental Director represents you and other participating network dentists and specialists in our role as administrator of dental programs in the state. This includes participating in the local dental association and its component societies.

The National Dental Director is available for discussion and consultation concerning issues of importance to you and other participating network dentists and dental specialists.

• Office 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.

• After-Hours Accessibility

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, 7 days a week. This access may be through an answering service or a recorded message after office hours. The service or recorded message should instruct Members with an Emergency to hang-up and call 911 or go immediately to the nearest emergency room.

• Emergency Care

According to Mississippi Code Ann. § 43-13-121, Medicaid and CHIP define a dental emergency as a condition that requires treatment and that causes pain and/or infection of the dental apparatus and/or contiguous structures.

Mississippi CHIP provides palliative dental services for non-EPSDT eligible beneficiaries. Palliative services are defined as the treatment of symptoms without treating the underlying cause, and frequently refer to treatment of pain without further treatment. Emergency care for the relief of pain and infection, emergency extractions and dental care related to the treatment of an acute medical or surgical condition are covered. Palliative treatment may be provided for relief of pain when no other CHIP services are provided.

Palliative (emergency) treatment cannot be billed with another therapeutic (definitive) procedure but can be billed with diagnostic procedures. Palliative (emergency) treatment of dental pain - minor procedure must be authorized prior to billing. Authorization is a condition for reimbursement and is not a guarantee of payment. Authorization requests may be submitted prior to or within thirty (30) days of the date of service. The authorization request must be submitted to the Utilization Management/Quality Improvement Organization (UM/QIO) along with the appropriate documentation. The beneficiary cannot be billed if the dental provider chooses to render services for palliative (emergency) treatment of dental pain prior to submitting an authorization request or if approval is not given. The UM/QIO will make the determination of medical necessity using the criteria set forth by DOM, and a TAN will be assigned. If a claim is submitted without a TAN, no reimbursement will be paid. Retroactive authorization after the thirty (30) day period will be allowed only in cases where beneficiary was approved for retroactive eligibility and is not applicable to any other situation. All terms of DOM's reimbursement and coverage criteria are applicable.

A dental emergency is a situation that cannot be treated simply by medication and that, left untreated, could affect the member's health or the stability of his/her dentition. Emergency services do not include:

- Prophylaxis, fluoride, and routine examinations
- Routine restorations, including stainless steel and composite crowns
- Dentures, partial dentures, and denture relines and repair
- Extraction of asymptomatic teeth, including third molars

All Molina provider offices are responsible for the effective response to and treatment of dental emergencies of patients on record. Furthermore, Molina requires that sufficient access be available to ensure that members can receive necessary emergency services in the office rather than in a hospital emergency room.

Molina shall permit treatment of all dental services necessary to address a dental emergency for a member without prior authorization. However, elective dental services not necessary for relieving pain and/or preventing immediate damage to dentition default to the standard prior authorization process.

To confirm whether the situation is a true emergency, the dentist must speak with the member or member's authorized representative to assess the member's problem and take the necessary actions. If it is determined by the provider and the member that it is a true dental emergency, then a provider may either:

- render services in the dental office to treat the emergency, or
- assist the patient in obtaining proper dental care from another dentist or specialist or a hospital emergency room, if the condition warrants emergency room treatment

In the case of a dental emergency or urgent dental condition, you shall make every effort to see the member immediately and within 24 hours.
If the member calls with an emergency before noon on a business day, the member should receive a response that day, if possible.
If the member calls with an emergency after noon on a business day, the member should receive a response that day, if possible, but no later than the following business day.
If the member calls with an emergency during non-business hours, your office must have an answering service or alternate number to reach the on-call provider.

• Waiver of Prior Authorization for Emergencies

Emergent and urgent care Services are covered by Molina without an authorization. This includes non-contracted Providers inside or outside of Molina's service area.

• Referrals

When a Provider determines medically necessary services that are beyond the scope of the dentist's practice or it is necessary to consult or obtain services from other in-network dental specialists unless the situation is one involving the delivery of Emergency Services. Information is to be exchanged between the dentist and specialist to coordinate care of the patient to ensure continuity of care. Providers need to document referrals that are made in the patient's medical record. Documentation needs to include the specialty, services requested, and diagnosis for which the referral is being made.

• Specialist Treatment

A patient can be referred directly to any dental specialist contracted with Molina Dental Services without authorization from SKYGEN USA. The dental specialist is responsible for obtaining prior authorization for services

Please refer to the Molina Dental Services Provider Online Directory for a listing of Molina Dental Services participating providers. Visit http://www.molinahealthcare.com and click "Find a Provider". Members may also call Member Services for assistance.

• Transfer of Care

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

If a successor dentist cannot get the required radiographs from the dentist from whom care is being transferred within 10 business days, the successor dentist should contact Provider Services. We will notify the originating dentist or specialist in writing within 30 calendar days that the successor dentist or specialist did not receive diagnostic quality radiographs. In this notice, we will notify the member's originating dentist that SKYGEN will charge them for radiographs that the successor dentist or specialist must retake for appropriate care if:

- The originating dentist or specialist has provided radiographs that were not of diagnostic quality as determined by Molina's clinical staff

OR

- Radiographs were not submitted to the successor dentist or specialist within 10 business days following a request for the radiographs

If the successor dentist or specialist deems that radiographs do not need to be repeated, a narrative must be included to explain the dental conditions found upon examination.

• Continuity of Care

Continuity of care refers to those circumstances when a dental procedure requires more than one office visit, and the member changes insurance providers between procedure visits. This typically applies in the case of orthodontic treatment. Please refer to the addendum to the document for details on the state or plan requirements regarding continuity of care for orthodontic treatment. Continuity of care standards do not apply in the case of a treatment plan being transitioned between providers

• Locum Tenens

Locum tenens arrangements are made between the providers whereas one provider will temporarily replace another provider for a period due to medical leave or vacation.

Locum tenens should not be used to temporarily replace a non-credentialed or disciplined provider until they are restored to the network.

A completed Locum Tenens form from the practice owner must be submitted to SKYGEN in advance of the use of a locum tenens provider. If locum tenens is used due to the incapacitation or death of a participating provider, then the letter must be signed by the executor of the estate. The locum tenens is good for 60 continuous calendar days within a 12-month period.

The locum tenens provider may not render services until the locum tenens relationship is approved by SKYGEN. To secure approval, we first affirm that the locum tenens provider has a valid NPI number and a valid state Medicaid number. Next, a member of our credentialing department will run two searches to determine whether there are any sanctions against the provider. Once these reports clear, the form is sent to a dental director for approval. From there, the locum tenens request goes to the credentialing committee for review and approval.

When approved, the participating SKYGEN provider can submit claims to receive payment for the covered benefits for services provided by the locum tenens provider. The locum tenens provider must hold a valid professional license within their practicing state. The existing provider's malpractice insurance is used to cover the locum tenens provider.

Indiscriminate billing under one provider's name or number without regard to the specific circumstances of rendering of the services is specifically prohibited and is grounds for recoupment or claim denial. Abuse of the locum tenens relationship may result in discipline of the billing provider up to and including termination of the provider's agreement. The common practice of one provider covering for another will not be construed as a violation of this section when the covering provider is on call and provides emergency or unscheduled services for a period not to exceed 60 continuous calendar days during a 12-month period.

• Clinical Coordination

Oral health care is an essential component of overall health. In many cases, the provision of good oral health care may require coordination between dentists and their patient's primary care physicians or facilities. It is important that your members' medical records include any detail about health conditions that may impact their oral health, along with the names and contact information for your members' primary physician and/or facility. This information will help you communicate with your members' treatment teams in the event of a medical issue that impacts their oral health and hygiene. You might also have occasion to reach to a member's primary care team if your care identifies potential medical concerns that might be better addressed outside of the dental office.

• Member Outreach

The CMS comprehensive and preventive child health program for individuals under the age of 21 is called Early and Periodic Screening, Diagnostic, and Treatment (EPSDT requires that every Molina network provider has documented member outreach policy and procedures to help ensure that members receive oral health services on a regular schedule. CMS specifically requires the following:

- For members of record (under age 21): Providers must attempt to make contact at least two times per year.
- For adult members of record (age 21 and over): Providers must attempt to make contact at least one time per year.

The outreach attempts must be documented in the member's medical record.

• Members with Special Needs

Certain patients with special needs require additional consideration for clinical treatment. Some patients with special needs may be able to be treated in a dental office, while others may require treatment in a facility where anesthesia can be administered. If you have a member with special needs who cannot be treated in your office, please reach out to a pediatric dentist or a dentist who routinely treats patients with special needs to discuss potential transfer of care.

If your office can treat patients with special needs, please be sure to document the names and contact information for people who are authorized to give permission for treatment for the member, if relevant.

• EPSDT (Early and Periodic Screening, Diagnostic, and Treatment)

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 Section1905 ®(5) 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.

• Patient Safety and Adverse Incidents

If a sentinel event (an unexpected, non-traumatic occurrence that causes a member's death) or an adverse incident (serious incident, therapeutic misadventure, iatrogenic injuries, or other adverse occurrences directly associated with care or service provided) occurs, you must report this to Molina immediately using the Provider Services number provided herein.

- **Enrollment in CHIP Programs**

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

- **Eligibility Verifications and Eligibility Effective Date**

The State of Mississippi through DOM determines eligibility for the CHIP 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.

Each Member shall be enrolled on the first calendar day of the first calendar month and is automatically renewed for twelve (12) months unless the Member becomes ineligible for the program and is disenrolled.

- **Credentialing and Re-Credentialing**

Molina Dental Services credentialing process follows NCQA (National Committee for Quality Assurance) credentialing guidelines for dentistry. All credentialing applications must satisfy NCQA and/or URAC standards of credentialing as they apply to dental services. Molina Dental Services has the sole right to determine which dentists it accepts and continues to allow as participating providers in the Molina Dental Services network.

In reviewing an application, the Credentialing Committee may request further information from the applicant. The Credentialing Committee may postpone a decision pending the outcome of an investigation of the applicant by a hospital, licensing board, government agency, institution, or any other organization, or the Committee may recommend other actions it deems appropriate. SKYGEN USA notifies Molina Dental Services of all disciplinary actions that involve participating providers.

Recredentialing is required at least every 36 months, per NCQA guidelines. Six months before you are due for recredentialing SKYGEN USA will notify you of your upcoming recredentialing due date. Our notification letter will include instructions for how to complete the recredentialing process.

Any acceptance of an applicant is conditioned upon the applicant's execution of a participation agreement with Molina Dental Services provider network. If you have questions about the credentialing process or need assistance, call Molina Dental Provider Network Services at: (855) 812-9211

• Credentialing Requirements

Dentists are enrolled in our provider network if they:

- Continuously meet the credentialing standards based upon the National Committee for Quality Assurance (NCQA) guidelines, as applicable
- Agree to adhere to the administrative procedures of both Molina and its partners (e.g., Health Maintenance Organizations [HMO] and insurance companies)

• Credentialing Details

For each individual dentist or facility who shall receive payment for services rendered to members, the following contracting paperwork is required:

- Completed and signed Molina Dental Provider Agreement
- W-9
- Disclosure of ownership form
- ADA survey regarding the accessibility of your office for members with special needs or hearing impairments, in addition to details on your practice's ability to treat developmentally disabled patients.
- Copy of IRS approval of Tax Identification Number letter

For each dentist in the office who will be rendering services to members, the following credentialing paperwork is required:

- Completed and signed Molina or state-specific application, as appropriate, including work history
- Copy of current state license
- Copy of current DEA or State CDS certificate, if applicable
- Evidence of current professional liability insurance ($1 million/$3 million minimum limits required for all CMS providers) or business insurance for dispensing providers without professional liability coverage, except where participating in a state Patient Compensation Fund, in which case the certificate of insurance must indicate required underlying insurance limits and fund participation
- Signed credentialing release and questionnaire/attestation pages
- Documentation explaining any affirmative answers from the attestation page
- Evidence of board certification, if applicable

- NPI number
- Disclosure of any of provider's employees who have been debarred or excluded from any federal or state healthcare programs
- Disclosure of criminal convictions by an employee of the provider if related to federal healthcare programs
- The provider's Medicaid identification number(s)

Upon receipt of an initial network application, the SKYGEN Credentialing Department will mail the provider a letter confirming receipt of the application. In the submission, all gaps must be explained, all attestation questions must be completed, a Credentials Release of Verification must be included, and all affirmative responses must include a written explanation.

SKYGEN performs primary source verification using NCQA-approved sources. We complete a credentialing checklist for each provider. For each element, this includes:

- Source used
- Date of verification
- Signature or initials of the person who verified the information
- Report date, if applicable

After the primary source verifications are completed, the provider's credentialing file is presented to the Molina Credentialing Committee for review. SKYGEN will provide written notification to the provider within 60 calendar days of the Committee's decision.

Both the credentialing and re-credentialing processes include the review of the exclusions list produced by the Office of Inspector General (OIG), Government Services Administration, and other state and federal bodies. Providers appearing on one of these lists MAY NOT participate in any government program (i.e., Medicaid and Medicare).

If a provider is excluded from our network, a copy of the report will be placed in the provider's file.

- **Incomplete Submissions**

We will contact your office by phone, fax, or email to discuss and request the missing information. This request will include the name and contact information for the SKYGEN Credentialing Specialist making the request. Review of the application is suspended until all information is received.

- **Correcting Enrollment Information**

If material is different from that supplied by the provider in the application identified during the verification process, SKYGEN will continuously attempt to secure the requested information. On credentialing applications, we will typically halt work if we cannot secure the requested materials by day 30. On re-credentialing applications, we will halt work if we cannot secure requested materials within 90 days of the initial request.

- **Re-Credentialing Details**

Providers must show they:

- Satisfy the NCQA credentialing requirements met during the time of initial credentialing

- Are not listed in any claim or utilization files indicating a pattern of inappropriate billing or utilization

- Are free of any substantiated member complaints regarding quality of care or quality of service issues

- Remain in good standing with federal and state regulatory bodies

If a provider does not satisfy one or more of these criteria, our Credentialing team flags the provider for a detailed review. The Credentialing Committee will determine if the issues rise to a level of concern that disqualifies the provider from treating Molina members and vote to terminate the provider from the network.

- **Credentialing Timelines**

Applications for credentialing and re-credentialing must be processed and either approved or denied within the timeframe specified by the state authority from the date of receipt of all required information. Providers who are accepted into the Molina network during initial credentialing will receive welcome letters within 30 business days from their approval date.

- **Credentialing Denials**

The SKYGEN USA Credentialing Committee has the discretion and authority to accept an application without restrictions. However, if the Credentialing Committee determines an application should be accepted with restriction or declined, the Committee recommends the appropriate action to the Executive Subcommittee for approval and offers the applicant an opportunity to request a reconsideration review or appeal the recommendation.

• Credentialing Denial Appeals Process

If the applicant accepts the opportunity for a reconsideration review, the Credentialing Committee reviews all original documents, as well as any additional information submitted for the reconsideration review. If an applicant appeals the Credentialing Committee's recommendation, a Peer Review Committee completes the review.

Molina Dental Services retains ultimate responsibility for the credentialing process and final credentialing decisions.

To appeal a decision, send a request for a reconsideration review or appeal in writing within 30 days of receiving an adverse recommendation to:

Molina Dental Services Credentialing Appeals
PO Box 2059
Milwaukee, WI 53201

• Post-Credentialing

Participating providers agree to bill SKYGEN for only those services rendered by them personally, or under their direct supervision by salaried employees or assistants duly certified pursuant to state law. Direct supervision includes, at a minimum, periodic review of the patient's records and immediate availability of the provider to confer with the salaried employee performing the service regarding a member's condition. This does not mean that the enrolled provider must be present in the same room; however, the enrolled provider must be present at the site where services are rendered, at the time they are performed (e.g., office suite, hospital, or clinic).

Note: Under no circumstances may a provider bill for services rendered by another provider. Services performed by non-credentialed providers in a group practice are not covered.

• Provider Data Maintenance

Upon acceptance into the network, authorized data entry personnel enter all your application and relevant practice information into the appropriate system(s). Documents associated with the application will be maintained in your file with the most current information on top; this data shall be retained securely. In lieu of retaining your paperwork, scanned images may be saved to your folder on the secure, internal Molina network. All records shall be retained for a minimum of 10 years following termination of the provider from the network. Documentation stored on file includes:

- Completed Dental Provider Service Agreement
- Completed provider application

- Credentialing Committee approval form
- Verification documents
- Copies of provider's credentials and certificate(s)
- Certificate of Insurance and any reports regarding claims against the provider
- Information regarding any sanctions or suits against the provider
- Disclosure of ownership form, if applicable

• Updating Information

UponIt is important for providers to ensure Molina Healthcare has accurate practice and business information. Accurate information allows us to better support and serve our provider network and members. 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, member assignments and referrals. Additionally, current information is critical for timely and accurate claims processing. Providers must validate the Provider Online Directory (POD) information at least quarterly for correctness and completeness. Providers must notify Molina in writing at least thirty (30) days in advance, when possible, of changes such as, but not limited to:

- Change in office location(s), office hours, phone, fax, or email
- Addition or closure of office location(s)
- Addition or termination of a Provider (within an existing clinic/practice)
- Change in Tax ID and/or NPI
- Opening or closing your practice to new patients
- Any other information that may impact member access to care

Please visit our Provider Online Directory at www.MolinaHealthcare.com/ProviderSearch to validate your information. Please notify your Provider Service Representative or complete the Provider Information Update Form found on our provider website under the "Forms" tab if your information needs to be updated or corrected.

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

Molina Dental Services 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. Providers are required to provide timely responses to such communications.

• Verifying Eligibility

To quickly verify member eligibility, do one of the following:

- Log on to Provider Web Portal: pwp.skygenusasystems.com
- Call Member Services: (844) 809-8438

Eligibility information received from the Provider Web Portal is the same information you would receive by calling Member Services. However, the Provider Web Portal is available 24 hours a day, 7 days a week- giving you quick access to information without requiring you to wait for an available Member Services representative during business hours.

• SKYGEN Provider Web Portal

Our Provider Web Portal offers quick access to easy-to-use self-service tools for managing daily administration tasks. The Provider Web Portal offers providers many benefits including:

- Lower administrative and participation costs.
- Faster payment through streamlined claim and authorization submissions.
- Real-time member eligibility verification.
- Immediate access to member information, claim and authorization history, and payment records at any time, 24 hours a day, 7 days a week.

Get Started! For help getting started with the Provider Web Portal, training or questions about the portal; contact the SKYGEN USA Electronic Outreach Team: 844-621-4587

A web browser, Internet connection, and a valid user ID and password are required for online access. From the Provider Web Portal, providers and authorized office staff can log in for secure access anytime from anywhere and handle a variety of day-to-day tasks, including:

- Verify member eligibility and review patient treatment history.

- Set up office appointment schedules that automatically verify eligibility and pre-populate claim forms for online submission.
- Submit claims and authorizations using pre-populated electronic forms and data entry shortcuts.
- Step through clinical guidelines as part of submitting authorizations for a quick indication of whether a service request is likely to be approved.
- Attach and securely send supporting documents, such as digital X-rays, EOBs, and treatment plans, for no extra charge.
- Generate a quick pricing estimate before submitting a claim.
- Check the real-time status of in-process claims and authorizations and review historical payment records.
- Review provider clinical profiling data relative to your peers.
- Download and print Provider Manuals, remittance reports, and more.

Online help is available from every page of the Provider Web Portal, offering quick answers and step-by-step instructions.

Provider Web Portal Registration

The Provider Web Portal was designed to help you keep your administrative costs low, give you immediate access to real-time information, and make it fast and easy to submit claims and authorizations.

If you don't find answers to your questions, or if want personalized training for yourself or your office staff, call the SKYGEN USA Electronic Outreach Team for assistance: 844-621-4587.

• Provider Services

Please contact Molina Dental Provider Services for any updates, changes, or inquiries at MDVSProviderSerivces@molinahealthcare.com

• Provider and Practice Support Tools

The strength of our service depends on the strength of the support we provide to you and your office. The two primary ways we support your office are by utilizing the SKYGEN Provider Web Portal and the Molina Healthcare Website at www.molinahealthcare.com

Background

• Provider Education

Molina offers educational opportunities in cultural competency concepts for Providers, their staff. Molina conducts Provider training during Provider orientation with annual reinforcement training offered through the Provider Service Representatives.

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

1. Provider written communications and resource materials.
3. Telephonic provider training.
4. Integration of cultural competency concepts and nondiscrimination of service delivery into Provider communications.

• 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 USA 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 2012 ADA claim form with appropriate ICD-9/ICD-10 and CDT codes for the services rendered and as defined by MCL 400.111i. or submission of claim through the SKYGEN USA provider portal

• Timely Filing

Provider shall promptly submit to SKYGEN for Covered Services rendered to Members. All Claims shall be submitted in a form acceptable to and approved by Molina and shall include all dental records pertaining to the Claim if requested by Molina or otherwise required by Molina’s policies and procedures.

Claims must be submitted by 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 Submission

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

- Provider Web Portal, pwp.skygenusasystems.com
- Electronic submission via clearinghouse, Payer ID: SKYGN
- HIPAA-compliant 837D file
- Paper 2012 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.

• Claims Review Process

Molina Dental Services Utilization Management evaluates claims submissions in such areas as:

- Diagnostic and preventive treatment
- Patient treatment planning and sequencing
- Types of treatment
- Treatment outcomes
- Treatment cost effectiveness

- **Checking Claim Status**

Providers may check status of a submitted claim via SKYGEN Provider Portal. Providers are encouraged to follow up on claims submissions within 30 calendar days after claim submission. If the claim has not been received, providers should contact SKYGEN. Claims being investigated for possible fraud, waste, or abuse or those pending medical necessity review are not clean claims.

Note: Members cannot be balance-billed for any charges or penalties incurred as a result of late or incorrect submissions.

- **Claims Payment**

The SKYGEN USA 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 pwp.skygenusasystems.com

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

- **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.

- **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

- **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 from pwp.skygenusasystems.com.)

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 USA Web Portal Team: 844-621-4587

- **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.

- **Utilization Management (UM)**

To ensure fair and appropriate reimbursement, Molina Dental Services Utilization Management philosophy recognizes the relationships between the dentist's treatment planning, treatment costs, and outcomes. The dynamics of these relationships are typically influenced by community practice patterns. With this in mind, our Utilization Management guidelines are designed to ensure health care dollars are distributed fairly and appropriately, as defined by the regionally based community practice patterns of local dentists and their peers. All Utilization Management analysis, evaluations, and outcomes are related to these community practice patterns. Molina Dental Services recognizes individual dentist variance within these patterns among a community of dentists and accounts for such variance. To ensure fair comparisons within peer groups, our Utilization Management evaluates specialty dentists as a separate group and not with general dentists, since the types and nature of treatment may differ

- **Wait Time Review**

If a member complains that wait times in a provider's office were excessive, Molina is required to notify the provider about the complaint. Typically, this comes through our complaints and grievances process. Our provider relations team may be engaged to do one-on-one education with the provider officer.

- **Covered Services**

SKYGEN will cover services within the program guidelines when the treatment has appropriate diagnoses and when medically necessary. Coverage limitations and reimbursement guidelines specific to this plan are outlined in the Benefit Grid located on the provider portal.

- **Prior Authorizations**

Molina Dental Services has specific utilization criteria, as well as a prior authorization review process, to manage the utilization of services. Whether prior authorization is required for a particular service, and whether supporting documentation is also required.

Nonemergency services requiring prior authorization should not be started until the authorization request is reviewed and approved. Nonemergency treatment started prior to the determination of coverage will be performed at the financial risk of the dental office. If coverage is denied, the treating dentist will be financially responsible and may not balance bill the member or Molina Dental Services.

Molina Dental Services must make a decision on a request for prior authorization within 2 business days from the date request is received, provided all information is complete. If you indicate, or we determine, that following this time frame could seriously jeopardize the member's life or health, or the ability to attain, maintain, or regain maximum function, we will make an expedited authorization decision and provide notice of our decision within 72 hours. Prior authorizations will be honored for 365 days from the date

they are issued. An authorization does not guarantee payment. The member must be eligible for benefits at the time services are provided.

Dental reviewers and licensed dental consultants approve or deny authorization requests based on whether the item or service is medically necessary, whether a less expensive service would adequately meet the member's needs, and whether the proposed item or service conforms to commonly accepted standards in the dental community.

Prior Authorization of Dental Treatment in an Outpatient Hospital or Ambulatory Surgical Center setting must be submitted as follows:

- Providers should submit request using ADA code D9999 with the required Molina Mississippi Hospital Worksheet and all services that are requested to be performed on the ADA Claim form.
    - Prior Authorization should be submitted on the SYGEN Provider
    - Mississippi Hospital Worksheet

- If **approved**, SKYGEN is to submit the Molina Mississippi Hospital Worksheet to Molina including the SKYGEN dental approval to review and determine the approval of the Outpatient Hospital or Ambulatory Surgical Center facility.
    - Provider will notify facility of approval. Facility will request prior authorization from Molina.
    - member.
- If **denied**, the provider and member have options listed for the appeals process on the notification received.

Please refer to the Clinical Criteria section in this provider manual for dental procedures that require prior authorization.

- **Expedited Prior Authorization**

Molina Dental Services will provide notice of decision for expedited authorizations for services no later than 24 hours after receipt.

• Post Treatment Review

Post-treatment review is made available to providers who are unable to get the services reviewed and approved prior to performing the services. A narrative of why the service was unable to be reviewed prior to being performed should be submitted with the request.

The post-treatment review process shall not retrospectively deny coverage for services when prior approval has been given, unless the approval was based on fraudulent, materially inaccurate, or misrepresented information submitted by the provider, member, or member's authorized representative

If a clinician determines that the treatment was inappropriate or excessive based upon the documentation received, the claim will not be paid. If there are relevant, extenuating circumstances, a narrative must be included with the claim.

• Non-Covered Services

A provider may bill a member for non-covered services if the provider obtains a Non-Covered Services agreement from the member prior to rendering such service which indicates:

• The services to be provided.

• Molina Dental Services will not pay for or be liable for these services.

• Member will be financially liable for such services.

The Non-Covered Services agreement can be found on the Provider Web Portal within the Documents tab: pwp.skygenusasystems.com

• Fraud, Waste, and Abuse

Molina Healthcare's Fraud, Waste and Abuse Plan benefits Molina Dental Services, its employees, members, providers, payers and regulators by increasing efficiency, reducing waste, and improving the quality of services. Molina Dental Services takes the prevention, detection, and investigation of fraud, waste and abuse seriously, and complies with state and federal laws. Molina Dental Services investigates all suspected cases of fraud, waste and abuse and promptly reports to government agencies when appropriate. Molina Dental Services takes the appropriate disciplinary action, including but not limited to, termination of employment, termination of provider status, and/or termination of membership.

Definitions Fraud, waste, and abuse are defined as:

Fraud. Fraud is intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit for them or

some other person. It includes any act that constitutes fraud under applicable federal or state law.

Waste. Waste is 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. For example: the attempt to obtain reimbursement for items or services where there was no intent to deceive or misrepresent, however the outcome of poor or inefficient billing methods (e.g. coding) causes unnecessary costs to the Medicaid and Medicare-Medicaid programs.

Abuse. Abuse is defined as provider practices that are inconsistent with sound fiscal, business, or medical practices, and result in unnecessary cost to the Medicaid and Medicare-Medicaid program 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 the Medicaid and Medicare-Medicaid program.

• Reporting Fraud, Waste, and Abuse

If you suspect cases of fraud, waste, or abuse, you must report it by contacting the Molina Dental Services 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, 7 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 Dental Services 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 Dental Services AlertLine can be reached toll free at 866-606-3889 or you may use the website to make a report at any time at https://MolinaHealthcare.AlertLine.com.

• Federal Laws and Statutes Affecting Providers

The Federal False Claims Act allows everyday people to bring “whistleblower” lawsuits on behalf of the government-knows as “qui tam” suits-against businesses or other individuals that defraud the government through programs, agencies, or contracts. Using the False Claims Act, you can help reduce fraud against the federal government. The False Claims Act, also called the “Lincoln Law” imposes liability on persons and companies who defraud governmental programs.

Providers should also be aware of the anti-kickback statute (42 U.S.C. Sec. 1320a-7b) and the physician self-referral law (42 U.S.C. Sec. 1395nn). Violations of these rules

could result in claims not being paid, monetary penalties, exclusion from participating in medical assistance, and Medicare Advantage programs or imprisonment.

CMS requires that Avēsis and providers who treat medical assistance and/or Medicare Advantage members check two federal exclusions databases and a state database for the state in which the provider is rendering service prior to the start of an employee or consultant's employment and monthly thereafter. The federal databases are Office of the Inspector General (OIG), List of Excluded Individuals and Entities (LEIE), the Government Services Administration, and System for Award Management (SAM).

Most states maintain exclusions that must also be screened prior to employment and monthly thereafter.

State of Mississippi Laws and Regulations

The State of Mississippi does not have its own False Claims Act, but has the following laws regarding fraudulent and false claims:

Mississippi Code Ann. §§ 43-13-209, -211, -213, -215 & -225

- A fine up to three times the Government's damages
- A civil fine ranging from $5,000 to $11,000 for each false or fraudulent claim submitted
- The costs of the civil action against the entity that submitted the false claims. Mississippi code Ann. § 43-13-215 (2013)

The Medicaid Fraud Control Act – A person who violates any provision of Sections 43-13-205 through 43-13-213 shall be guilty of a felony, and, upon conviction thereof, shall be punished by imprisonment for not more than five years, or by a fine of not more than Fifty Thousand Dollars ($50,000), or by both. Sentences imposed for convictions of separate offenses under this article may run consecutively.

The complete set of Mississippi laws governing Medicaid fraud and abuse may be found in Mississippi Code Ann. §§ 43-13-2014 through 233.

Suspected Child Abuse or Neglect

Cases of suspected or adult abuse or neglect might be uncovered routine examinations.

Child abuse is the infliction of injury, sexual abuse, unreasonable confinement, intimidation, or punishment that results in physical pain or injury, including mental injury. Abuse is an act of commission.

If suspected cases are discovered, an oral report should be made immediately by telephone or otherwise, to a representative of the local Department of Social Services office or by calling the Mississippi Department of Child Protection Services Hotline at (800) 222-8000 or the Mississippi Department of Human Services Adult Protective

Services at (800) 227-7308. For more information on reporting child abuse, please refer to Section 43-21-105 and Section 43-21-353 of the Mississippi Code. You can also report child abuse online at https://reportabuse.mdcps.ms.gov/.

- **Termination of Provider Participation**

Molina and provider(s) have the right to terminate a Molina Dental Provider Service Agreement at any time, provided written notice is supplied within the timelines set by your provider contract.

- **Voluntary Termination**

If you or your office no longer wishes to see our members, you must notify us in writing and agree to comply with the continuity of care policy for the plan for which you provide services. Generally, you may close your practice to our members provided you gave us written notice.

- **Involuntary Termination**

If you Molina may terminate your agreement at any time for immediate cause, which includes, but is not limited to:

- The failure of a provider to maintain or obtain a license to practice medicine in the state where services are provided
- The failure of a provider to obtain and/or maintain hospital privileges at a hospital or contracted ambulatory healthcare facility
- The cancellation of a provider's coverage or insurability under his/her professional liability insurance
- A provider’s conviction of a felony
- Unprofessional conduct by or on behalf of a provider as defined by the laws of the state where services are rendered
- A filing of bankruptcy (whether voluntary or involuntary) by a provider, declaration of insolvency by a provider, or the appointment of a receiver or conservator of a provider’s assets

If conditions arise that cause Molina to issue a notice of termination, in most cases the provider shall be given the opportunity to mediate the issue within time frames set forth in the contract. If the provider fails to implement a satisfactory cure within the required time frame, his/her network participation will be terminated. There may be instances

where a provider's agreement with Molina may be terminated immediately. Conditions that may lead to this action include, but are not limited to, situations where:

- A provider breaches a material term of his/her agreement or the provider manual, including, without limitation, the representations and warranties or responsibilities defined in these documents and in such a way that the problem cannot be mediated
- The provider poses an imminent danger to Molina members or the public health, safety, and welfare
- The provider is charged with a felony or a crime of moral turpitude
- The provider is convicted of an offense related to Medicare or Medicaid
- The provider fails to satisfy the credentialing or re-credentialing program requirements
- The provider ceases participation in Molina network through non-renewal of the credentialing application or denial of approval for participation

Participating providers shall be automatically unenrolled from the Molina network upon their death or retirement or if their license expires, lapses, or is inactivated by the applicable state licensing board.

- **Termination Appeals**

Providers terminated for a quality issue have appeal rights. The notice of termination will provide the appeal rights and method and timeframe for requesting an appeal.

Upon receipt of written notification of appeal stating the grounds for the appeal, Molina will convene a hearing panel to review the appropriate information. The decision will be either confirmed or overturned. If the original decision is overturned, the contracting entity and/or participating provider will be reinstated. If the original decision is confirmed, the contracting entity and/or participating provider shall continue to have the right to dispute resolution as outlined in their contract.

Providers terminated for a reason other than a quality issue do not have provider rights. A provider may reapply for inclusion in the network.

• Suspensions

Molina may, in its sole and absolute discretion, suspend a provider and/or dental office's participation in the network if any of the following were to occur:

- Billing or claims submission issues occurring with such frequency that Molina, in its sole and absolute discretion, determines the provider and/or office should be suspended pending further investigation and the resolution of said issues

- Breach of contract by the provider or office, until what caused the breach has been cured

- Other concerns that Molina in its sole discretion believes may have a negative impact to member health and safety

• Complaints, Grievances, and Appeals

Background Molina Dental Services are committed to providing high-quality dental services to all members.

As part of that commitment, we work to ensure all members have every opportunity to exercise their rights to a fair and timely resolution to any complaints, grievances, and appeals. Our procedures for handling and resolving complaints, grievances, and appeals are designed to:

- Ensure members and providers receive a fair, just, and speedy resolution by working cooperatively with providers and supplying any documentation related to the member grievance and/or appeal, upon request.

- Treat providers and members with dignity and respect at all levels of the grievances and appeals resolution process.

- Inform providers of their full rights as they relate to grievance and appeal resolutions, including their rights of appeal at each step in the process.

- Resolve provider grievances and appeals in a satisfactory and acceptable manner within the Molina Dental Services protocol.

- Comply with all regulatory guidelines and policies with respect to member complaints, grievances, and appeals.

- Efficiently monitor the resolution of provider-related grievances, to allow for tracking and identifying unacceptable patterns of care over time.

- **Inquiries**

Calls are classified as an inquiry when the member, authorized representative, state, or others ask a question or describe an issue without overt dissatisfaction.

- **Complaints**

According to State of Mississippi, a complaint is an expression of dissatisfaction (verbally or written) that results in either an Appeal or a Grievance, regardless of whether identified by the member as a "complaint," received by any employee of the contractor orally or in writing that is of a less serious or formal nature that is resolved within one (1) business day of receipt. It includes but is not limited to: the quality of care or services provided, failure to respect the member's rights, or a dispute over an extension of time proposed by the State of Mississippi to make an authorized decision.

Any complaint not resolved within one calendar day shall be treated as a grievance. A complaint includes, but is not limited to, inquiries, matters, misunderstandings, or misinformation that can be promptly resolved by clearing up the misunderstanding or providing accurate information.

- **Claim Disputes and Reconsideration**

Providers disputing a Claim previously adjudicated must request such action within 90 days of Molina's original remittance advice date. Regardless of type of denial/dispute (service denied, incorrect payment, administrative, etc.); all Claim disputes must be submitted on the Molina Claims Request for Reconsideration Form (CRRF) found on Provider website. The form must be filled out completely in order to be processed.

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

- Any documentation to support the adjustment and a copy of the Authorization form (if applicable) must accompany the reconsideration request.

- The Claim number clearly marked on all supporting documents

To request a reconsideration of a claim's denial, a provider may write to:
Molina Dental Services
PO Box 649
Milwaukee, WI. 53201

• Grievances

A Provider may file a grievance orally or in writing. An expression of dissatisfaction, regardless of whether identified by the Provider as a “Grievance”, received by Molina about any matter or aspect of Molina or its operation, other than a Molina’s Adverse Benefit Determination.

Grievances may be filed within thirty (30) calendar days from the date of event causing dissatisfaction. A written acknowledgement letter must be sent within five (5) calendar days of receipt of a Grievance. Grievances must be resolved as expeditiously as possible as but no later than thirty (30) calendar days from receipt.

The timeframe for Grievance resolution may be extended up to fourteen (14) calendar days and in compliance with State regulation.

• Appeals

There are two (2) types of appeals that Molina will accept:

- Administrative appeals are those involving adverse determination for reasons other than medical necessity (e.g., filing timeliness, missing prior authorization, etc.).
- Medically Necessary appeals involve findings that there was no medical necessity for the claim.

Appeals must be filed within thirty 90 calendar days from the Adverse Benefit Determination or denial. A written acknowledgement letter must be sent within ten (10) calendar days of receipt of the Appeal. Appeal must be resolved as expeditiously as possible, and no later than thirty 30 calendar days from receipt.

The timeframe for Appeals resolution may be extended up to fourteen (14) calendar days in compliance with State regulation.

For decisions not resolved wholly in the Provider’s favor, Providers have the right to request a State Administrative Hearing from the Division of Medicaid

• Expedited Resolution of Appeal

Providers may request that an appeal be expedited in compliance with State regulations. An expedited appeal will be acted on quickly and a decision made within three (3) calendar days. Molina may extend the time frame by up to fourteen (14) calendar days if the Member requests the extension. Molina may request an additional fourteen (14) calendar days if the extension is in the interest of the Member and Molina advises the Member in writing within two (2) calendar days of the decision to extend the time frame. Molina will review the request to ensure it meets the requirements for expedited review. If the case does not meet expedited review, the requestor is notified, and the case is processed as a standard appeal. Providers may request a State Administrative Fair Hearing through the Division of Medicaid or its Subcontractor for any

Appeal that is not resolved wholly in the Provider's favor. Once a Provider has exhausted Molina's appeal process, they may file a State Administrative Fair Hearing within thirty (30) calendar days of the final decision by Molina. Providers may request a State Administrative Fair Hearing from the Division of Medicaid as follows:

Phone: (800) 421-2408
Fax: (601) 359-9153

By Mail:
Division of Medicaid, Office of the Governor
Attn: Office of Appeals
550 High Street, Suite 1000
Jackson, MS 39201

Should a State Administrative Fair Hearing result in the reversal of an Adverse Benefit Determination, Molina shall bear all costs associated with the hearing. These costs may include, but are not limited to; medical appropriateness reviews by the Division of Medicaid contracted Independent Physician Reviewers, hearing officer's fees, attorney's fees, and court reporter's fees.

- **Prior Authorization Appeals**

In the event an authorization is denied, providers may submit on behalf of the member (with written approval) to act as a designated representative. Authorization Appeals must be filed in writing within 90 days following the date the denial letter was mailed. A decision is issued within 30 days if an extension was not requested and granted.

To request reconsideration of a denied authorization, a provider may write to:

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

• Member Inquiries, Grievances, and Appeals

SKYGEN is not delegated to resolve member appeals and grievances. If a member wants to file a grievance or appeal, the member should contact the Member Services number listed on the member ID card. If a member contacts the SKYGEN Member Services department, SKYGEN will transfer the call to the appropriate department for assistance. While SKYGEN is not delegated for this responsibility, we will cooperate with and assist in resolving member concerns. All appeal and grievance procedures comply with Federal and State regulations and meet appropriate accreditation standards.

A Member may file a Complaint or a Grievance orally or in writing. Complaints may be submitted within 30 calendar days of the date of the event causing the dissatisfaction. Grievances may be filed at any time after the date of event causing dissatisfaction. A Complaint is an expression of dissatisfaction, regardless of whether identified by the Member as a “Complaint”, received by any employee of Molina that is of a less serious or formal nature that is resolved within one calendar day of receipt. If the complaint cannot be resolved, it will be treated as a formal grievance A written acknowledgement letter must be sent within five calendar days of receipt of a Grievance. Grievances must be resolved as expeditiously as possible, but no later than 30 calendar days from receipt

Appeals may be filed orally or in writing. If the appeal request is made orally, Molina must get assigned, written appeal request after getting the verbal appeal request, unless an expedited (fast) plan appeal is requested. An appeal is a request for Molina to review an Adverse Benefit Determination. An Adverse Benefit Determination for a Member may include a decision to deny or limit health care services a Member believes he or she is entitled to get. In the case of a Member, the Adverse Benefit Determination may include determinations on dental services a Member believes he or she is entitled to receive, including delay in providing, arranging for, or approving the health care services (such that a delay would adversely affect the health of the Member).

Appeals may be filed within 60 calendar days from the Adverse Benefit Determination notice. A written acknowledgement letter must be sent within 10 calendar days of receipt of the Appeal. Appeal must be resolved as expeditiously as possible as; no later than 30 calendar days from receipt.

• Cultural Competency and Linguistic Services

The Cultural Competency Plan exists to ensure the delivery of culturally competent services and ensure the provision of Linguistic Access and Disability-related Access to all members including those with limited English Proficiency. The plan is based on guidelines outlined in National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health Care, published by the US Department of Health and Human Services (HHS), Office of Minority Health (OMH). The Cultural Competency Plan describes how the individuals and systems within the Organization will effectively provide services to people of all cultures, races, ethnic backgrounds 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.

Molina's Medicaid/Medicare-Medicaid Plan providers (medical, behavioral, dental, community based, and pharmacy providers who work with Enrollees that require culturally-, linguistically-, or disability-competent care) serves a diverse population of Members with specific cultural needs and preferences.

Title VI of the Civil Rights Act, the Americans with Disabilities Act (ADA) and Section 504 of the Rehabilitation Act of 1973 and other regulatory / contract requirements ensures that limited English proficient (LEP) and members who are deaf, hard of hearing or have speech or cognitive/intellectual impairments have equal access to health care services through the provision of high quality cultural and linguistic services. Molina Healthcare provides a number of important cultural and linguistic services at no cost to assist members and Providers/Practitioners

• Translation Services and Special Needs Assistance

Providers may request interpreters for Members whose primary language is other than English by calling Molina's Contact Center toll free at 844-826-4335. If Contact Center representatives are unable to interpret in the requested language, the representative will immediately connect you and the Member to a qualified language service provider.

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

All eligible Members who are Limited English Proficient (LEP) are entitled to receive interpreter services. Pursuant to Title VI of the Civil Rights Act of 1964, services provided for Members with LEP, limited reading proficiency (LRP), or limited hearing or sight are the financial responsibility of the Provider. Under no circumstances are Molina Members responsible for the cost of such services. Written procedures are to be maintained by each office or facility regarding their process for obtaining such services. Molina is available to assist Providers with locating these services if needed.

• Deaf and Hard of Hearing Members

Molina provides a TTY/TDD connection accessible by dialing 711. This connection provides access to Member & Provider Contact Center, Quality, Healthcare 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 three 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.

• Functional Illiteracy

A person with functional illiteracy is someone with basic education but whose reading and writing skills are inadequate for everyday needs. Health illiteracy is the degree to which individuals lack the capacity to obtain, process, and understand basic health information and services needed to make appropriate health decisions. This becomes important to a provider when a member is unable to accurately complete registration and medical/dental history forms.

Signs a member seen in your practice may be functionally illiterate or have lower than proficient health literacy include difficulty:

- Circling the date of a medical appointment on a follow-up appointment form
- Completing required forms accurately
- Following basic, printed follow-up or procedure preparation requirements
- Reiterating printed information about personal oral health conditions

Strategies your office might consider implementing to help all patients successfully access the written materials available through your office include:

- Orally reviewing printed medical history or other forms with patients to ensure accuracy and completeness of the information
- Complementing the distribution of printed material with oral explanations of treatment preparation or follow-up instructions
- Offering to complement written appointment reminders with phone call reminders

• Cultural Competency Training

Training of employees and provider, and quality monitoring are the cornerstones of successful culturally competent service delivery. For that reason, the cultural competency program is integrated into the overall provider training and quality monitoring programs. An integrated quality approach is aimed at enhancing the way people think about our members, service delivery and program development so that cultural competency becomes a part of everyday thinking.

• Cultural Competency Grievances

If you believe Molina has failed to adequately provide cultural or linguistic support to a member in your care, you can file a grievance with us. This may be done in person or by mail and write to:

Molina Healthcare of Mississippi
Attn: Compliance
188 E. Capitol St. Suite 700
Jackson, MS 39201

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, 800-368–1019 or 800-537–7697 (TDD).

• Clinical Criteria

Molina Dental Services criteria utilized for this medical necessity determination was developed from information collected from American Dental Association's Code Manuals, clinical articles and guidelines, as well as dental schools, practicing dentists, insurance companies, other dental related organizations, and local state or health plan requirements. A number of procedures require prior authorization before initiating treatment. When prior authorizing these procedures please note the documentation requirements. Should the procedure need to be initiated under an emergency condition to relieve pain and suffering, you are to provide treatment to alleviate the patient’s condition. However, to receive reimbursement for the treatment, Molina Dental Services will require the same criteria/ documentation are provided (with the claim for payment) and the same criteria be met to receive payment for the treatment.

Medical Necessity

Molina Dental Services defines medical necessity as accepted health care services and supplies provided by health care entities appropriate to the evaluation and treatment of

a disease, condition, illness, or injury and consistent with the applicable standard of care. Dental care is medically necessary to prevent and eliminate orofacial disease, infection, and pain, to restore form and function to the dentition, and to correct facial disfiguration or dysfunction. Medical necessity is the reason why a test, a procedure, or an instruction is performed. Medical necessity is different for each person and changes as the individual changes. The dental team must provide consistent methodical documentation of medical necessity for coding.

• Periodicity Schedules

Recommendations for Pediatric Oral Health Assessment, Preventive Services, and Anticipatory Guidance Counseling of the American Academy of Pediatric Dentistry (AAPD) states:

Since each child is unique, the recommendations are designed for the care of children who have no contributing medical conditions and are developing normally. These recommendations will need to be modified for children with special health care needs or if disease or trauma manifests variations from normal. The AAPD emphasizes the importance of very early professional intervention and the continuity of care based on the individualized needs of the child. Refer to the text of this guideline for supporting information and references. Refer to the text in the Guideline on Periodicity of Examination, Preventive Dental Services, Anticipatory Guidance, and Oral Treatment for Infants, Children, and Adolescents for supporting information and references.

The Periodicity Schedule for your state can be found on the American Academy of Pediatric Dentistry (AAPD) website.

• Preventive Care

Molina typically follows the standards of care and periodicity schedules for preventive treatment set by the American Dental Association and the American Academy of Pediatric Dentistry

• Mississippi Guidelines for Preventive Care

Periodic oral evaluation D0120 is payable two (2) per benefit year either D0120, D0145, or D0150. Five months between billing either D0120, D0145 or D0150.

CHIP beneficiaries receiving D0140 are not limited. Typically, this type of evaluation is a referral for a specific problem and/or present with dental emergencies, trauma, acute infection, etc.

Comprehensive oral evaluation D0150 is used by a general dentist and/or specialist when performing a comprehensive evaluation of an EPSDT eligible beneficiary. This service is allowed twice per fiscal year (July 1-June 30th) for EPSDT eligible beneficiaries and must be at least five (5) months apart. In cases where the beneficiary received services from more than one (1) dentist within this time period, payment of these services is made to the provider whose claim is received first.

Oral evaluation of children under the age of 3 D0145 is payable for children ages 0-3 for CHIP beneficiaries. This evaluation is payable twice per year and must be at least five (5) months apart.

Sealants

Sealants are covered for CHIP beneficiaries when applied to newly erupt first and second permanent molars or to first and second pre-molars. Sealant may be placed on primary molar only for children at highest risk for caries i.e. special needs children and will require prior authorization. Sealants are allowed once per three years for CHIP beneficiaries 14 and younger and prior authorization does not override the five-year limitation. Providers may bill for sealants only when the sealants are applied to all pits and fissures on the occlusal surface and in some instances the lingual groove surface of upper molars. Documentation must include the tooth number and tooth surface being treated.

• Diagnostic Care - Radiographs

Molina typically follows the standards of care and periodicity schedules for the use of radiographs as set by the American Dental Association. Radiographs should be kept to a minimum to be consistent with good diagnostic procedures. Radiographs must be of sufficient quality to be readable. If the radiograph quality is too poor to read, reimbursement will not be made to the dentist for the radiographs. All radiographs must be labeled with the beneficiary's name and date taken

• Mississippi Guidelines for Radiographs

Full mouth radiograph or panoramic radiograph is allowed once every two years per member except under unusual circumstances. Two years must have elapsed from the date the previous panoramic was given before the same provider can be paid for the next panoramic. A full mouth series should include 10-14 intraoral films and bitewings.

Payment will not be made for both full mouth intraoral and panoramic. If an emergency extraction is done on the day a full mouth series is taken, payment will not be made for any additional radiographs.

Laboratory Services

Full Providers must have a Clinical Laboratory Improvement Amendment (CLIA) certificate number on file with the fiscal agent for laboratory and pathology charges to be paid. Providers may bill for lab and pathology services if the provider performs the service. The provider may only bill for tests that CLIA has approved to be performed in his/her office.

Diagnostic Casts

Diagnostic casts made and billed by the dental provider are reimbursable only for orthodontic workups.

• Restorative Care

Molina typically follows the standards of care for restorative treatment that are typical for the region in which the service is being delivered.

Restorative services are covered for CHIP beneficiaries. These services are covered for the purposes of repairing the effects of dental caries; protection of teeth from further damage; re-establishing tooth function; and restoring or preserving an esthetic appearance. Restorative treatment must be the result of an appropriate and thorough examination by a dentist and should be part of a treatment plan that includes:

- Assessment and intervention related to the child's dentition status;
- Caries risk assessment;
- Oral hygiene;
- The child's compliance with the dental treatment plan (in the office and at home); and
- The child's behavioral and developmental status, including any special needs.

Mississippi CHIP policy for coverage of dental restorative services is based on recommendations from the American Academy of Pediatric Dentistry, the CMS Guide to Children's Dental Care in CHIP, and the American Dental Association Current Dental Terminology (CDT) reference manual. Restorative services should be provided as part of a comprehensive dental screening, diagnostic, and treatment plan that emphasizes prevention and early treatment of dental conditions in children.

• Mississippi Guidelines for Restorative Care

Mississippi's CHIP policy for coverage of dental restorative services is based on recommendations from the American Academy of Pediatric Dentistry, the CMS Guide to Children's Dental Care in Medicaid, and the American Dental Association Current Dental Terminology (CDT) reference manual. Restorative services should be provided as part of a comprehensive dental screening, diagnostic, and treatment plan that emphasizes prevention and early treatment of dental conditions in children.

• Amalgam Restorations

- Amalgam restorations (including polishing) are covered for EPSDT eligible beneficiaries for the restoration of carious lesions and/or developmental defects in primary and permanent posterior teeth.
- Tooth preparation, all adhesives (including amalgam bonding agents), liners, and bases are included as part of the restoration.
- Prior authorization is not required.
- Documentation in the beneficiary's record must clearly describe the restoration provided, the reason for the restoration, and the appropriate ADA CDT Procedure code, tooth number, and tooth surface.
- All restored surfaces on a single tooth are considered connected if performed on the same date. Payment will be made for a particular surface on a single tooth only once in each episode of treatment, irrespective of the number or combinations of restorations placed.
- Topical or local anesthesia is not reimbursed separately

• Composite Restoration

- • Resin-based composite restorations (direct) are covered for CHIP beneficiaries for the restoration of carious lesions and/or developmental defects in primary and permanent anterior and posterior teeth.
- Gold foil and inlay/onlay restorations are not covered.
- Documentation in the beneficiary's record must clearly describe the restoration provided, the reason for the restoration, and the appropriate ADA CDT Procedure code,
- Tooth number, and tooth surface.
- All restored surfaces on a single tooth are considered connected if performed on the same date. Payment will be made for a particular surface on a single tooth only once

in each episode of treatment, irrespective of the number or combinations of restorations placed.

- Topical or local anesthesia is not reimbursed separately

- **Cast Crowns**

In general, criteria for crowns will be met only for permanent teeth or primary teeth where no permanent successor is present needing multi-surface restorations where other restorative materials have a poor prognosis.

Mississippi CHIP covers prefabricated stainless-steel crowns and porcelain-fused-to-metal crowns for CHIP beneficiaries according to the policy criteria described below. Other types of crowns (e.g., resin, porcelain/ceramic, noble metal, etc.) are not covered.

Stainless steel crowns (SSCs), including prefabricated SSC primary tooth and prefabricated SSC permanent tooth, are covered for beneficiaries when an amalgam or composite restoration is not sufficient to meet the dental needs of the beneficiary. Prefabricated stainless-steel crowns with resin window or prefabricated esthetic coated stainless steel crowns (primary tooth) are covered for anterior teeth only. Prior authorization is not required for stainless steel crowns.

Stainless steel crowns are covered when at least one of the following criteria is met:

- Restoration of primary teeth with caries on more than one surface;
- Primary or permanent teeth with extensive caries;
- Restoration of primary teeth caries on more than one surface;
- Primary or permanent teeth with extensive caries;
- Primary or permanent teeth with cervical demineralization, decalcification, and/or developmental defects (such as hypoplasia and hypocalcification); When failure of other available restorative materials is likely (e.g., interproximal cavities extending beyond line angles, patients with bruxism);
- Following pulpotomy or pulpectomy;
- Restoration of a primary tooth that is to be used as an abutment for a space maintainer;
- Intermediate restoration of fractured teeth;
- Children at high risk for development of dental caries based on a risk assessment of factors including, but not limited to, previous caries; early clinical signs of potential caries development; lack of fluoride; frequent exposure to cavity-producing foods and drinks; behavioral, developmental, or medical conditions that affect the child's ability to practice preventive dental care; family history of extensive caries; and other

risk factors identified in dental professional literature. Risk factors must be thoroughly documented by the dentist in the beneficiary's dental record.

- CHIP eligibility alone is not sufficient reason for application of crowns.
- Children who require caries treatment under general anaesthesia because of behavioral, medical, or developmental conditions where behavior management and in-office sedation are not safe or effective.

Porcelain-Fused-to-Metal crowns, including predominantly base metal, are covered only for permanent anterior teeth.

Coverage criteria for porcelain-fused-to-metal crowns are the same as the criteria for stainless steel crowns.

Prior authorization is required for porcelain-fused-to-metal crowns.

Both stainless steel crowns and porcelain-fused-to-metal crowns are not indicated and will not be covered in the following circumstances:

- Absence of documentation that clearly demonstrates coverage policy is met;
- Primary tooth with exfoliation expected within six (6) months;
- Tooth has advanced periodontal disease, bone resorption, or insufficient tooth or root structure to sustain retention of the tooth;
- Crowns to alter vertical dimension

• Documentation Requirements for Crowns

Background Documentation to support the use of stainless-steel crowns and porcelain-fused-to-metal crowns must be maintained by the dentist in the beneficiary record. In addition to the Documentation Requirements listed, dentists must provide:

- Written documentation that supports the use of crown(s) for at least one of the covered indicators listed in this section.

- Radiographs are required prior to placement of crown(s). Exception: If the child requires general anesthesia for dental treatment and must receive dental treatment in the hospital rather than a dentist office, and the hospital is unable to perform dental radiographs, the requirement for radiographs prior to placement of crown(s) is waived. The dentist must document, very clearly and thoroughly in the beneficiary record, why radiographs were not done.

- Appropriate ADA CDT procedure code, tooth number, and tooth surface for each tooth receiving a crown.

- When applicable, reason for referral to the hospital (inpatient or outpatient) or an ambulatory surgical center (ASC) for placement of crowns and why the treatment could not be done in the dentist office (e.g., required general anesthesia due to severe behavioral management issues).

- If applicable, reason for early replacement of crown(s). A provider is responsible for any replacements necessary within the first twelve (12) months for restoration of primary teeth and the first twenty-four (24) months for restoration of permanent teeth, except when failure or breakage results from circumstances beyond the control

- Photographs – are not required but may be used in addition to radiographs and written documentation.

Placement of crowns that do not meet coverage criteria in this policy or failure to provide required documentation may result in repayment of CHIP funds upon post-payment review or audit.

Protective restorations require prior authorizations. Radiographs must be submitted with the prior authorization request

Post and Core

Cast and core coverage is limited to ages 21 and younger. Coverage is further limited to anterior endodontically treated teeth. Prior authorization is required. Radiographs must be submitted with the prior authorization request. Authorization still be approved on a case by case basis when determined to be medically necessary. Providers must retain proper and complete documentation to verify medical necessity.

• Endodontics

Endodontic therapy for permanent teeth does not requires prior authorization. A post-operative radiograph is required to verify service was provided and the fee is inclusive of endodontic therapy. The fee for endodontic therapy does not include restoration to close a root canal access. Criteria for approval of endodontic treatment include evidence of one or more of the following:

- Tooth is damaged because of trauma or carious exposure
- Fill is properly condensed/obturated; filling material does not extend excessively beyond the apex

A request for prior authorization for endodontic therapy will not meet criteria if:

- The endodontic treatment is for aesthetic reasons
- Gross periapical or periodontal pathosis is demonstrated radiographically
- Caries are demonstrated radiographically to be present along the crestal bone or into the furcation, deeming the tooth non-restorable
- The generally poor oral condition does not justify root canal therapy
- Endodontic therapy is for third molars, unless they are an abutment for a partial denture
- The tooth has advanced periodontal disease and/or pocket depths greater than 5mm
- Endodontic therapy is in anticipation of placement of an overdenture
- An endodontic filling material not accepted by the FDA is used

• Periodontics

Molina typically follows the standards of care of periodontic treatment as set by the American Dental Association and the American Academy of Periodontology. This includes

- Gingivectomy or Gingivoplasty
- Periodontal Scaling and Root Planing

More than one periodontal procedure in the same quadrant per fiscal year requires prior authorization.

A pre-treatment radiographic image demonstrating significant calculus must be submitted with prior authorization.

These are treated with more detail in the sections that follow.

• Gingivectomy or Gingivoplasty

Criteria for approval of gingivectomy or gingivoplasty include evidence of one or more of the following:

Comprehensive periodontal evaluation (i.e., description of periodontal tissues, pocket depth chart, tooth mobility, mucogingival relationships)

Covered service is payable for CHIP beneficiaries.

- **Periodontal Scaling and Root Planing**

Criteria for approval of periodontal scaling and root planing include evidence of one or more of the following:

- Periodontal procedures are limited to once per quadrant per fiscal year. Prior authorization is required with a pre-treatment radiographic image.
- Scaling cannot be billed together on the same date of service.
- Payable for CHIP beneficiaries ages 10-19.

- **Prosthodontics – Removable and Fixed**

Criteria for approval of prosthodontic services includes:

• Evidence the prosthetic services are intended to restore oral form and function due to premature loss of permanent teeth that would result in significant occlusal dysfunction.

• Requests for partial dentures will only be considered for recipients with good oral health and hygiene, good periodontal health (AAP Type I or II), and a favorable prognosis where continuous deterioration is not expected.
• Abutments should be adequately restored and not have advanced periodontal disease.
• Pre-existing removable prosthesis (includes partial and full dentures) must be at least 5 years old and unserviceable to qualify for replacement.
A request for prior authorization for a removable prosthesis will not meet criteria if:
• There is a pre-existing prosthesis that is not at least five years old and unserviceable
• Good oral health and hygiene, good periodontal health, and a favorable prognosis are not present
• There are untreated caries on or active periodontal disease around the abutment teeth
• Less than 50 percent of bone support is visible radiographically in abutment teeth
• The recipient cannot accommodate and properly maintain the prosthesis (i.e., gag reflex, potential for swallowing the prosthesis, severely handicapped)
• The recipient has a history or an inability to wear a prosthesis due to psychological or physiological reasons

• Mississippi Guidelines for Prosthodontics (Removable)

• Removable prosthodontics are payable as an accidental injury benefit or are recommended by your child's doctor or dentist to treat severe craniofacial anomalies or full-cusp Class III malocclusions.

• Doctor or dentist to treat severe craniofacial anomalies or full-cusp Class III malocclusions.

• Dentures/partials (with cast framework) will only be covered in cases where teeth are congenitally missing, i.e. Ectodermal Dysplasia. Denial reasons include lost teeth due to cavities, periodontal disease or trauma.

• Extractions and Oral Maxillofacial Surgery

The prophylactic removal of asymptomatic teeth (e.g., third molars) or other teeth exhibiting no overt clinical pathology (for orthodontics) may be covered, subject to consultant review.

Symptoms should be present for approval of all third molar extractions. Those symptoms may include cysts, resorption of adjacent teeth, angulation causing inability for tooth to erupt, and other clinical symptoms. Normal eruption pain is not considered a pathological symptom that would require an extraction.

The removal of primary teeth whose exfoliation is imminent does not meet criteria.

• Orthodontics

CHIP Members may qualify for orthodontic care under the program.

CHIP members ages 0-19 qualify for D8080 and D8670 as an accidental injury benefit while enrolled in CHIP, and there were no impairment or disease prior to the accident. They are also covered if medical necessity is determined based on the following criteria:

- Severe Craniofacial Anomalies
- Full cusp Class III malocclusions
- Temporomandibular Joint (TMJ) disorder
- Syndrome and Craniomandibular disorder

In order to obtain approved prior authorization for orthodontia for a CHIP beneficiary, the following must be submitted:

- Narrative detailing medical necessity

- Diagnostic models
- Cephalometric, panoramic, or full-mouth survey radiographic images
- Intraoral photographs

All orthodontic services require prior authorization. The prior authorization request should document that the member has a fully erupted set of permanent teeth. At least 1/2 to 3/4 of the clinical crown should be exposed, unless the tooth is impacted or congenitally missing. The required documentation and treatment plan must be submitted with the request for prior authorization of services.

Treatment should not begin prior to receiving notification from SKYGEN indicating coverage or non-coverage for the proposed treatment plan. If you begin treatment before receiving an approved or denied prior authorization, you are financially obligated to complete treatment at no charge to the member or face possible termination of your Provider Agreement. You cannot bill prior to services being performed.

If the request for prior authorization is denied, your request will be returned to you with the denial notice.

- **Billing for Orthodontic Treatment**

The start and billing date of orthodontic services is defined as the date when the bands, brackets, or appliances are placed in the member's mouth. The member must be eligible on this date of service.

If a member becomes ineligible during treatment and before full payment is made, it is the member's responsibility to pay the balance for any remaining treatment. You must notify the member of this requirement prior to beginning treatment.

To guarantee proper and prompt payment of orthodontic cases, please electronically file or mail a copy of the completed ADA form with the banding date filled in.

Initial payments for orthodontics (code D8080) include pre-orthodontic visit, radiographs, treatment plan, records, diagnostic models, initial banding, debanding, 1 set of retainers, and 12 months of retainer adjustments (if retainer fees are not separate).

Orthodontia related services are limited to $5000 per member per lifetime. Eligible members are ages 19 and younger. The maximum case payment for orthodontic treatment will be 1 initial payment (D8080) and 7 quarterly payments thereafter, covering 21 periodic orthodontic treatment visits (D8670). Additional periodic orthodontic treatment visits beyond 21 will be your financial responsibility and not the member’s.

Reimbursement for orthodontic consultation, cephalogram, diagnostic casts, photographs and radiographs and other charges pertaining to the orthodontic evaluation are included in the comprehensive orthodontic treatment rate. Providers are not allowed to bill separately for these services unless the request for orthodontia is denied. If the orthodontia treatment plan is denied, reimbursement for pre-treatment orthodontic records such as a consultation, panoramic, cephalometric film, intraoral and extraoral photographs, and diagnostic casts will be paid separately to an orthodontist, once (1) per three (3) years per member per orthodontist. If an orthodontist bills for records more than once within a three-year period, a narrative describing medical necessity.

Members may not be billed for broken, repaired, or replacement of brackets or wires.

If a member becomes ineligible for CHIP during the course of treatment, the orthodontic provider should complete the treatment. Eligibility status can change from month to month, and there is a possibility that eligibility will be reinstated. The member or his/her guardian will be responsible for any bills accrued during the interim.

Please notify Molina Dental Services should the member discontinue treatment for any reason.

Continuation of Orthodontic Treatment

SKYGEN requires the following information for possible payment of continuation of care cases:

- The original banding date
- A detailed paid-to-date history showing dollar amounts for initial banding and periodic orthodontic treatment fees.
- A copy of member's prior approval including the total approved case fee, banding fee, and periodic orthodontic treatment fees
- Photographs of the ORIGINAL diagnostic models (or OrthoCAD), or radiographs (optional), banding date, and a detailed payment history if the member started treatment under commercial insurance or fee for service

It is your responsibility, with the member, to get this required information. Cases cannot be set up for possible payment without complete information.

- **Surgery-Anesthesia**

All forms of sedation and anesthesia administered in a dental office-based setting must comply pursuant to Miss. Code Ann. § 73-9-13 to ensure that beneficiaries are provided with the benefits of anxiety and pain control in a safe and efficacious manner.

The use of topical anesthetics and local anesthesia are inclusive of the procedure being performed and cannot be billed separately.

The use of general anesthesia or IV sedation is considered acceptable for procedures covered by the health plan, provided appropriate criteria are met. These include, but may not be limited to, extensive or complex oral surgical procedures such as:

- Impacted wisdom teeth
- Surgical root recovery from maxillary antrum
- Surgical exposure or impacted or unerupted cuspids
- Radical excision of lesions in excess of 1.25 cm
- General anesthesia or IV sedation may also be allowed for any of the following medical situations:
- Medical conditions that require monitoring such as cardiac problems or severe hypertension
- Underlying hazardous medical condition (such as cerebral palsy, epilepsy, mental retardation including Down Syndrome), which might render the member non-compliant
- Documented failed sedation or a condition where severe periapical infection would render local anesthesia ineffective

CHIP beneficiaries' benefits are provided for anesthesia and for associated facility charges when the mental or physical condition of the Member requires dental treatment to be rendered under physician-supervised general anesthesia in a hospital setting, surgical center or dental office. These services include general sedation and nitrous oxide. A pre-treatment narrative and post treatment anesthesia records are required.

- **Maxillofacial Prosthetics**

Maxillofacial prosthetics are not typically a covered benefit under a dental insurance plan. These are typically provided by a board-certified prosthodontist and are routinely covered by medical insurance.

- **Forms and Documents**

- Electronic Funds Transfer (EFT) Agreement
- Orthodontic Continuation of Care Form
- Member ID Card
- Provider Information Update Form
- Sample Claim Form
- NPI Provider Enrollment Form
- Non-Covered Services Disclosure Form
- Hospital Worksheet
- Hospital Scorecard
- Locum Tenens Form

- **Electronic Funds Transfer (EFT) Agreement**

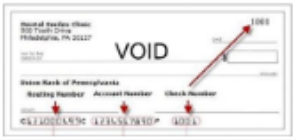
MOLINA HEALTHCARE

Electronic Funds Transfer (EFT) Authorization Agreement

Get your reimbursement faster and easier with EFT! To receive your payments by EFT, please complete this form and return it with a scanned or faxed copy of a voided check. *(This Authorization Agreement will not be valid without a* voided check.*)*

Submission Options	
Send this completed form and voided check to Molina Healthcare via:	**Fax:** 844-584-3686 *or* **Email:** Dental&VisionDevelopment@MolinaHealthCare.com
Submission Reason	
Select one checkbox.	❑ New EFT Authorization | ❑ Account or bank change to existing EFT Authorization

Provider Information		
Provider Name *(Include d/b/a, if any.)*	Taxpayer Identification Number	*Select one checkbox.* ❑ SSN | ❑ EIN
Street Address		
City	State	Zip Code
Phone Number	Email Address	

Financial Institution Information	
Financial Institution Name	Financial Institution Routing Number *(Include 9 digits with any leading zeros.)*
Account Number *(Include up to 10 digits with any leading zeros.)*	*To indicate account type, select one checkbox.* ❑ Checking Account | ❑ Savings Account
Note: Please return this form with a *voided check* or the Authorization Agreement will not be valid.	

Authorization

I hereby authorize Scion Dental, on behalf of itself and its affiliates, (hereinafter "Company") to initiate credit entries to the account at the financial institution listed above for all payments. I authorize and request the financial institution to accept credit entries by Company to such account and to credit the same to such account. If Company credits more money than the correct payment amount due to duplicate electronic funds transfers (where "duplicate" is defined as multiple electronic funds transfers received for the same services rendered, the same membership, and the same dates of service) or erroneous electronic funds transfers (where "erroneous" is defined as complete electronic funds transfers received in error) I authorize Company to withdraw the overpayment electronically. I accept responsibility for any resulting loss of payment and release Company from any liability for or arising from my failure to submit accurate or updated information to Company. I understand that I must communicate any changes in my information to Company. This authorization is effective as of the signature date below and is to remain in full force and effect until Company has received written notification from me of its termination or Company notifies me that this service has been terminated. I agree to provide notification of change/termination 30 days in advance. By signing this authorization, I acknowledge that I have read and agree to the conditions set forth herein. Furthermore, I certify that the information provided is true and accurate in all respects and that I have been duly authorized to enter into this agreement.

Printed Name	Title
Authorized Signature	Date

- **Orthodontic Continuation of Care Form**

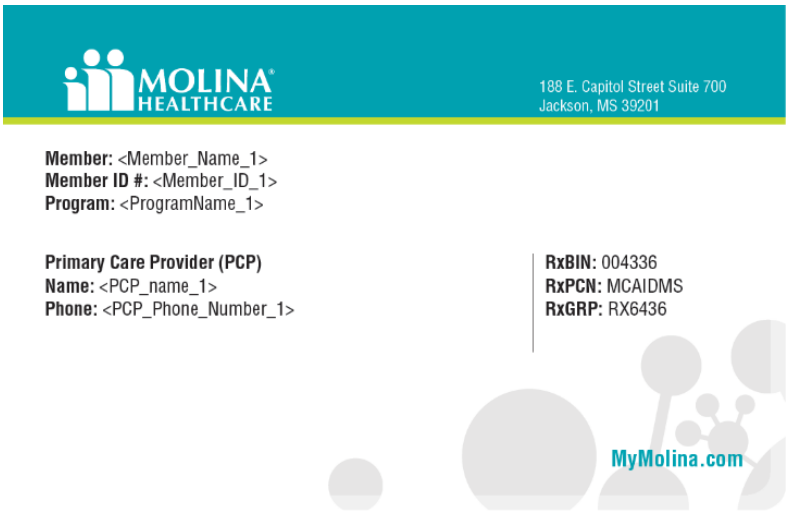
Orthodontic Continuation of Care Request Form

Date: _____
Patient Name: _____
Member ID: _____
Member DOB: _____
Code(s) Requiring COC: _____
Current Provider Name: _____
Current Provider NPI#: _____
Banding Date: _____
Total Dollars Paid for Case to Date: _____
Remaining Visits:_____
Balance Requested for Remainder of Case:_____
Previous Carrier (if applicable):_____
Previous Provider Name:
_____
Previous Provider Phone #:
_____
Previous Provider Address :
_____

Procedure:
• Complete this form and submit, along with required clinical documentation outlined in Provider Manual Continuation of Care section, as a prior authorization for code D8999 and all applicable orthodontic codes.
• All documentation should be submitted to:
Molina Healthcare Authorizations
P.O. Box 2154
Milwaukee, WI 53201
• 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:
• This form completed.
• Completed 2012 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.

- **Member ID Card**



- **Provider Information Update Form (PIF)**

Guide to Provider Forms

ACTION	YOU WILL NEED TO COMPLETE THE SECTIONS IDENTIFIED BELOW ON THE PROVIDER INFORMATION UPDATE FORM (PIF) AND ANY ADDITIONAL DOCUMENTS LISTED. ALL DOCUMENTS MUST BE COMPLETED AND RETURNED
Add a Provider to the group	• PIF – Complete Section A, Section N* * Section N can be copied when adding multiple providers
Terming a provider	• PIF – Complete Section A and Section J • Term letter on your organization's letterhead
Closing a service location(s)	• PIF – Complete Section A and Section H
Change Phone/Fax	• PIF – Complete Section A, Section F
Change the Pay-To/ Billing Address	• PIF – Complete Section A and Section I • W-9 • Sample Claim Form (de-identified)
Change or add a service location	• PIF – Complete Section A, Section G
Add a new group to the same Tax Identification Number (TIN)	• PIF – Complete Section A • W-9 • Sample Claim Form (de-identified)
Change Group Name Only	• PIF – Complete Section A and Section D • Sample Claim Form (de-identified) • W-9
Change TIN only	• PIF – Complete Section A and Section B • W-9 • Sample Claim Form (de-identified)

Individual Name Change	• PIF – Complete Section A and Section E
Provider Directory Update	• PIF – Complete Section A and Section L
Panel Update	• PIF – Complete Section A and Section K
Hospital Affiliations Update	• PIF – Complete Section A and Section M
Group/Provider NPI change	• PIF – Complete Section A and Section C
FORMS:	**FORM USAGE:**
Provider Information Update Form (PIF)	This form is used to communicate changes, deletions and additions regarding participating providers to Molina Healthcare.
W-9	This document is issued by the U.S. Internal Revenue Service (IRS). Molina Healthcare uses it to update the TIN owner name, doing business as name, and Tax ID when received with a PIF.
Credentialing - Individual Providers	**YOU WILL NEED TO...**
If you have a CAQH number	Complete CAQH Provider Data Form. You also need to update and give Molina Healthcare permission to review. Visit the website at http://www.caqh.org.
If you do not have a CAQH number	Go to http://www.caqh.org to request a CAQH number and fill out the information. You will need to give permission to Molina Healthcare to review.
Credentialing - Facilities and Other Providers	**YOU WILL NEED TO ...**

Including Hospitals, Ambulatory Surgical Centers, Home Health Agencies, Durable Medical Equipment (DME) Suppliers, SNFs, Urgent Care Centers, and Retail Clinics	Print, complete, fax, email or mail the Healthcare Delivery Organization Form. This form can be found on our website at MolinaHealthcare.com/providers Molina Healthcare of Mississippi Attention: Provider Contracts 188 E. Capitol Street, Suite 700 Jackson, MS 39201 Email: MHMSProviderContracting@MolinaHealthcare.com
CONTACT INFORMATION	If you have additional questions please contact Molina Healthcare's Provider Services department at (844) 826-4335 between the hours of 7:30 a.m. to 6 p.m. CST, Monday through Friday.

MOLINA HEALTHCARE
Your Extended Family.

Provider Information Update Form (PIF)

Today's Date___/___/_____

This form and the associated documentation are required to notify Molina Healthcare of Mississippi of any changes to your group/practice information and/or to begin the credentialing process. This form is also available at **www.MolinaHealthcare.com.**

Type of Group: ☐ Medical Group ☐ Specialist ☐ PCP ☐ Hospital ☐ Urgent Care ☐ FQHC/RHC ☐ Behavioral Health ☐ PHO-IPA ☐ ASC ☐ Other

SECTION A

Current Group/Practice Information (*All fields in this section are required*)

Group/Practice Name: _____

Group/Practice Tax ID: _____ Group/Practice Medicaid #: _____

Group/Practice NPI #: _____ Contact Number: _____

Email address: _____ Contact Name: _____

Group/Practice Add, Name Change, Tax ID Number Change and NPI Change

If changing both the Group/Practice Name and the Tax ID Number, a new contract is required. Please contact Molina Healthcare Provider Services at (844) 826-4335. A representative will be available to assist you Monday through Friday, 8 a.m. - 5 p.m. EST.

Return to first page.

SECTION B

Tax ID Number Change Effective Date_____/_____/_____

Previous Tax ID Number _____ New Tax ID Number _____

Return to first page.

SECTION C

Group/Provider NPI Change

☐ **Group** ☐ **Individual**

Group/Provider Name: _____

Previous NPI: _____ New NPI: _____

Return to first page.

SECTION D

Group/Practice Add or Change Effective Date ____/____/____

Previous Group/Practice name: _____ Medicaid #: _____

New Group/Practice name: _____ Medicaid #: _____

Return to first page.

OTHER CHANGES

SECTION E

Individual Name Change

Previous Name: _____ New Name: _____

Return to first page.

SECTION F

Change Phone/Fax Effective Date ___/___/_____

Previous Phone Number: _____ New Phone Number: _____

Previous Fax Number: _____ New Fax Number: _____

Address: _____ City, State, Zip: _____

Return to first page.

SECTION G

☐ **Add a Service Location** ☐ **Change a Service Location** Effective Date: ___/___/_____

Previous Address	**New Address**
Address 1: _____	Address 1: _____
Address 2: _____	Address 2: _____
City, State, Zip: _____	City, State, Zip: _____
Phone Number: _____	Phone Number: _____
Fax Number: _____	Fax Number: _____
Email: _____	Email: _____

Return to first page.

SECTION H

___ Closing a Service Location Effective Date: ____/____/_____

Address 1: _____

Address 2: _____

City, State, Zip: _____

Reason: (Required) _____

Authorizing Signature Printed: _____

Authorizing Signature: _____

Phone Number: _____ Fax Number: _____

Email Address:

Date: / /_____

Return to first page.

SECTION I

Billing Address Change Effective Date ____/____/_____

Previous Billing Information	New Billing Information
Billing Contact: _____	Billing Contact: _____
Address 1: _____	Address 1: _____
Address 2: _____	Address 2: _____
City, State, Zip: _____	City, State, Zip: _____
Phone Number: _____	Phone Number: _____
Fax Number: _____	Fax Number: _____

- Is this a Notice Address Change? ☐No ☐Yes

The notice Address is the particular party's address for delivery or mailing of notice purposes.

Return to first page.

SECTION J

Terming a Provider

A termination letter is required on company letterhead including: name of the provider to be termed, group name, effective date of termination, reason for termination and address of practice location(s).

If terming provider is a PCP, who will assume patient panel?

Provider Name (Last, First, MI) _____

Return to first page.

SECTION K

Panel Update Effective Date ____/____/____

☐ Existing Patients Only ☐ Close Panel to all Members ☐ Open Panel

Reason: (Required) _____

Return to first page.

SECTION L

Provider Directory Update Effective Date ____/____/____

☐ Include in Provider Directory ☐ Exclude from Provider

Directory Reason: *(Required)* _____

Return to first page.

SECTION M

Hospital Affiliations Update Effective Date ____/____/____

☐ Add Hospital Affiliation(s) ☐ Remove Hospital Affiliation(s)

Names of Hospital(s) _____

Return to first page.

SECTION N

Provider Joining a Group/Practice Effective Date: / / Locum Tenen: ☐ Y ☐ N

Provider Name (Last, First, MI): _____

Provider Type (MD, DO, etc.): _____ Date of Birth: _____

Individual Provider NPI Number: _____ CAQH Provider Number: _____

Note: Please ensure the provider has completed and/or re-attested to the CAQH Application and has authorized Molina Healthcare to access the provider's record on the CAQH website.

MS Medicaid Provider ID: _____

Specialty: _____ Secondary Specialty: _____

Applying as: ☐ PCP ☐ Specialist ☐ Allied Health Professional

Board Certified: ☐ Yes ☐ No Effective Date: ___/___/_____ Expiration Date: ___/___/_____

Certification Board: _____

Group/Practice Name:

Group/Practice Address: _____

City, State, Zip: _____

Phone Number: _____ Fax Number: _____

Email Address: _____

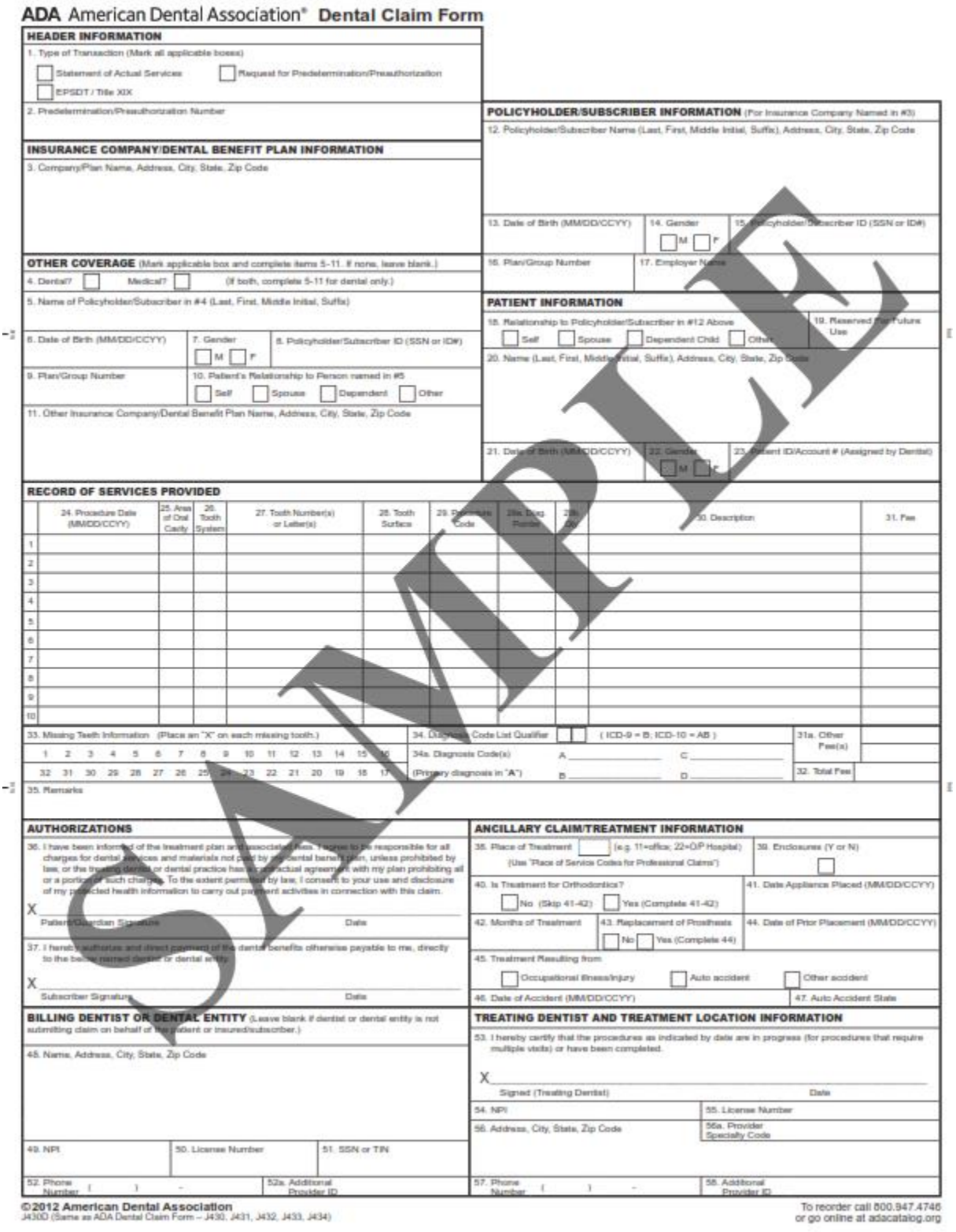
Return to first page.

If you have any questions, visit our website at www.MolinaHealthcare.com or call Provider Services at (844) 826-4335. Representatives are available to assist you Monday through Friday from 7:30 a.m. to 6:00 p.m.

Please mail, fax or email this form and supporting documentation to:

Molina Healthcare of Mississippi
Attn: Provider Contracting
188 E. Capitol Street, Suite 700
Jackson, MS 39201
MHMSProviderContracting@MolinaHealthcare.com

- **Sample Claim Form**



ADA American Dental Association® Dental Claim Form

HEADER INFORMATION

1. Type of Transaction (Mark all applicable boxes)
☐ Statement of Actual Services ☐ Request for Predetermination/Preauthorization
☐ EPSDT / Title XIX

2. Predetermination/Preauthorization Number

INSURANCE COMPANY/DENTAL BENEFIT PLAN INFORMATION

3. Company/Plan Name, Address, City, State, Zip Code

OTHER COVERAGE (Mark applicable box and complete items 5-11. If none, leave blank.)

4. Dental? ☐ Medical? ☐ (If both, complete 5-11 for dental only.)

5. Name of Policyholder/Subscriber in #4 (Last, First, Middle Initial, Suffix)

6. Date of Birth (MM/DD/CCYY) | 7. Gender ☐ M ☐ F | 8. Policyholder/Subscriber ID (SSN or ID#)

9. Plan/Group Number | 10. Patient's Relationship to Person named in #5 ☐ Self ☐ Spouse ☐ Dependent ☐ Other

11. Other Insurance Company/Dental Benefit Plan Name, Address, City, State, Zip Code

POLICYHOLDER/SUBSCRIBER INFORMATION (For Insurance Company Named in #3)

12. Policyholder/Subscriber Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code

13. Date of Birth (MM/DD/CCYY) | 14. Gender ☐ M ☐ F | 15. Policyholder/Subscriber ID (SSN or ID#)

16. Plan/Group Number | 17. Employer Name

PATIENT INFORMATION

18. Relationship to Policyholder/Subscriber in #12 Above ☐ Self ☐ Spouse ☐ Dependent Child ☐ Other | 19. Reserved For Future Use

20. Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code

21. Date of Birth (MM/DD/CCYY) | 22. Gender ☐ M ☐ F | 23. Patient ID/Account # (Assigned by Dentist)

RECORD OF SERVICES PROVIDED

	24. Procedure Date (MM/DD/CCYY)	25. Area of Oral Cavity	26. Tooth System	27. Tooth Number(s) or Letter(s)	28. Tooth Surface	29. Procedure Code	29a. Diag. Pointer	29b. Qty.	30. Description	31. Fee
1										
2										
3										
4										
5										
6										
7										
8										
9										
10										

33. Missing Teeth Information (Place an "X" on each missing tooth.)
1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16
32 31 30 29 28 27 26 25 24 23 22 21 20 19 18 17

34. Diagnosis Code List Qualifier ☐☐ (ICD-9 = B; ICD-10 = AB)
34a. Diagnosis Code(s) A _____ C _____
(Primary diagnosis in "A") B _____ D _____

31a. Other Fee(s)
32. Total Fee

35. Remarks

AUTHORIZATIONS

36. I have been informed of the treatment plan and associated fees. I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless prohibited by law, or the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted by law, I consent to your use and disclosure of my protected health information to carry out payment activities in connection with this claim.

X _____
Patient/Guardian Signature Date

37. I hereby authorize and direct payment of the dental benefits otherwise payable to me, directly to the below-named dentist or dental entity.

X _____
Subscriber Signature Date

BILLING DENTIST OR DENTAL ENTITY (Leave blank if dentist or dental entity is not submitting claim on behalf of the patient or insured/subscriber.)

45. Name, Address, City, State, Zip Code

49. NPI | 50. License Number | 51. SSN or TIN

52. Phone Number ( ) - | 52a. Additional Provider ID

ANCILLARY CLAIM/TREATMENT INFORMATION

38. Place of Treatment ☐ (e.g. 11=office; 22=O/P Hospital) (Use "Place of Service Codes for Professional Claims") | 39. Enclosures (Y or N) ☐

40. Is Treatment for Orthodontics? ☐ No (Skip 41-42) ☐ Yes (Complete 41-42) | 41. Date Appliance Placed (MM/DD/CCYY)

42. Months of Treatment | 43. Replacement of Prosthesis ☐ No ☐ Yes (Complete 44) | 44. Date of Prior Placement (MM/DD/CCYY)

45. Treatment Resulting from ☐ Occupational Illness/Injury ☐ Auto accident ☐ Other accident

46. Date of Accident (MM/DD/CCYY) | 47. Auto Accident State

TREATING DENTIST AND TREATMENT LOCATION INFORMATION

53. I hereby certify that the procedures as indicated by date are in progress (for procedures that require multiple visits) or have been completed.

X _____
Signed (Treating Dentist) Date

54. NPI | 55. License Number

56. Address, City, State, Zip Code | 56a. Provider Specialty Code

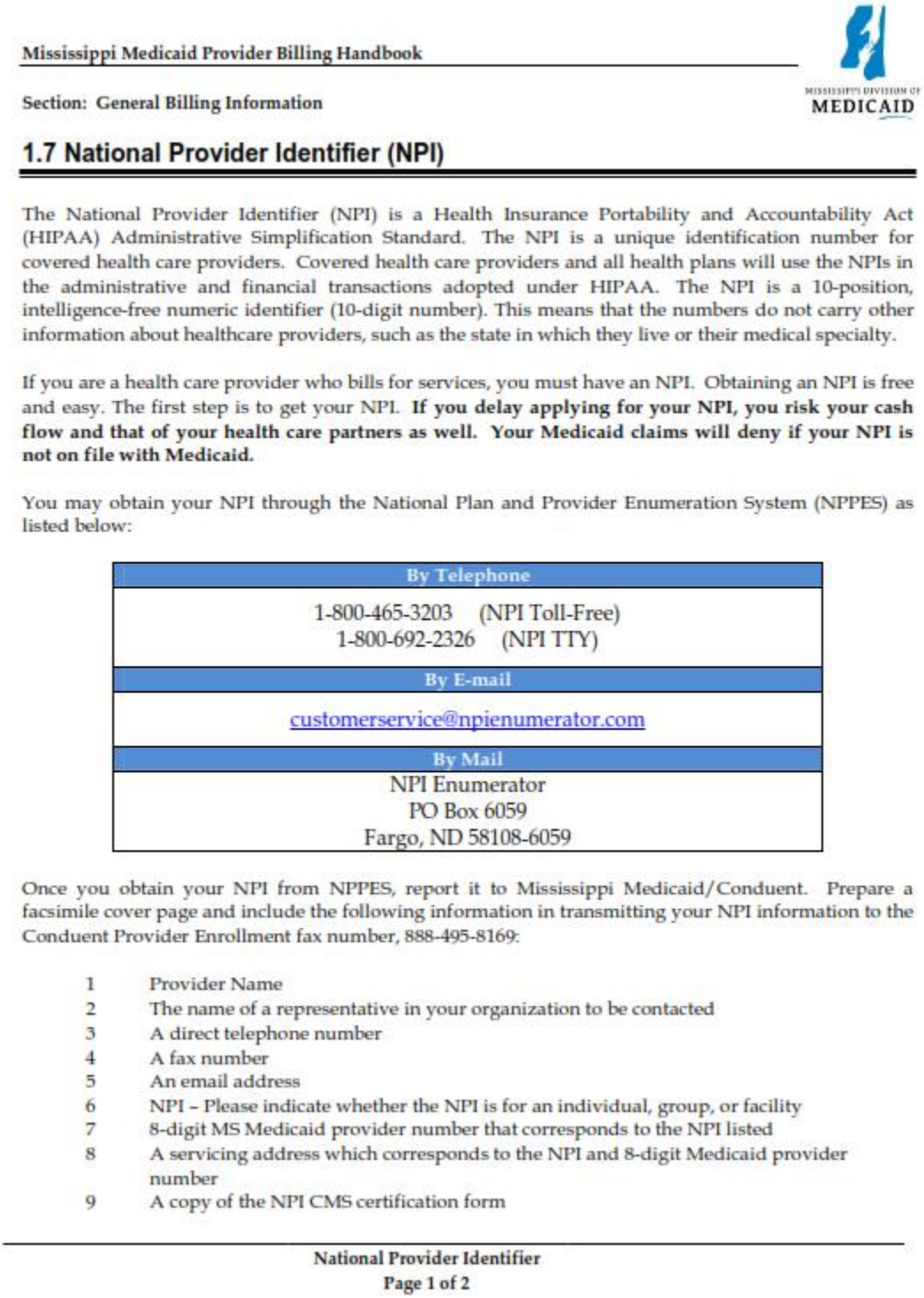
57. Phone Number ( ) - | 58. Additional Provider ID

J430D (Same as ADA Dental Claim Form – J430, J431, J432, J433, J434)

To reorder call 800.947.4746 or go online at adacatalog.org

- **Mississippi Division of Medicaid- NPI Provider Enrollment Form**

Please reference the Mississippi Division of Medicaid for more information. This form can be found on the Mississippi Divison of Medicaid website: https://ms-medicaid.com/NPI%20Submission%20Form.pdf



Mississippi Medicaid Provider Billing Handbook

Section: General Billing Information

MISSISSIPPI DIVISION OF MEDICAID

1.7 National Provider Identifier (NPI)

The National Provider Identifier (NPI) is a Health Insurance Portability and Accountability Act (HIPAA) Administrative Simplification Standard. The NPI is a unique identification number for covered health care providers. Covered health care providers and all health plans will use the NPIs in the administrative and financial transactions adopted under HIPAA. The NPI is a 10-position, intelligence-free numeric identifier (10-digit number). This means that the numbers do not carry other information about healthcare providers, such as the state in which they live or their medical specialty.

If you are a health care provider who bills for services, you must have an NPI. Obtaining an NPI is free and easy. The first step is to get your NPI. **If you delay applying for your NPI, you risk your cash flow and that of your health care partners as well. Your Medicaid claims will deny if your NPI is not on file with Medicaid.**

You may obtain your NPI through the National Plan and Provider Enumeration System (NPPES) as listed below:

By Telephone
1-800-465-3203 (NPI Toll-Free) 1-800-692-2326 (NPI TTY)
By E-mail
customerservice@npienumerator.com
By Mail
NPI Enumerator PO Box 6059 Fargo, ND 58108-6059

Once you obtain your NPI from NPPES, report it to Mississippi Medicaid/Conduent. Prepare a facsimile cover page and include the following information in transmitting your NPI information to the Conduent Provider Enrollment fax number, 888-495-8169:

1. Provider Name
2. The name of a representative in your organization to be contacted
3. A direct telephone number
4. A fax number
5. An email address
6. NPI – Please indicate whether the NPI is for an individual, group, or facility
7. 8-digit MS Medicaid provider number that corresponds to the NPI listed
8. A servicing address which corresponds to the NPI and 8-digit Medicaid provider number
9. A copy of the NPI CMS certification form

National Provider Identifier
Page 1 of 2

You may also use the NPI Submission Form to submit your NPI to Mississippi Medicaid. The form is located at https://ms-medicaid.com/NPI%20Submission%20Form.pdf . It is recommended that you print the completed form and fax it, along with the NPI Certification Form, to Conduent Provider Enrollment at 601-206-3015. If the NPI Certification Form is not included with your NPI information, the NPI will **NOT** be entered on your Medicaid provider file and the incomplete NPI information will be returned. You may contact Conduent Provider and Beneficiary Services at 1-800-884-3222 if you have additional questions or to verify your NPI has been added to your provider file.

- **Non-Covered Services Disclosure Form**

To be completed by Physician Rendering Care

I am recommending that_____receive services
Member Name and Identification Number
that are not covered by the Molina Covered Benefits Schedule. I am willing to accept my Usual and Customary Fee as payment in full. The following procedure codes are recommended:

CODE	DESCRIPTION	FEES

The total amount due for service(s) to be rendered is $_____

Doctor's Signature *Date*

To be completed by Member

I_____, have been told that I require
Print Your Name
services or have requested services that are not covered by the Molina Covered Benefits Schedule.

Covered Benefits Schedule.

Read the question and check either YES or NO	YES	NO
My doctor has assured me that there are no other covered benefits.		
I am willing to receive services not covered by my Health Plan		
I am aware that I am financially responsible for paying for these services.		
I am aware that my Health Plan is not paying for these services.		

I agree to pay $_____per month. If I fail to make this payment, I may be subject to collection action.

Member's Signature if over eighteen (18) or Parent / Guardian *Date*

- **Hospital Worksheet**

Molina Mississippi Hospital Worksheet

Member's Name:

Member's DOB:

Member's ID Number:

Provider's Name:

Facility Name:

Dental Services Anticipated:

Type of Failed Attempt:

Special Healthcare Needs:

(Special healthcare needs include any physical, developmental, mental, sensory, behavioral, cognitive, or emotional impairment or limiting condition that requires medical management, healthcare intervention, and/or use of specialized services or programs.)

Anticipated DOS:

Contact Name:

Contact Email:

Contact Fax:

- **Hospital Scorecard**

MOLINA HEALTHCARE

HOSPITAL and AMBULATORY SURGICAL CENTER (ASC)

PATIENT NAME: _____

ID NUMBER: _____ **DATE OF BIRTH:** _____

DENTIST NAME: _____

HOSPITAL OR ASC NAME: _____

Age Range	Points
☐ 0 – 3	12
☐ 4 – 5	10
☐ 6 – 7	6
☐ 8 – 9	2
☐ 10 – 21	0

Services Required	Points
☐ 13 or more	12
☐ 10 – 12	10
☐ 7 – 9	8
☐ 4 – 6	6

(Multiple services on the same tooth count as one service)

Behavior Management
(Note: patient progress notes required)

Factor (check all that apply)	Points
☐ Acute Situational Anxiety	5
☐ Oral Sedation unsuccessful	5
☐ Nitrous Oxide unsuccessful	3
☐ Local Anesthesia unsuccessful	1

Medical Diagnosis
(Note: letter from medical provider required)

Factor (check all that apply)	Points
☐ Developmental disability	12
☐ Intellectual disability	10
☐ Asthma	10
☐ Heart condition	10
☐ ADHD	5
☐ Allergies (not seasonal)	5
☐ Other _____	__

Eligible for Hospital or ASC (20 points or more) **TOTAL POINTS:** _____

Dentist Comments: _____

_____

Contact Person Name: _____ **Treatment Date:** _____

Contact Person Phone: _____ **Fax:** _____

Notes:

- Medical conditions not listed may also be considered as criteria for approval; include supporting documentation
- Member Records with scores of 20 are more subject to an audit (pre-pay or retrospective)
- A treatment plan on the most current ADA claim for must be sent with this form

- **Locums Tenens Form**

Molina Locum Tenens Form

Locum Tenens is a Latin phrase that means: Holding the Place. Locum Tenens arrangements are between providers whereas one provider will temporarily replace another provider for a period of time. After Molina receives notification of a Locum Tenens situation, the Participating Provider may submit a claim under his/her name and provider number and receive payment for covered benefits for services provided by the locum tenens provider.

Please complete below:	
Tax Identification Number:	
Provider Name and NPI:	
Locum Tenens Name and NPI:	
Contact Person:	
Contact Phone Number:	
Effective Date for Locum Tenens Relationship:	
Reason for Locum Tenens Relationship:	
Expected Termination Date for Locum Tenens Relationship:	

The following documentation **must** accompany this form:

1. A written notice from the owner of the facility to Molina in advance advising of the use of a locum tenens provider. If the use of the locum tenens is due to the incapacitation or death of the Participating Provider, then the letter must be signed by the executor of the estate.
2. Copy of the Locum Tenens provider's license
3. Proof of professional liability of one million dollars per occurrence/three million aggregate minimum

In accordance with the Provider Agreement, the Participating Provider may pay the locum tenens provider for his/her services on a per diem basis or similar fee for time basis. The locum tenens provider may not provide services to members for a period of time in excess of sixty (60) continuous days within a twelve (12) month period.