November 2018

# Dental Provider Manual

## Molina Healthcare of Michigan

### Healthy Michigan Program and Molina Dual Options (MI Health Link)

# Contents

# Quick Reference Guide

## Provider Web Portal

Getting paid for services you've provided to patients should be quick, easy, and convenient. Our user friendly Provider Web Portal offers a full set of self-service tools that help you get more done, faster.

### Everything You Need ● When You Need It ● 24/7/365

Use the Provider Web Portal to:

- Check member eligibility
- Set up office appointment schedules
- Review patient treatment history
- Submit claims and authorizations
- Send supporting documentation, such as EOBs and x-rays
- Generate a quick pricing estimate before submitting a claim
- Check the real-time processing status of claims and authorizations
- Download and print Provider Manuals, remittance reports, and more

To access the Provider Web Portal, click this link:

pwp.skygenusasystems.com

# Quick Contacts

| For information about… | Contact… |
|---|---|
| Provider Disputes/Appeals and Complaints mailing address | Molina Dental Services Provider Dispute/Appeals and Complaints<br>PO Box 649<br>Milwaukee, WI 53201 |
| Claim Form mailing address | Molina Dental Services Claims<br>PO Box 2136<br>Milwaukee, WI 53201 |
| Corrected Claims mailing address | Molina Dental Services Corrected Claims<br>PO Box 641<br>Milwaukee, WI 53201 |
| Contracting Portal | contracting.skygenusasystems.com (access code: **MI**) |
| Credentialing Team | 844-862-4564<br>Email: dental&visiondevelopment@molinahealthcare.com |
| Electronic Funds Transfer | pwp.skygenusasytems.com<br>Phone: 844-621-4587<br>Email: providerportal@skygenusa.com |
| Fraud & Abuse Hotline | 866-606-3889 |
| Healthy Michigan Molina Dental Member Services | 888-898-7969 |
| Molina Dual Options (MI Health Link) Molina Dental Member Services | 855-735-5604 |
| Molina Dental Provider Services | 855-322-4077 |
| Provider Web Portal | pwp.skygenusasystems.com |

# Quick Reference

| Quick Reference to Common Questions | |
|---|---|
| **Healthy Michigan Member Eligibility** | To verify member eligibility:<br>• Log on to Provider Web Portal: pwp.skygenusasystems.com<br>• Call Member Services for the Interactive Voice Response (IVR) eligibility hotline: 888-898-7969 |
| **Molina Dual Options (MI Health Link) Member Eligibility** | To verify member eligibility:<br>• Log on to Provider Web Portal: pwp.skygenusasystems.com<br>• Call Member Services for the Interactive Voice Response (IVR) eligibility hotline: 855-735-5604 |
| **Authorization Submission** | Submit authorizations in one of the following formats:<br>• Provider Web Portal: pwp.skygenusasystems.com<br>• Electronic submission via clearinghouse, Payer ID: **SKYGN**<br>• HIPAA-compliant 837D file<br>For help submitting authorizations via Provider Web Portal, call: 844- 621-4587 |

| Quick Reference to Common Questions | |
|---|---|
| **Claims Submission** | Molina Dental Services requests that claims are submitted within ninety (90) days after services are rendered. All claims must be received by Molina Dental Services no later than three hundred sixty-five (365) calendar days (1 year) from the date of service.<br><br>Submit claims in one of the following formats:<br><br>• Provider Web Portal: pwp.skygenusasystems.com<br>• Electronic submission via clearinghouse, Payer ID: **SKYGN**<br>• HIPAA-compliant 837D file<br>• Paper 2012 ADA Dental Claim Form, sent via postal mail:<br>Molina Dental Services Claims<br>PO Box 2136<br>Milwaukee, WI 53201<br><br>For help submitting claims via Provider Web Portal, call: 844-621-4587 |
| **Healthy Michigan Provider Appeals – Authorizations** | 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.<br><br>To request reconsideration of a denied authorization, a provider may:<br><br>• Write to:<br>Molina Dental Services Dispute/Appeals and Complaints<br>PO Box 649<br>Milwaukee, WI 53201 |

| Quick Reference to Common Questions | |
|---|---|
| **Molina Dual Options (MI Health Link) Provider Appeals – Authorizations** | 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 60 days following the date the denial letter was mailed. A decision is issued within 30 days if an extension was not requested and granted.<br><br>To request reconsideration of a denied authorization, a provider may:<br><br>• Write to:<br>Molina Dental Services Dispute/Appeals and Complaints<br>PO Box 649<br>Milwaukee, WI 53201 |
| **Healthy Michigan Provider Appeals – Claims** | Claim Appeals must be filed in writing within 90 days following the date the remittance advice was mailed. A decision is made within 30 days if an extension was not requested and granted.<br><br>To request a reconsideration of a claims denial, a provider may:<br><br>• Write to:<br>Molina Dental Services<br>PO Box 649<br>Milwaukee, WI 53201 |
| **Molina Dual Options (MI Health Link) Provider Appeals – Claims** | Claim Appeals must be filed in writing within 60 days following the date the remittance advice was mailed. A decision is made within 30 days if an extension was not requested and granted.<br><br>To request a reconsideration of a claims denial, a provider may:<br><br>• Write to:<br>Molina Dental Services<br>PO Box 649<br>Milwaukee, WI 53201 |

| Quick Reference to Common Questions | |
|---|---|
| **Member Appeals** | Submit written appeals to:<br>Molina Dental Services<br>Attention: Member Appeals<br>880 West Long Lake Road<br>Suite 600<br>Troy, MI 48098-4504<br>Fax appeals to: 248- 925-1799<br><br>**Healthy Michigan Member Appeals** – Member Appeals must be filed in writing within 60 days following the date the denial letter was mailed. A decision is issued within 30 days if an extension was not requested and granted<br>**Molina Dual Options (MI Health Link)** - Member Appeals must be filed in writing within 60 days following the date the denial letter was mailed. A decision is issued within 30 days if an extension was not requested and granted |
| **Provider Web Portal** | For training or help registering for or using the Provider Web Portal, contact the SKYGEN USA Electronic Outreach Team: 844-621-4587 |

# 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' 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.*

# Section 1: Member Rights & Responsibilities

This section explains the rights and responsibilities of Molina Dental Services members as written in the Michigan Member Handbook. Michigan 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.

**Below are the Member Rights and Responsibilities:**

**Molina Dental Services Member Rights & Responsibilities Statement**
Molina Dental Services staff and providers will comply with all requirements concerning your rights.

## Healthy Michigan Member Rights & Responsibilities

### Member Rights

Molina Dental Services members have the right to**:**

• Get information on the structure and operation of the health plan, its services, practitioners and providers and member rights and responsibilities
• Choose your Primary Care Provider
• Know if a co-payment or contribution is required
• Know the names, education, and experience of your health care providers
• Be treated with respect with recognition of your dignity and your right to privacy
• Take part in decision-making with your doctor about your health care, including the right to refuse treatment and candidly discuss appropriate or medically necessary treatment options of your conditions, regardless of cost or coverage
• Get a fair and timely reply to requests for service
• Voice complaints or appeals about the organization and the care it provides
• Know that your member information will be kept private. It is only used in reports to the state to show that the Plan is following state rules and laws
• Ask how your provider is paid
• To make recommendations regarding the Plan’s member rights and responsibility policy
• Be free from any form of restraint or seclusion used as means of coercion, discipline, convenience or retaliation
• Request and receive a copy of your medical records, and request that they be amended or corrected

• Be provided culturally and linguistically appropriate health care services
• Be provided covered healthcare services
• Be free to exercise your rights without adversely affecting the way Molina Dental Services, our providers or the State treat you
• Be free from other discrimination prohibited by State and Federal regulations
• Request clinical practice guidelines upon request
• Get a second medical opinion
• Get help with any special language needs

## Member Responsibilities

Molina Dental Services members have the responsibility to:

• Provide Molina Dental Services and its practitioners and providers with the necessary information needed to care for you
• Know, understand, and follow the terms and conditions of the health plan
• Follow plans and instructions for care that they have agreed to with their providers
• Seek out information in order to make use of the services
• Take part in decision-making about your healthcare. Understand your health problems and participate in developing mutually agreed-upon treatment goals
• Report other insurance benefits, when you are eligible, to your Department of Human Services Specialist and the Beneficiary Helpline at 800-642-3195, TTY (866) 501-5656
• Show your Molina Healthcare ID card, Medicaid mihealth card and valid ID to all dental providers before receiving services
• Never let anyone use your Molina Healthcare ID card or Medicaid mihealth card
• Choose a primary dental provider, schedule an appointment within 60 days of enrollment and build a relationship with the dental provider you have chosen
• Make appointments for routine checkups and immunizations (shots)
• Keep your scheduled appointments and be on time
• Provide complete information about your past medical history
• Provide complete information about current medical problems
• Ask questions about your care
• Follow your provider's medical advice
• Respect the rights of other patients and health care workers
• Use emergency room services only when you believe an injury or illness could result in death or lasting injury
• Notify your primary dental provider if emergency treatment was necessary and follow-up care is needed
• Make prompt payment for all cost-sharing responsibilities
• Report changes that may affect your coverage to your Department of Human Services specialist. This could be an address change, birth of a child, death, marriage or divorce, or change in income
• Promptly apply for Medicare or other insurance when you are eligible

# Molina Dual Options MI Health Link Member Rights & Responsibilities

## Member Rights

Molina Dental Services members have the right to:

- Get information in a way that meets your needs
- Be treated with respect, fairness and dignity at all times
- Get timely access to covered services and drugs
- Have your personal health information protected
- See your medical records
- Information about the plan, its network providers, and your covered services
- Leave the plan at any time
- Network providers cannot bill you directly
- Make decisions about your health care
- To know your treatment options and make decisions about your health care
- To say what you want to happen if you are unable to make health care decisions for yourself
- To make complaints and to ask us to reconsider decisions we have made

## Member Responsibilities

Molina Dental Services members have the responsibility to:

- Read the member handbook to learn what is covered and what rules you need to follow to get covered services and drugs
- Tell the Plan about any other health or prescription drug coverage you have
- Tell your doctor and other health care providers that you are enrolled in our Plan
- Help your doctors and other health care providers give you the best care
- Be considerate
- Pay what you owe
- Tell the Plan if you move

# Section 2: Provider Rights & Responsibilities

Molina Dental Services and SKYGEN USA have established the following core concepts in our approach to a positive provider experience:

- **Access** to flexible participation options in provider networks.
- **Outreach** programs that lower provider participation costs.
- **Technology** tools that increase efficiency and lower administrative costs.
- **Feedback** that measures provider and member satisfaction.

## Provider Rights

Enrolled participating providers have the right to:

- Communicate with patients, including members, regarding dental treatment options.
- Recommend a course of treatment to a member, even if the course of treatment is not a covered benefit or approved by Molina Dental Services.
- File an appeal Supply accurate, relevant, and factual information to a member in conjunction with an appeal, complaint, or grievance filed by the member.
- Object to policies, procedures, or decisions made by Molina Dental Services.
- Be informed of the status of their credentialing or re-credentialing application, upon request.

## Provider Responsibilities

Participating providers have the following responsibilities:

- If a recommended treatment plan is not covered or approved, the participating dentist, if intending to charge the member for the non-covered services, must notify and obtain agreement from the member in advance. (**See Section 8: Eligibility and Member Services**)
- A provider wishing to terminate participation with the Molina Dental Services network must follow the termination guidelines stipulated in the Molina Dental Services provider contract.
- A provider may not bill both medical codes and dental codes for the same procedure.

- Must be accessible 24 hours a day, seven days a week, either personally or through coverage arrangements with a designated dental provider. After hours coverage must meet the requirements below:
    - Provides instructions for a dental emergency situation
    - Provides means or reaching an on-call dental provider
  - May not limit their practices because of a Member's dental condition or the expectation for the need of frequent or high cost-care.
  - Providers must not discriminate against enrollees based on their payment status and cannot refuse to serve Members because they receive assistance with Medicare cost sharing from a State Medicaid and Federal Medicare-Medicaid Program.
  - It is important for participating providers to ensure Molina Dental Services has accurate practice and business information. Providers must notify Molina Dental Services 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
    - Any other information that may impact Member access to care
  - All contracted Providers to participate in and comply with SKYGEN USA's Electronic Solution Requirements, which include, but are not limited to, electronic submission of prior authorization requests, health plan access to electronic medical records (EMR), electronic claims submission, electronic fund transfers (EFT), electronic remittance advice (ERA) and registration for and use of SKYGEN USA's Provider Web Portal (Provider Portal).

## Positive Provider Experience

Committed dentists are essential to the success of every government-sponsored dental program. At Molina Dental Services, we have structured our provider networks to give dentists the flexibility they need to participate in dental programs on their own terms.

We consider ourselves allies of dental associations while maintaining flexibility within the changing political climate surrounding government-sponsored dental programs. We recognize the significant link between good dental care and overall patient health, and we advocate increasing provider funding while improving member education and outreach. We partner with providers to deliver high-quality care to all members of government-sponsored dental programs.

## Consistent, Transparent Authorization Decisions

Trained paraprofessionals and dental consultants use predefined clinical guidelines to ensure a consistent approach for determining authorizations submitted for review. When you submit an authorization through the Provider Web Portal, you have the option of stepping through the guideline yourself, for a quick indication of whether your authorization request is likely to be approved. Authorization requirements are also outlined in **Clinical Criteria in Section 18.**

## Provider Data Accuracy and Validation

It 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.

# Section 3: Cultural Competency

## Background

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.

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.

## Provider and Community Training

Molina Healthcare offers educational opportunities in cultural competency concepts for providers on a regular basis. This is a summary of the Cultural Competency Plan; providers may use links on the Molina Healthcare website to obtain the full Cultural Competency Plan.

Cultural Competency trainings are offered to providers and supporting staff. Cultural Competency Training programs are also available to Community Based Organizations.

Provider training is conducted concurrent with and integrated into provider orientation with annual reinforcement training. Additional training reinforcement is provided through Continuing Medical Education (CME) monographs developed by the health plan, and periodically accompanying provider communications. Cultural Notes, a monthly newsletter publication, is emailed to interested providers highlighting important cultural customs relevant to plan members.

Training is provided in modules delivered through a variety of methods including, but not

limited to, one or more of the following:

1. Written materials – Provider Manual
2. Access to enduring reference materials available through health plan representatives and the Molina Healthcare website
3. Integration of cultural competency concepts into provider communications; and
4. Continuing Medical Education

**Integrated Quality Improvement – Ensuring Access**

Molina Healthcare ensures member access to language services such as oral interpreting, written translation and access to programs and services that are congruent with cultural norms and provide quality care.

Molina Healthcare provides oral interpreting of written information to any plan member who speaks any non-English language regardless of whether that language meets the threshold of a prevalent non-English language. Molina Healthcare notifies plan members of the availability of oral interpreting services and informs them of how to access oral interpreting services. Members are informed that there is no charge for interpreting and translation services.

Members may also request written member materials in alternate languages and formats, which are provided within 14 business days. Such congruency with member populations leads to better communication, understanding and member satisfaction.

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

## Program and Policy Review Guidelines

Molina Healthcare conducts assessments at regular intervals of the following information in order to ensure its programs are most effectively meeting the needs of its members and providers:

- Annual review of membership demographics (preferred language, ethnicity, race)
- Local geographic population demographics and trends derived from publicly available sources (Group Needs Assessment)
- Network Assessment
- Applicable national demographics and trends derived from publicly available sources
- Health status measures such as those measured by HEDIS as available
- Comparison with selected measures such as those in Healthy People 2010
- Measures available through national testing programs such as the National Health and Nutrition Examination Survey (NHANES)

## Cultural and Linguistic Services

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.

The Michigan Department of Health and Human Services (MDHHS), CMS, Molina Healthcare and its affiliates expect Providers/Practitioners to adhere to the following:

## 24 Hour Access to Interpreters

Providers/Practitioners may request interpreters for members whose primary language is other than English by calling Molina Healthcare's Member Services Department at: Healthy Michigan 888-898-7969 or Molina Dual Options (MI Health Link) 855-735-5604. If Member Services representatives are unable to provide the interpretation services internally, the member and Provider/Practitioner are then connected to a telephonic language line interpreter service. TTY/TTD services are available for deaf and hard of hearing members by calling the Michigan Relay Service at 711.

It is never permissible to ask a family member, friend or minor to interpret. State and Federal laws state that it is never permissible to turn a member away or limit the services provided to them because of language barriers. It is also never permitted to subject a member to unreasonable delays due to language barriers or provide services that are lower in quality than those offered in English.

## Face to Face Interpretation

Providers/Practitioners may request face to face interpretation (including Sign Language) for scheduled medical visits, if needed, due to the complexity of information exchange or if requested by the member. To request face to face interpretation services call our Member Services Department at: Healthy Michigan 888-898-7969 or Molina Dual Options (MI Health Link) 855-735-5604. Our Member Services Representatives will arrange for an interpreter. Please keep in mind that at least 3 business days are required to make arrangements for this service. If you have any questions, please call Molina's Health Education Department at (855) 322-4077.

Face to face interpretation is desirable for certain complex medical situations such as the need to give complex instructions (i.e. such as how to inject insulin, or postsurgical care), the discussion of health issues requiring major lifestyle changes, the discussion of a terminal prognosis, or other critical healthcare issues. Interpreter services should be provided if a member believes that his or her rights to equal access to medical care, under Title VI or the ADA, will not be met without the services of a face to face interpreter.

# Section 4: 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.

> "… SKYGEN USA website is very user-friendly and provides very quick access to a large amount of essential information that is very helpful in doing our daily business in our dental practice."
>
> —Office Manager, Dental Group, current client in West Virginia

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.

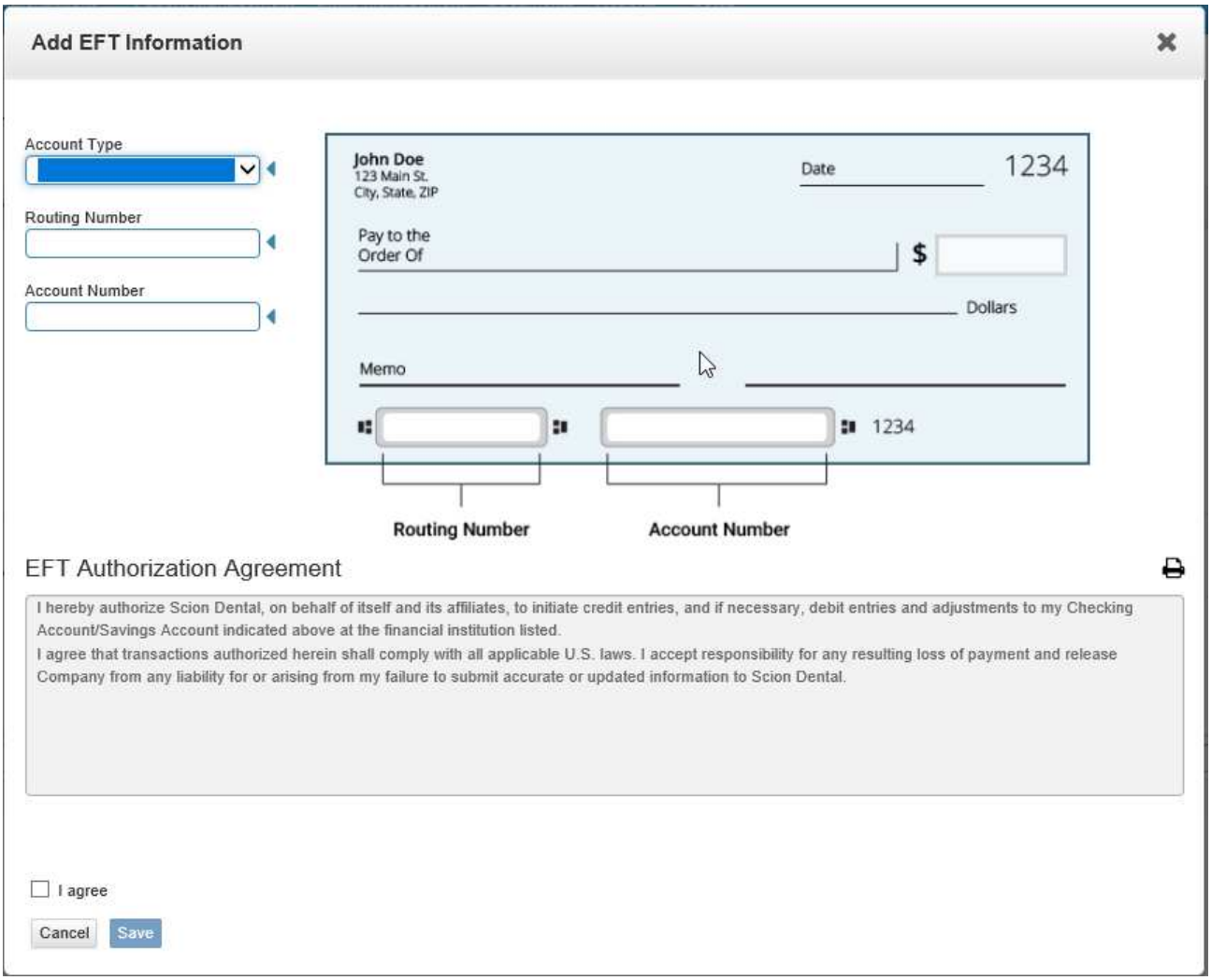
# Section 5: Electronic Payments

## Electronic Funds Transfer (EFT)

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.

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.

## Electronic Remittance Reports

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.

# Section 6: Health Insurance Portability and Accountability Act (HIPAA)

As a health care provider, if you transmit any health information electronically, your office is required to comply with all aspects of the Health Insurance Portability and Accountability Act (HIPAA) regulations that have gone/will go into effect as indicated in the final publications of the various rules covered by HIPAA.

Molina Dental Services have implemented numerous operational policies and procedures to ensure we comply with all HIPAA Privacy Standards, and we intend to comply with all Administrative Simplification and Security Standards by their compliance dates. We also expect all providers in our networks to work cooperatively with us to ensure compliance with all HIPAA regulations.

The provider and Molina Dental Services agree to conduct their respective activities in accordance with the applicable provisions of HIPAA and such implementing regulations.

When you contact Molina Dental Services Member Services, you will be asked to supply your Tax ID or NPI number. When you call regarding member inquiries, you will be asked to supply specific member identification such as member ID or Social Security Number, date of birth, name, and/or address.

As regulated by the Administrative Simplification Standards, the benefit tables included in this Provider Manual reflect the most current coding standards (CDT-2014) recognized by the American Dental Association (ADA). Effective as of the date of this manual, Molina Dental Services require providers to submit all claims with the proper CDT codes listed in this manual. In addition, all paper claims must be submitted on the 2012 ADA claim form.

To request copies of Molina Dental Services HIPAA policies, call Provider Services at 855-322-4077.

> To report a potential security issue, call the Molina Healthcare Fraud Hotline: 866-606-3889.

## National Provider Identifier (NPI)

The Health Insurance Portability and Accountability Act (HIPAA) of 1996 required the adoption of a standard unique provider identifier for health care providers. An NPI number is required for all claims submitted to SKYGEN USA for payment. You must use your individual and billing NPI numbers.

To apply for an NPI, do one of the following:

- Complete the application online at https://nppes.cms.hhs.gov.
- Download and complete a paper copy from https://nppes.cms.hhs.gov.
- Call **800-465-3203** to request an application.

## Medicaid ID Requirements

In order to comply with federal rule 42 CFR 438.602, effective January 1, 2018 providers are required to be fully enrolled with the Community Health Automated Medicaid Processing System (CHAMPS) with an active Medicaid ID to receive payment for submitting clean claims to Molina Healthcare. MDHHS will prohibit Molina Healthcare from making payment to all providers not enrolled in CHAMPS.

# Section 7: Utilization Management

## Community Practice Patterns

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 Utilization Management 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.

## Evaluation

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

## Results

With the objective of ensuring fair and appropriate reimbursement to providers, Molina Dental Services Utilization Management helps identify providers whose treatment patterns show significant deviation from the normal practice patterns of the community of their peers (typically less than 5 percent of all dentists). Molina Dental Services is contractually obligated to report suspected fraud, waste, abuse, or misuse by members and participating dental providers to Molina Healthcare.

# Non-Incentivization Policy

It is Molina Dental Services practice to ensure our contracted providers make treatment decisions based on medical necessity for individual members. Providers are never offered, nor shall they ever accept, any kind of financial incentives or any other encouragement to influence their treatment decisions.

The Molina Dental Services Utilization Management team bases their decisions on only appropriateness of care, service, and existence of coverage. Molina Dental Services does not specifically reward practitioners or other individuals for issuing denials of coverage or care. If financial incentives exist for Utilization Management decision makers, they do not include or encourage decisions which result in underutilization.

# 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.

**Provider Fraud**. A health care provider who is enrolled in Medicaid and Molina Dual Options (MI Health Link) is also subject to federal and state penalties for Healthy MI and Molina Dual Options Plan fraud. Report any provider you suspect of:

## Reporting suspected fraud, waste, or 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. You may also report cases of fraud, waste or abuse to Molina Dental Services Compliance Department. You have the right to have your concerns reported anonymously without fear of retaliation.

Molina Dental Services
Attn: Compliance Officer
880 West Long Lake Rd., Suite 600
Troy, MI 48098
Phone: 855-606-3889
Fax: 248-925-1797

Remember to include the following information when reporting:

- Nature of complaint
- Names of individuals and/or entity involved in suspected fraud and/or abuse including address, phone number, Medicaid ID number and any other identifying information

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

Michigan Department of Health and Human Services (MDHHS)

Office of Inspector General

PO Box 30062

Lansing, MI 48909-7979

You may call the 24-hour hotline at (855) MIFRAUD

(855-643-7283) toll-free or visit the website at:

www.michigan.gov/fraud

OR

State Attorney General
Health Care Fraud Division
Department of Attorney General
Medicaid Fraud Control Unit
P.O. Box 30218
Lansing, MI 48909
Phone: 1-855-MI-FRAUD 855-643-7283Online: www.michigan.gov/fraud

## Deficit Reduction Act: The False Claims Act

Section 6034 of the Deficit Reduction Act of 2005 signed into law in 2006 established the Medicaid Integrity Program in section 1936 of the Social Security Act. The legislation directed the Secretary of the United States Department of Health and Human Services (HHS) to establish a comprehensive plan to combat provider fraud, waste, and abuse in the Medicaid program, beginning in 2006. The Comprehensive Medicaid Integrity Plan is issued for successive five-year periods.

Under the False Claims Act, those who knowingly submit or cause another person to submit false claims for payment of government funds are liable for up to three times the government's damages plus civil penalties of $5,500 to $11,000 for each false claim.

The False Claims Act allows private persons to bring a civil action against those who knowingly submit false claims. If there is a recovery in the case brought under the False Claims Act, the person bringing the suit may receive a percentage of the recovered funds.

For the party found responsible for the false claim, the government may exclude them from future participation in Federal health care programs or impose additional obligations against the individual.

The False Claims Act is the most effective tool U.S. taxpayers have to recover the billions of dollars stolen through fraud every year. Billions of dollars in health care fraud have been exposed, largely through the efforts of whistleblowers acting under federal and state false claims acts.

For more information about the False Claims Act visit www.TAF.org.

## Whistleblower Protection

The False Claims Act (FCA) provides protection to qui tam relators who are discharged, demoted, suspended, threatened, harassed, or in any other manner discriminated against in the terms and conditions of their employment as a result of their furtherance of an action under the FCA. 31 U.S.C. § 3730(h). Remedies include reinstatement with comparable seniority as the qui tam relator would have had but for the discrimination, two times the amount of any back pay, interest on any back pay, and compensation for any special damages sustained as a result of the discrimination, including litigation costs and reasonable attorneys' fees.

## Fraud and Abuse Hotlines

Molina Dental Services Fraud and Abuse Hotline: **866-606-3889**

Michigan Department of Health and Human Services – Office of the Inspector General 855-MI-FRAUD (643-7283).

# Section 8: Eligibility & Member Services

Any person who is enrolled in a Molina Healthcare's Healthy Michigan and Molina Duals Options (MI Health Link) program is eligible for benefits under the Plan.

Effective **July 1, 2018**, Molina Healthcare of Michigan will provide dental services to pregnant women, ages 19 to 64. Pregnant Medicaid members will be able to use their Molina Healthcare Medicaid ID card to obtain dental services.

## Healthy Michigan Plan

The Healthy Michigan Plan is the name of Governor Snyder's initiative to extend Medicaid eligibility to more Michigan residents and became effective April 1, 2014. Healthy Michigan members may select Molina Healthcare for coverage. To enroll, residents must meet all of the following criteria:

Between the ages of 19 and 64

- Not currently eligible for Medicaid
- Not eligible for, or enrolled in Medicare
- Earning up to 133 percent of the federal poverty level
- person and $34,000 for a family of four
- Physicians are not responsible for collecting copays from Healthy Michigan Plan

For more information on the Healthy Michigan Plan, please visit:
www.michigan.gov/healthymiplan

## Eligibility and Enrollment in Molina Dual Options Plan (MI Health Link) a Medicare-Medicaid Program

A. Members who wish to enroll in Molina's Dual Options Plan (must meet the following eligibility criteria:

- Age 21 and older at the time of enrollment;
- Entitled to benefits under Medicare Part A and enrolled under Medicare Parts B and D, and receiving full Medicaid benefits;
- Enrolled in the Medicaid Aid to the Aged, Blind, and Disabled (ABAD) category of assistance;
- Beneficiaries who meet all other Demonstration criteria and are in the following Medicaid 1915 waivers: Persons who are Elderly; Persons with Disabilities; Persons with HIV/AIDS; Persons with Brain Injury; and Persons residing in Supportive Living Facilities;

- Individuals with End Stage Renal Disease (ESRD) at the time of enrollment

## Member Identification Card

Members receive identification cards from Molina. Participating providers are responsible for verifying that members are eligible when services are rendered and for determining whether recipients have other health insurance. Because it is possible for a member's eligibility status to change at any time without notice, presenting a member identification card does not guarantee a member's eligibility, nor does it guarantee provider payment.

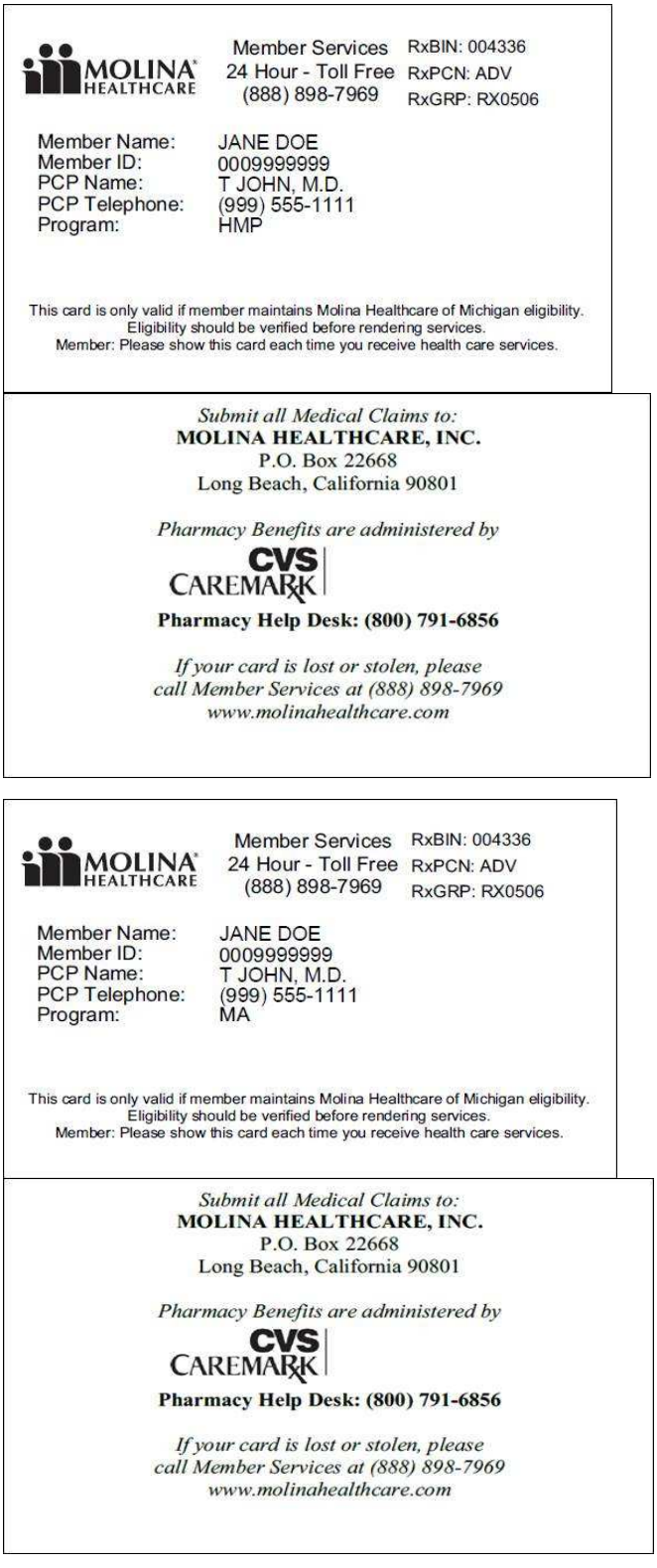
Molina Dental Services recommends each dental office make a photocopy of the member's identification card each time treatment is provided. Please be aware that the Molina identification card is not dated and does not need to be returned to Molina should a member lose eligibility.

> **NOTE** Presenting a member ID card does not guarantee that a person is currently enrolled in a Molina program.

For more information about member identification cards and health plan information, call Molina Dental Services Member Services at:

- Healthy Michigan - 888-898-7969
- Molina Dual Options (MI Health Link) 855-735-5604.

## Sample Medicaid ID Card



MOLINA HEALTHCARE

Member Services
24 Hour - Toll Free
(888) 898-7969

RxBIN: 004336
RxPCN: ADV
RxGRP: RX0506

Member Name: JANE DOE
Member ID: 0009999999
PCP Name: T JOHN, M.D.
PCP Telephone: (999) 555-1111
Program: HMP

This card is only valid if member maintains Molina Healthcare of Michigan eligibility.
Eligibility should be verified before rendering services.
Member: Please show this card each time you receive health care services.

*Submit all Medical Claims to:*
**MOLINA HEALTHCARE, INC.**
P.O. Box 22668
Long Beach, California 90801

*Pharmacy Benefits are administered by*
CVS CAREMARK

**Pharmacy Help Desk: (800) 791-6856**

*If your card is lost or stolen, please*
*call Member Services at (888) 898-7969*
*www.molinahealthcare.com*

MOLINA HEALTHCARE

Member Services
24 Hour - Toll Free
(888) 898-7969

RxBIN: 004336
RxPCN: ADV
RxGRP: RX0506

Member Name: JANE DOE
Member ID: 0009999999
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PCP Telephone: (999) 555-1111
Program: MA

This card is only valid if member maintains Molina Healthcare of Michigan eligibility.
Eligibility should be verified before rendering services.
Member: Please show this card each time you receive health care services.

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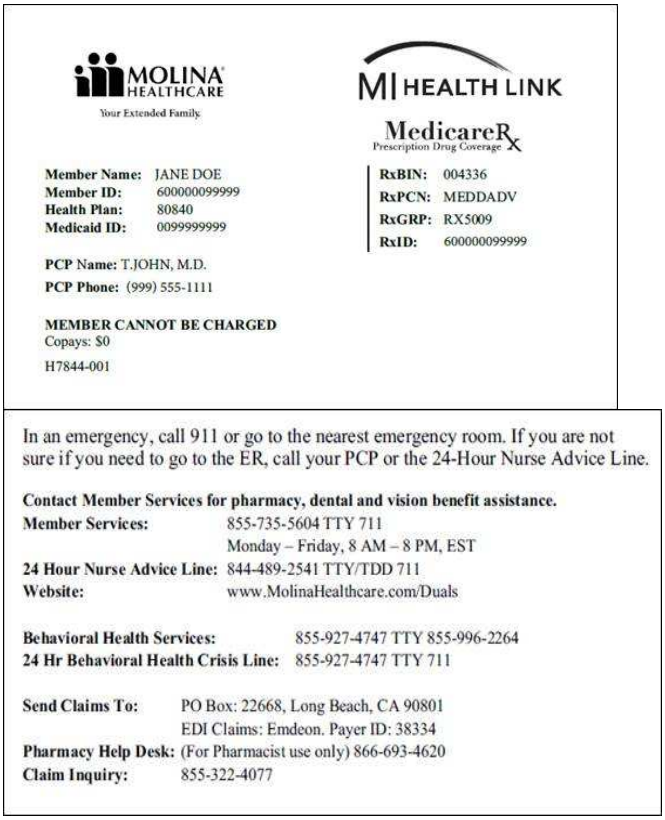
P.O. Box 22668
Long Beach, California 90801

*Pharmacy Benefits are administered by*
CVS CAREMARK

**Pharmacy Help Desk: (800) 791-6856**

*If your card is lost or stolen, please*
*call Member Services at (888) 898-7969*
*www.molinahealthcare.com*

### Sample MI Health Link ID Card




# Verifying Member Eligibility

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

- Log on to Provider Web Portal: [pwp.skygenusasystems.com](pwp.skygenusasystems.com)
- Call Member Services:
    - Healthy Michigan - 888-898-7969
    - Molina Dual Options (MI Health Link) - 855-735-5604.

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.

**NOTE** Because a member's eligibility can change at any time without prior notice, verifying eligibility does not guarantee payment.

## Verifying Eligibility via Provider Web Portal

Our Provider Web Portal allows quick, accurate verification of member's eligibility for covered benefits, as of the date of service. Log in using your ID and password at pwp.skygenusasystems.com.

First-time users need to register by contacting the Electronic Outreach Team: 844-621-4587.

Once logged in, you can quickly verify eligibility for an individual patient or for a group of patients, and you can print an online eligibility summary report for your records.

## Verifying Eligibility via IVR

Use our Interactive Voice Response (IVR) system to verify eligibility for an unlimited number of patients.

Call Member Services: Healthy Michigan - 888-898-7969 or Molina Dual Options (MI Health Link) - 855-735-5604. Follow the prompts to identify yourself and the patient whose eligibility you are verifying. Our system analyzes the information entered and verifies the patient's eligibility. If the system cannot verify the member information, you will be transferred to a Member Services Representative. You also have the option of transferring to a Member Services Representative after completing eligibility checks, if you have additional questions.

## Disenrollment

The Michigan Department of Health and Human Services allows for disenrollment from Medicaid Health Plans via the following Special Disenrollment protocol:

***Reasons for Special Disenrollment***

- Violent/Life-Threatening: Situations that involve physical acts of violence; physical or verbal threats of violence made against providers, staff or the public; or where stalking situations exist

***Documentation for Special Disenrollment***

- Detailed documentation to support the disenrollment request
- Incident Report or summary of members actions is required from provider's office
- Copy of dismissal letter or correspondence to the member
- Copy of the Police Report and reference number given by the Police Department
- Copy of the altered/forged prescription

Completed forms and documentation should be sent to:

Molina Healthcare

Attn: Enrollment Accounting Manager

880 West Long Lake Road, Suite 600

Troy, MI 48098

Fax: (877) 816-4528

All member of Molina's Dual Options Plan (MI Health Link) are full benefit dual eligible (e.g., they receive both Medicare and Medicaid). CMS rules state that these members may enroll or disenroll from Participating Plans and transfers between Participating Plans on a month-to-month basis any time during the year; and will be effective on the first day of the month following the request to do so.

## Specialist Referrals

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, as defined in the section of this Provider Manual, **Section 19: Benefit Plan Details and Authorization Requirements**. If you are unfamiliar with the Molina Dental Services contracted specialty network or need help locating a specialist provider, call Member Services: Healthy Michigan 888-898-7969 or Molina Dual Options (MI Health Link) 855-735-5604.

## Appointment Availability Standards

Molina Dental Services has established appointment time requirements to ensure members receive dental services within a time period appropriate to their dental health condition. We expect our dental providers to meet these appointment standards for a number of important reasons, including:

- Ensure members receive the care they need to protect their health
- Maintain member satisfaction
- Reduce unnecessary use of alternative services such as emergency room visits

Molina Dental Services dentists are expected to meet the following minimum standards for appointment availability:

- Routine dental care must be scheduled within 21 business days of request
- Urgent care must be available within 48 hours.
- Initial visit must be within 8 weeks of request
- Preventive care within 6 weeks of request
- Emergent care must be available to Member twenty-four (24) hours-a-day, seven (7) days-a-week.

Molina Dental Services will educate providers about appointment standards, monitor the adequacy of the process, and take corrective action if required.

## Missed Appointments

Enrolled participating providers are not allowed to charge members for missed appointments.

If your office sends letters to members who miss appointments, the following language may be helpful to include:

- "We missed you when you did not come for your dental appointment on Month/Date. Regular checkups are needed to keep your teeth healthy."
- "Please call to reschedule another appointment. Call us in advance if you cannot keep the appointment. Missed appointments are very costly to us. Thank you for your help."

Molina Dental Services recommends contacting the member by phone or postcard prior to the appointment to remind the individual of the time and place of the appointment.

The Centers for Medicare & Medicaid Services (CMS) and the Michigan Department of Health and Human Services (MDHHS) interpret federal law to prohibit a provider from billing any Molina Dental Services member for a missed appointment. In addition, your missed appointment policy for members enrolled in Molina Dental Services cannot be stricter than your policy for private or commercial patients.

If a Molina Dental Services member exceeds your office policy for missed appointments and you choose to discontinue seeing the member, ask the member to contact Molina Dental Services at:

Healthy Michigan 888-898-7969 or Molina Dual Options (MI Health Link) 855-735-5604 for assistance finding another dentist.

## Billing the Member

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.

## Payment for Non-covered Services

Enrolled participating providers shall hold members and Molina Dental Services harmless for the payment of non-covered services except as provided in this paragraph.

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

> Providers must inform members in advance and in writing when the member is responsible for non-covered services.

# Section 9: Non-Emergency Transportation

## Non-Emergency Medical Transportation

For members who have non-emergency medical transportation as a covered service, Molina Healthcare covers transportation to medical facilities when the member's medical and physical condition does not allow them to take regular means of public or private transportation (car, bus, air, etc.). This requires a written prescription from the member's doctor. Examples of non-emergency medical transportation include, but are not limited to, litter vans and wheelchair accessible vans. Members must have Prior Authorization from Molina Healthcare for these services before the services are given. Additional information regarding the availability of this benefit is available by contacting Customer Service at 1-888-898-7969.

## Non-Emergency Non-Medical Transportation

Molina Healthcare provides transportation to covered services for our Medicaid and Molina Dual Options (MI Health Link) members. Transportation by Logisticare is provided when members have no other means to get to their doctor appointments, x-rays, lab tests, pharmacy, medical supplies or other medical care.

In partnership with Logisticare, Molina is offering providers access to Logisticare Facility Services Web Portal (FSW). The Logisticare Facility Services Web portal provides a tool that allows you to request and manage our **Medicaid and Molina Dual Options (MI Health Link) member's** transportation requests on online.

**Sign up now to:**

- Improve access to care by allowing Provider office to book trips for members while in the office, eliminating "no ride" to office and/or forgotten appointments
- Assist members in getting rides home by booking "will call" return trips back to homes from office
- Improve member satisfaction and provider/patient relationships by assisting members in booking rides
- Improve HEDIS performance by providing assistance to get to office for quality measure visits
- Track member bookings and rides in system and can quickly access ride information

- Increase accuracy of trip bookings by allowing providers to directly book trips
- Reduce “no show” appointments
- Providers can plan visits more accurately through scheduling rides in advance.

To sign up for the booking tools, providers can email their request to MHMtransportationservices@molinahealthcare.com.

# Section 10: Prior Authorization & Documentation Requirements

## Prior Authorization for Treatment

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, is defined in this Provider Manual in **Section 19: Benefit Plan Details and Authorization Requirements.**

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.

Requests for prior authorization should be entered online through the Provider Web Portal (pwp.skygenusasystems.com), submitted electronically in a HIPAA-compliant data file (See **Section 10: Prior Authorization & Documentation Requirements**). Any claims or authorizations submitted without the required documentation will be denied and must be resubmitted to obtain reimbursement.

Molina Dental Services must make a decision on a request for prior authorization within 14 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. If you have questions about a prior authorization decision or wish to speak to the dental reviewer, call: 855-322-4079.

If Molina Dental Services denies approval for any requested service, the member will receive written notice of the reasons for each denial and will be notified of how to appeal the decision. The requesting provider will also receive notice of the decision.

Appeals regarding authorization determinations for Healthy Michigan members must be filed within 90 days of the authorization denial date. Molina Dental Services will review the appeal and render a decision within 30 days if an extension is not requested and granted. Molina Dental Services will deliver expedited resolutions within 72 hours.

Appeals regarding authorization determinations for Molina Dual Options (MI Health Link) members must be filed within 60 days of the authorization denial date. Molina Dental Services will review the appeal and render a decision within 30 days if an extension is not requested and granted. Molina Dental Services will deliver expedited resolutions within 72 hours.

Member appeals must be submitted in writing to:

Molina Dental Services
Attention: Member Appeals
880 West Long Lake Road
Suite 600
Troy, MI 48098-4504
Fax appeals to: 248-925-1799

# Section 11: Authorization Submission Procedures

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

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

## Submitting Authorizations via Provider Web Portal

Providers may submit authorizations directly to SKYGEN USA through our Provider Web Portal: pwp.skygenusasystems.com.

Submitting authorizations via the web portal has several significant advantages:

- The online dental form has built-in features that automatically verify member eligibility and make data entry quick and easy.
- The online authorization process steps you through clinical guidelines, when applicable, giving you a quick indication of how your authorization request will be evaluated and whether it's likely to be approved. (Successfully completing a clinical guideline does not guarantee payment.)
- The online authorization process indicates whether supporting documentation is required and allows you to attach and send documents as part of the authorization request.
- Dental reviewers and consultants receive your authorization requests and supporting documentation faster, which means you receive decisions faster.
- As soon as an authorization is determined, its status is instantly updated online and available for review.

If you have questions about submitting authorizations online, attaching electronic documents, or accessing the Provider Web Portal, call SKYGEN USA Web Portal Team 844-621-4587.

## Submitting Authorizations via Clearinghouses

Providers may submit electronic claims and authorizations to SKYGEN USA directly via either the Change Healthcare or DentalXChange clearinghouses. If you use a different clearinghouse, your software vendor can provide you with information you may need to ensure electronic files are forwarded to SKYGEN USA.

SKYGEN USA Payer ID is **SKYGN**. By using this unique Payer ID with electronic files, Change Healthcare and DentalXChange can ensure that claims and authorizations are submitted successfully to SKYGEN USA.

For more information about Change Healthcare and DentalXChange, visit their websites www.changehealthcare.com/ and www.dentalxchange.com.

## Submitting Authorizations via 837D File

If you can't submit claims and authorizations electronically through the Provider Web Portal or a clearinghouse, SKYGEN USA will work with you individually to receive electronic files submitted using the HIPAA Compliant 837D transaction set format. To inquire about this option, please call Molina Dental Services Provider Services at: 855-322-4077.

## Attaching Electronic Documents

If you use the Provider Web Portal, you can quickly and easily attach and send electronic documents as part of submitting a claim or authorization.

SKYGEN USA also accepts dental radiographs and other documents electronically via Fast Attach™ for authorization requests. For more information, visit www.nea-fast.com or call NEA (National Electronic Attachment, Inc.): **800-782-5150**.

# 2012 ADA Approved Dental 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) (Primary diagnosis in "A") A _____ B _____ C _____ 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.)

48. 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

**ADA** American Dental Association®

America's leading advocate for oral health

The following information highlights certain form completion instructions. Comprehensive ADA Dental Claim Form completion instructions are printed in the CDT manual. Any updates to these instructions will be posted on the ADA's web site (ADA.org).

## GENERAL INSTRUCTIONS

A. The form is designed so that the name and address (Item 3) of the third-party payer receiving the claim (insurance company/dental benefit plan) is visible in a standard #9 window envelope (window to the left). Please fold the form using the 'tick-marks' printed in the margin.

B. Complete all items unless noted otherwise on the form or in the CDT manual's instructions.

C. Enter the full name of an individual or a full business name, address and zip code when a name and address field is required.

D. All dates must include the four-digit year.

E. If the number of procedures reported exceeds the number of lines available on one claim form, list the remaining procedures on a separate, fully completed claim form.

## COORDINATION OF BENEFITS (COB)

When a claim is being submitted to the secondary payer, complete the entire form and attach the primary payer's Explanation of Benefits (EOB) showing the amount paid by the primary payer. You may also note the primary carrier paid amount in the "Remarks" field (Item 35). There are additional detailed completion instructions in the CDT manual.

## DIAGNOSIS CODING

The form supports reporting up to four diagnosis codes per dental procedure. This information is required when the diagnosis may affect claim adjudication when specific dental procedures may minimize the risks associated with the connection between the patient's oral and systemic health conditions. Diagnosis codes are linked to procedures using the following fields:

Item 29a – Diagnosis Code Pointer ("A" through "D" as applicable from Item 34a)

Item 34 – Diagnosis Code List Qualifier (B for ICD-9-CM; AB for ICD-10-CM)

Item 34a – Diagnosis Code(s) / A, B, C, D (up to four, with the primary adjacent to the letter "A")

## PLACE OF TREATMENT

Enter the 2-digit Place of Service Code for Professional Claims, a HIPAA standard maintained by the Centers for Medicare and Medicaid Services. Frequently used codes are:

11 = Office; 12 = Home; 21 = Inpatient Hospital; 22 = Outpatient Hospital; 31 = Skilled Nursing Facility; 32 = Nursing Facility

The full list is available online at "www.cms.gov/PhysicianFeeSched/Downloads/Website_POS_database.pdf"

## PROVIDER SPECIALTY

This code is entered in Item 56a and indicates the type of dental professional who delivered the treatment. The general code listed as "Dentist" may be used instead of any of the other codes.

| Category / Description Code | Code |
|---|---|
| **Dentist**<br>A dentist is a person qualified by a doctorate in dental surgery (D.D.S.) or dental medicine (D.M.D.) licensed by the state to practice dentistry, and practicing within the scope of that license. | 122300000X |
| **General Practice** | 1223G0001X |
| **Dental Specialty** (see following list) | Various |
| Dental Public Health | 1223D0001X |
| Endodontics | 1223E0200X |
| Orthodontics | 1223X0400X |
| Pediatric Dentistry | 1223P0221X |
| Periodontics | 1223P0300X |
| Prosthodontics | 1223P0700X |
| Oral & Maxillofacial Pathology | 1223P0106X |
| Oral & Maxillofacial Radiology | 1223D0008X |
| Oral & Maxillofacial Surgery | 1223S0112X |

Provider taxonomy codes listed above are a subset of the full code set that is posted at "www.wpc-edi.com/codes/taxonomy"

# Section 12: Claim Submission Procedures

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

## Submitting Claims via Provider Web Portal

Providers may submit claims directly to SKYGEN USA through our Provider Web Portal: pwp.skygenusasystems.com.

Submitting claims via the web portal has several significant advantages:

- The online dental form has built-in features that automatically verify member eligibility and make data entry quick and easy.
- The online process allows you to attach and send electronic documents as part of the submitting a claim.
- Before submitting a claim, you can generate an online payment estimate.
- Claims enter the SKYGEN USA benefits administration system faster, which means you receive payment faster.
- As soon as a claim is paid, its status is instantly updated online, and a remittance report is available for review.

If you have questions about submitting claims online, attaching electronic documents, or accessing the Provider Web Portal, call Provider Services: 844- 621-4587.

## Submitting Claims via Clearinghouses

Providers may submit electronic claims and authorizations to SKYGEN USA directly via either the Change Healthcare or DentalXChange clearinghouses. If you use a different clearinghouse, your software vendor can provide you with information you may need to ensure electronic files are forwarded to SKYGEN USA.

SKYGEN USA Payer ID is **SKYGN**. By using this unique Payer ID with electronic files, Change Healthcare and DentalXChange can ensure that claims and authorizations are submitted successfully to SKYGEN USA.

For more information about Change Healthcare and DentalXChange, visit their websites: www.changehealthcare.com/ and www.dentalxchange.com.

## Submitting Claims via HIPAA-Compliant 837D File

If you can't submit claims and authorizations electronically through the Provider Web Portal or a clearinghouse, SKYGEN USA will work with you individually to receive electronic files submitted using the HIPAA Compliant 837D transaction set format. To inquire about this option, please call Provider Services at: 855-322-4077.

## Attaching Electronic Documents

If you use the Provider Web Portal, you can quickly and easily attach and send electronic documents as part of submitting a claim or authorization.

SKYGEN USA, in conjunction with NEA (National Electronic Attachment, Inc.), also allows enrolled providers to submit documents electronically via FastAttach™. This program allows secure transmissions of radiographs, periodontics charts, intraoral pictures, narratives, and Explanation of Benefits (EOBs).

FastAttach™ is compatible with most claims clearinghouses and practice management systems. For more information, visit http://www.nea-fast.com or call NEA at **800-782-5150**.

## Submitting Claims on Paper Forms

To ensure timely processing of paper claims, the following information must be included on the 2012 ADA Dental Claim Form:

- Member Name
- Member Medicaid ID Number
- Member Date of Birth
- Provider Name
- Provider Location
- Billing Location
- Provider NPI
- Payee Tax Identification Number (TIN)
- Date of Service for each service line

Use approved ADA dental codes, as published in the current CDT book or as defined in this manual, to identify all services. Include on the form 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. Use the proper postage when mailing bulk documentation. Mail with postage due will be returned. Mail paper claims to:

Molina Dental Services Claims
PO Box 2136
Milwaukee, WI 53201

## Coordination of Benefits (COB) and Third Party Liability

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.

# Corrected Claim Submission Guidelines

## When Should I Submit a Corrected Claim?

A corrected claim should ONLY be submitted when an original claim or service was PAID based upon incorrect information.

A Corrected Claim must be submitted 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.

On the other hand, 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.

## What Scenarios are subject to the Corrected Claim Process?

A corrected claim should only be submitted if the original service(s) PAID based on incorrect information.

Some examples of correction(s) that need to be made to a prior **PAID** claim are:

- Incorrect Provider NPI or location
- Payee Tax ID
- Incorrect Member
- Procedure codes
- Services originally billed and paid at incorrect fees (including no fees)
- Services originally billed and paid without primary insurance

## How do I submit a Corrected Claim?

All corrected claims must be submitted on paper to the corrected claims PO Box for proper processing and include the following:

- Current version of the ADA form and all required information.
- The ADA form must be clearly noted “Corrected Claim”
- In the remarks field (Box 35) on the ADA form indicate the original paid encounter number and record all corrections you are requesting to be made.

*NOTE: If all information does not fit in Box 35, please attach an outline of corrections to the claim form.*

Submit to:

Molina Healthcare – Corrected Claim

PO Box 641

Milwaukee, WI 53201

### What Scenarios ARE NOT subject to the Corrected Claim Process?

A corrected claim should not be submitted if the original claim or service(s) which are the subject of the correction denied or were not previously submitted.

Some examples of items that are not considered claim corrections are:

- Any request to "Reprocess" a claim with no changes being made. This includes requests to reprocess a claim based on a new authorization being obtained.
- Any changes being made to a claim or service that denied for any reason such as missing tooth, quad, or arch information, incorrect code, age inappropriate code being billed, missing primary EOB, incorrect provider, etc.
- Any request to recoup a denied service. You DO NOT need to recoup a denied service as denied services are invalid and have no impact on member service/tooth history or accumulators.

If you received a claim or service denial due to missing/incomplete/incorrect information or you have since obtained authorization for services, please submit a new claim with the updated information per your normal claim submission channels. Timely filing limitations apply when a denied claim is being resubmitted with additional information for processing.

If you received a claim or service denial which you do not agree with, including denials for no authorization, please refer to your provider handbook for the proper method for submitting an appeal or reprocess request.

### What happens if I submit a Corrected Claim to the wrong PO Box or don't include the required documentation?

Following the above guidelines will allow you to receive payment as expediently as possible. Failure to follow these guidelines may result in unnecessary delay and/or rejection of your submission.

## Resubmitting a denied claim

To resubmit a claim that has been denied with additional information, follow the standard **Error! Reference source not found.** in **Section 12: Claims Submission Procedures** of this Provider Manual. Timely filing limitations apply when a claim is resubmitted for reprocessing.

## Submitting a corrected claim

To reverse and correct a payment that should not have been made, submit a corrected claim on the 2012 ADA Dental Claim Form and send paper forms and documents to:

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

## Receipt and Audit of Claims

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.

## Claims Adjudication and 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
PO Box 649
Milwaukee, WI 53201

## Overpayment and Incorrect Payments Refund Requests

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
PO Box 641
Milwaukee, WI 53201

# Section 13: Providing Services in Hospitals

## Submitting an Authorization for Dental Surgery Services

Molina Dental Services requires its network providers to render services only at participating hospitals. Before providing dental care to a patient in a hospital, first submit a prior authorization form (PA) request and receive approval for the planned services. The Dental Surgery prior authorization form can be found on the Documents tab in the Provider Web Portal at pwp.skygenusasystems.com.

> **NOTE** When you submit a prior authorization request for hospital services, include a note in the "**Remarks"** section that indicates your purpose is obtain approval for **inpatient dental surgery services.** The prior authorization can be uploaded to SKYGEN USA's Provider Web Portal.

To submit a PA for hospital services, use any of the following options:

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

## Participating Hospitals

Please refer to the Molina Dental Services Provider Online Directory for a listing of Molina Dental Services participating hospitals. Visit http://www.molinahealthcare.com and click "Find a Provider" or "Find a Hospital."

Molina Dental Services Provider Online Directory

# Section 14: Complaints, Grievances, Appeals

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.

## Provider Complaints and Disputes/Appeals

Differences sometimes arise between dental providers and insurers/benefit administrators regarding prior authorization determinations and payment decisions. Since many of these issues result from misunderstanding of service coverage, processing policy, or payment levels, we encourage providers to contact us for explanation and education. Contact Provider Services at 855-322-4077.

A designated Molina Dental Services complaint coordinator is dedicated to the expedient, satisfactory resolution of provider complaints, grievances, and appeals.

Participating providers who disagree with authorization decisions made by Molina Dental Services reviewers or dental consultants for Healthy Michigan members may submit a written appeal within 90 days of the original authorization denial date.

Participating providers who disagree with authorization decisions made by Molina Dental Services reviewers or dental consultants for Molina Dual Options (MI Health Link) members may submit a written appeal within 60 days of the original authorization denial date.

## Post-Service Appeal

Post-service appeal is considered an appeal of any adverse determination after rendering a service or procedure.

There are two types of post service provider appeals: administrative decisions and medical necessity review. To determine Medical Necessity, in conjunction with independent professional medical judgment, Molina Dental Services will use nationally recognized guidelines, which include but are not limited to, third party guidelines, CMS guidelines, State guidelines, guidelines from recognized professional societies, and advice from authoritative review articles and textbooks. A clean claim* must be on file and processed to be considered for a post service appeal.

(*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).

## Administrative Denials

Molina Dental Services has a one level appeal process for the practitioner appeal of post-service administrative denials. An example of an administrative denial is failure to authorize services according to required timeframes.

*Level 1*

A. A provider must submit a written appeal within 90 calendar days of the claim denial notification along with the explanation of payment.
B. The appeal must include NEW supporting evidence and/or documentation justifying the service, care or treatment being appealed and reason for notification outside of Molina Dental Services notification timeframes. Portions of the medical record may be submitted.
    a. Reason Authorization was not obtained
    b. Full Clinical Notes
    c. Any required supporting documentation (x-rays, photos, etc.)
C. Upon receipt of the appeal, the Dental Director or other qualified dentist will review all documentation submitted and fully investigate all aspects of the clinical care provided without deference to the original determination.
D. The Dental Director or other qualified dentist will/may consult with a dentist of the same or similar specialty as the case in review.

A decision will be rendered and written notification provided within 30 calendar days of the receipt of a post-service appeal.

### Medical Necessity Denials

For Medicaid services only, the provider can request a reconsideration of a prior authorization denial within 30 calendar days from the date listed on the prior authorization denial letter in writing or by calling the peer to peer line.

Submit complaints and disputes to:

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

A licensed dental consultant is available for peer to peer consultation to discuss the denial decision with any treating dental provider by calling 855-322-4079, from 8:30 am to 5pm Monday through Friday.

## Member Appeals

A member may appeal any Molina Dental Services decision which denies or reduces services. Member appeals are reviewed under our administrative appeal procedure.

Appeals regarding authorization determinations for Healthy Michigan members must be filed within 90 days of the authorization denial date. Molina Dental Services will review the appeal and render a decision within 30 days if an extension is not requested and granted.

Appeals regarding authorization determinations for Molina Dual Options (MI Health Link) members must be filed within 60 days of the authorization denial date. Molina Dental Services will review the appeal and render a decision within 30 days if an extension is not requested and granted. A member or member's authorized representative may file an expedited appeal within ten (10) calendar days of the received date of the adverse determination. Molina Dental Services will deliver expedited resolutions within 72 hours.

Member appeals must be submitted in writing to:

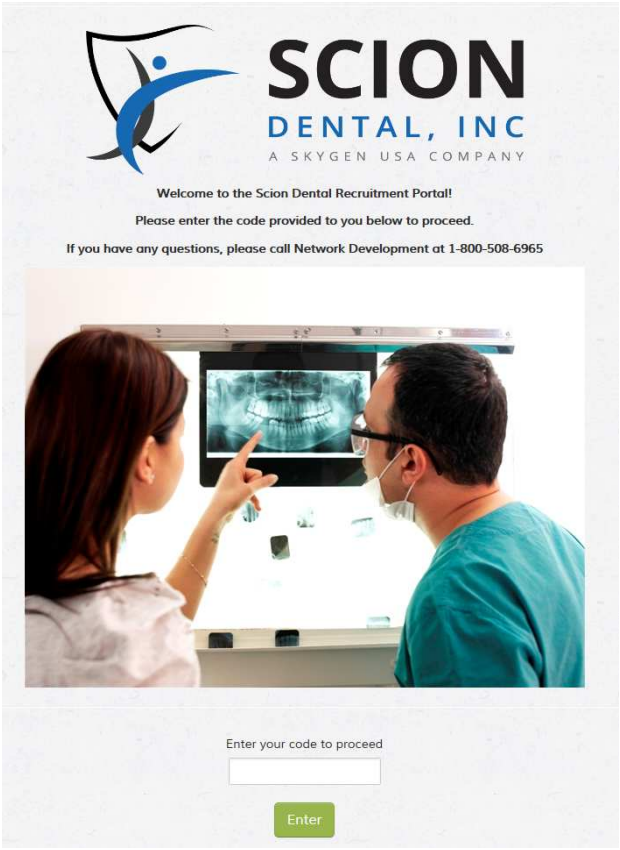
Molina Dental Services
Attention: Member Appeals
880 West Long Lake Road
Suite 600
Troy, MI 48098

# Section 15: Provider Enrollment & Contracting

If you have any questions about the contracting or credentialing process, please contact Molina Dental Services 844-862-4564 or email dental&visiondevelopment@molinahealthcare.com.

To enroll in the Molina Dental Services provider network, access enrollment information and documents, or add a clinic location, visit: [contracting.skygenusasystems.com](contracting.skygenusasystems.com)

Enter code MI, and then click **Enter**.



# Section 16: Provider Credentialing

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 Medicaid 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.

## Credentialing Process

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.

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: 844-862-4564.

## Obtaining a Credentialing Application

Molina Dental Services offers electronic credentialing through SKYGEN USA's Credentialing Portal. First register on the Credentialing Portal to complete the electronic credentialing process. Register at

http://skygenusa.com/Solutions/On-Demand-Solutions/Credentialing-Service/SKYGEN-USA-Credentialing.htm

## Recredentialing Process

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. If you have questions about recredentialing or need assistance, call Molina Dental Provider Network Services at 844-862-4564.

## Credentialing Decision Appeals

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.

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

# Section 17: The Patient Record

## Organization

1. The record must have areas for documentation of the following information:
    - Registration data including a complete health history.
    - Medical alert predominantly displayed inside chart jacket.
    - Initial examination data.
    - Radiographs.
    - Periodontal and Occlusal status.
    - Treatment plan/Alternative treatment plan.
    - Progress notes to include diagnosis, preventive services, treatment rendered, and medical/dental consultations.
    - Miscellaneous items (correspondence, referrals, and clinical laboratory reports).

2. The design of the record must provide the capability or periodic update, without the loss of documentation of the previous status, of the following information:
    - Health history.
    - Medical alert.
    - Examination/Recall data.
    - Periodontal status.
    - Treatment plan.

3. The design of the record must ensure that all permanent components of the record are attached or secured within the record.
4. The design of the record must ensure that all components must be readily identified to the patient (i.e., patient name, and identification number on each page).

5. The organization of the record system must require that individual records be assigned to each patient.

## Content

**The patient record must contain the following:**

1. Adequate documentation of registration information which requires entry of these items:
    - Patient's first and last name.
    - Date of birth.
    - Sex.
    - Address.
    - Telephone number.
    - Name and telephone number of the person to contact in case of emergency.

2. An adequate health history that requires documentation of these items:
    - Current medical treatment.
    - Significant past illnesses.
    - Current medications.
    - Drug allergies.
    - Hematologic disorders.
    - Cardiovascular disorders.
    - Respiratory disorders.
    - Endocrine disorders.
    - Communicable diseases.
    - Neurologic disorders.
    - Signature and date by patient.
    - Signature and date by reviewing dentist.
    - History of alcohol and tobacco usage including smokeless tobacco.

3. An adequate update of health history at subsequent recall examinations which requires documentation of these items:
    - Significant changes in health status.
    - Current medical treatment.
    - Current medications.
    - Dental problems/concerns.
    - Signature and date by reviewing dentist.

4. A conspicuously placed medical alert inside the chart jacket that documents highly significant terms from health history. These items are:
    - Health problems which contraindicate certain types of dental treatment.
    - Health problems that require precautions or pre-medication prior to dental treatment.
    - Current medications that may contraindicate the use of certain types of drugs or dental treatment.
    - Drug sensitivities.
    - Infectious diseases that may endanger personnel or other patients.

5. Adequate documentation of the initial clinical examination which is dated and requires descriptions of findings in these items:
    - Blood pressure. (Recommended)
    - Head/neck examination.
    - Soft tissue examination.
    - Periodontal assessment.
    - Occlusal classification.
    - Dentition charting.

6. Adequate documentation of the patient's status at subsequent Periodic/Recall examinations which is dated and requires descriptions of changes/new findings in these items:
    - Blood pressure. (Recommended)
    - Head/neck examination.

- Soft tissue examination.
- Periodontal assessment.
- Dentition charting.

7. Radiographs which are:
    - Identified by patient name.
    - Dated.
    - Designated by patient's left and right side.
    - Mounted (if intraoral films).

8. An indication of the patient's clinical problems/diagnosis
9. Adequate documentation of the treatment plan (including any alternate treatment options) that specifically describes all the services planned for the patient by entry of these items:
    - Procedure.
    - Localization (area of mouth, tooth number, surface).

10. An adequate documentation of the periodontal status, if necessary, which is dated and requires charting of the location and severity of these items:
    - Periodontal pocket depth.
    - Furcation involvement.
    - Mobility.
    - Recession.
    - Adequacy of attached gingiva.
    - Missing teeth.

11. An adequate documentation of the patient's oral hygiene status and preventive efforts which requires entry of these items:
    - Gingival status.
    - Amount of plaque.
    - Amount of calculus.

- Education provided to the patient.
- Patient receptiveness/compliance.
- Recall interval.

12. An adequate documentation of medical and dental consultations within and outside the practice which requires entry of these items:
    - Provider to whom consultation is directed. Information/services requested.
    - Consultant's response.

13. Adequate documentation of treatment rendered which requires entry of these items:
    - Date of service/procedure.
    - Description of service, procedure and observation. Documentation in treatment record must contain documentation to support the level of American Dental Association Current Dental Terminology code billed as detailed in the nomenclature and descriptors. Documentation must be written on a tooth by tooth basis for a per tooth code, on a quadrant basis for a quadrant code and on a per arch basis for an arch code.
    - Type and dosage of anesthetics and medications given or prescribed. Localization of procedure/observation (tooth #, quadrant etc.).
    - When general anesthesia and/or IV sedation is used the following should be documented:
        - Pre-operative and post-operative blood pressures and heart rate
        - Start and stop times of anesthesia
        - Type, strength and dosage of drugs administered
    - Signature of the Provider who rendered the service.

14. Adequate documentation of the specialty care performed by another dentist that includes:
    - Patient examination.
    - Treatment plan.
    - Treatment status.

## Compliance

1. The patient record has one explicitly defined format that is currently in use.
2. There is consistent use of each component of the patient record by all staff.
3. The components of the record that are required for complete documentation of each patient's status and care are present.
4. Entries in the records are legible.
5. Entries of symbols and abbreviations in the records are uniform, easily interpreted and are commonly understood in the practice

# Section 18: Clinical Criteria

## 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.

## Prior Authorization of Treatment

Some procedures require prior authorization before treatment is started. When submitting these procedures for prior review, also submit supporting documentation, if required. Prior authorization requirements and documentation requirements are summarized in this Provider Manual in **Section 19: Benefit Plan Details and Authorization Requirements.**

For information about submitting prior authorizations and required documentation, see **Section 10: Prior Authorization & Documentation Requirements.**

Dental surgery services must be performed in participating hospitals and require prior authorization. See **Section 13: Providing Services in Hospitals.**

## Emergency Treatment

Should a procedure need to be initiated to relieve pain and suffering in an emergency situation, you are to provide treatment to alleviate the patient's condition. To receive reimbursement for emergency treatment, submit all required documentation along with the claim for services rendered. Molina Dental Services uses the same clinical criteria (and requires the same supporting documentation) for claims submitted after emergency treatment as it would have used to determine prior authorizations for the same services.

## Radiology Requirements

**Note**: Please refer to benefit tables for radiograph benefit limitations.

## Radiographic Examination of the New Patient

- Child – primary dentition

  The Panel recommends posterior bitewing radiographs for a new patient, with a primary dentition and closed proximal contacts.

- Child – transitional dentition

  The Panel recommends an individualized periapical/occlusal examination with posterior bitewings OR a panoramic radiograph and posterior bitewings, for a new patient with a transitional dentition.

- Adolescent – permanent dentition prior to the eruption of the third molars

  The Panel recommends an individualized radiographic examination consisting of selected periapicals with posterior bitewings for a new adolescent patient.

- Adult – dentulous

  The Panel recommends an individualized radiographic examination consisting of selected periapicals with posterior bitewings for a new dentulous adult patient.

- Adult – edentulous

  The Panel recommends a full-mouth intraoral radiographic survey OR a panoramic radiograph for the new edentulous adult patient.

## Radiographic Examination of the Recall Patient

Patients with clinical caries or other high-risk factors for caries

- Child – primary and transitional dentition

  The Panel recommends that posterior bitewings be performed at a 6-12 month interval for those children with clinical caries or who are at increased risk for the development of caries in either the primary or transitional dentition.

- Adolescent

  The Panel recommends that posterior bitewings be performed at a 6-12 month interval for adolescents with clinical caries or who are at increased risk for the development of caries.

- Adult – dentulous

  The Panel recommends that posterior bitewings be performed at a 6-12 month interval for adults with clinical caries or who are at increased risk for the development of caries.

- Adult – edentulous

  The Panel found that an examination for occult disease in this group cannot be justified on the basis of prevalence, morbidity, mortality, radiation dose and cost. Therefore, the Panel recommends that no radiographs be performed for edentulous recall patients without clinical signs or symptoms.

Patients with no clinical caries and no other high risk factors for caries

- Child – primary dentition

  The Panel recommends that posterior bitewings be performed at an interval of 12-24 months for children with a primary dentition with closed posterior contacts that show no clinical caries and are not at increased risk for the development of caries.

- Adolescent

  The Panel recommends that posterior bitewings be performed at intervals of 12-24 months for patients with a transitional dentition who show no clinical caries and are not at an increased risk for the development of caries.

- Adult – dentulous

  The Panel recommends that posterior bitewings be performed at intervals of 24-36 months for dentulous adult patients who show no clinical caries and are not at an increased risk for the development of caries.

- Patients with periodontal disease, or a history of periodontal treatment for child – primary and transitional dentition, adolescent and dentulous adult
- The Panel recommends an individualized radiographic survey consisting of selected periapicals and/or bitewing radiographs of areas with clinical evidence or a history of periodontal disease, (except nonspecific gingivitis).

Growth and Development Assessment

- Child – Primary Dentition

  The panel recommends that prior to the eruption of the first permanent tooth, no radiographs be performed to assess growth and development at recall visits in the absence of clinical signs or symptoms.

- Child – Transitional Dentition

  The Panel recommends an individualized Periapical/Occlusal series OR a Panoramic Radiograph to assess growth and development at the first recall visit for a child after the eruption of the first permanent tooth.

- Adolescent

  The Panel recommends that for the adolescent (age 16-19 years of age) recall patient, a single set of Periapicals of the wisdom teeth OR a panoramic radiograph.

- Adult

  The Panel recommends that no radiographs be performed on adults to assess growth and development in the absence of clinical signs or symptoms. Clinical Criteria Descriptions

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.

### Restorative Services

- Any repair or replacement of a restoration is the provider's responsibility for 2 years following the placement of the restoration.
- Members age 21 and under are eligible for Indirect Resin Crowns when clinically indicated.
- Indirect Resin Crown for members under 21 years of age requires a prior authorization. Submit with PA:
    - Pre-operative x-ray
    - Narrative if reason for crown is not obvious on x-ray image

### Endodontic Therapy/Root Canal Therapy

- Members age 21 and under are eligible for root canal therapy on all permanent teeth (excluding 1, 16, 17, 32)
- Tooth must be periodontally sound. Must have greater than 50% bone support.
- Tooth must not have subcrestal caries or caries in the furcation.
- Tooth must have opposing tooth in occlusion.
- Submit with PA:
    - Pre-operative x-ray showing apex
    - Narrative if reason for root canal is not obvious on x-ray image

### Endodontic Retreatment

- Members age 21 and under are eligible for endodontic retreatment once per tooth per lifetime (excluding 1, 16, 17, 32)
- Tooth must be periodontally sound. Must have greater than 50% bone support.

- Tooth must not have subcrestal caries or caries in the furcation.
- Tooth must have opposing tooth in occlusion.
- Submit with PA:
    - Pre-operative x-ray showing apex
    - Narrative if reason for retreatment is not obvious on x-ray image

### Scaling and root planing

- Benefit for Molina Dual Options (MI Health Link) members only
    - D4341
        - 4 or more teeth in the quadrant
        - 5 mm or more pocketing on 2 or more teeth indicated on the perio charting
        - Presence of root surface calculus and/or noticeable loss of bone support on x-rays
        - General prognosis of teeth is good, no excessive decay or pocketing of 8 mm and above
    - D4342
        - 1 to 3 teeth in the quadrant
        - 5 mm or more pocketing on 2 or more teeth indicated on the perio charting
        - Presence of root surface calculus and/or noticeable loss of bone support on x-rays
        - General prognosis of teeth is good, no excessive decay or pocketing of 8 mm and above
- Required documentation with PA:
    - A periodontal treatment plan
    - Periodontal charting of oral condition and pocket depths, with all six surfaces on each tooth charted
    - Current labeled, readable peri-apical images of the mouth and posterior bitewings. No Panorex images.

### Full dentures

- Existing denture greater than 5 years old
- Remaining teeth do not have adequate bone support or are non-restorable
- If the recipient has a history or an inability to wear prosthesis due to psychological or physiological reasons, the prosthesis will not be covered.
- Multiple appointments are necessary for fabrication of prosthesis. These multiple steps are inclusive in the fee for the removable prosthetic and are not eligible for additional compensation.
- All of the following procedures must be used to fabricate the dentures:
    - Individual positioning of the teeth
    - Waxup of the entire denture body
    - Conventional laboratory processing

- Submit with PA:
    - Patient history
    - Patient records and a narrative if reason for full denture is not obvious from documentation
    - Full mouth x-rays or panoramic x-ray
- Adjustments, Relines, and Rebases are covered according to the benefit grid, but these services are not covered within 6 months of placement.

### Immediate Full Dentures

- Same requirements as traditional full dentures with the additional requirements:
    - When immediate extractions involve only the anterior teeth, whether maxillary or mandibular.
- Submit the same documentation as with a traditional full denture with this additional requirement:
    - State on the PA request that the denture will be an immediate denture, which teeth will be extracted at the denture insertion, and the reason an immediate denture is needed.

### Partial dentures

- Existing partial denture greater than 5 years old
- Replacing one or more anterior teeth
- Member has less than 8 posterior teeth in occlusion. Fixed bridges and dentures are to be considered occluding teeth.
- Replacing permanent teeth only
- For maxillary partials, the remaining teeth must be structurally and periodontally sound with good distribution, to support a partial for 5 years
- If the recipient has a history or an inability to wear a prosthesis due to psychological or physiological reasons, the prosthesis will not be covered.
- Multiple appointments are necessary for fabrication of prosthesis. These multiple steps are inclusive in the fee for the removable prosthetic and are not eligible for additional compensation
- All of the following procedures must be used to fabricate the dentures:
    - Individual positioning of the teeth
    - Waxup of the entire denture body
    - Conventional laboratory processing
- Submit with PA:

    - Full mouth series of x-rays clearly showing adjacent and opposing teeth
    - Patient history
    - Any dental or medical condition that indicates extraction of remaining teeth.
- Adjustments, Relines, and Rebases are covered according to the benefit grid, but these services are not covered within 6 months of placement.

### Extractions

- Surgical procedures such as surgeries of the jaw or facial bones are considered a medical benefit, not a dental benefit.
- An extraction of an erupted tooth includes elevation and/or forceps removal. It includes minor contouring of the bone and closure if needed.
- A surgical extraction requires the removal of bone and/or sectioning of a tooth and may require the elevation of the mucoperiosteal flap. Minor contouring of the bone and closure of the tissue is included.
- The extraction procedure code must follow the CDT guidelines and is not based on the amount of time required, the difficulty of the extraction, or any special circumstances.
- An extraction is not covered if exfoliation is imminent.
- Multiple extractions in the same quadrant for preparation of complete dentures are not considered surgical extractions unless guidelines for surgical extractions are met.
- The extraction of an impacted tooth is not covered for prophylactic removal of asymptomatic teeth that exhibit no overt pathology.

### Tooth Reimplantation

- Tooth reimplantation is a benefit for members under age 21 when permanent anterior teeth are avulsed or displaced due to traumatic injury.

### Alveoloplasty

- Alveoloplasty performed in conjunction with extractions is a separate procedure performed at the time of the extractions in the surgical preparation of the ridge for complete or partial dentures.
- Alveoloplasty in an edentulous area not performed in conjunction with extractions (secondary alveoloplasty) is not covered if recent extractions have been performed in that quadrant.

### General anesthesia / IV sedation (Dental Office Setting) - 1 or more of the criteria below

- Anesthesia services may be billed separately from the surgical procedure.
- A diagnosis code for anesthesia is required on all claim forms.
- IV sedation and general anesthesia are not a benefit for the convenience of the dentist or beneficiary and are limited to situations when these anesthesia services are

medically necessary. Apprehension and/or anxiety of the beneficiary are not considered valid medical reasons for IV sedation or general anesthesia.

- IV sedation and general anesthesia is not covered when it is used preceding the administration of local anesthesia as the primary anesthetic agent.
- IV sedation and general anesthesia may not be billed in combination with each other.
- Nitrous oxide analgesia is not a separate reimbursable procedure.
- Nitrous oxide and locally administered anesthetics are included in the reimbursement of the procedure performed.

### Hospital or Ambulatory Surgery Center

- A hospital call is a covered benefit for all ages when dental care must be provided in a hospital for medical reasons. The hospital call can be submitted in addition to the applicable procedure codes for the services provided on the date of service. Medical Prior Authorization is required.

# Section 19: Benefit Plan Details and Authorization Requirements

The following benefit plan details and related authorization requirements apply to all of the following Molina Dental Services benefit plans:

- Healthy Michigan
- Molina Dual Options (MI Health Link)

The only differences across these plans are based on patient age. When checking coverage rules or whether authorization requirements apply for a particular procedure code, be sure to verify the patient's age as of the date of service.

In the following table, if **Yes** is indicated in the **Authorization Request** column then a service requires a prior authorization. If documentation is indicated in the **Requirement** column, then supporting documentation is required before the authorization can be approved or the claim can be paid. When a prior authorization is required, submit it (along with any required documentation) to Molina Dental Services for approval before beginning non-emergency or routine treatment. If immediate treatment is required in an emergency situation, submit required documentation after treatment with the claim.

# Coverage Details | Authorization Requirement

## Molina Healthcare of Michigan
## Healthy Michigan as of 1/1/18

| Code | Description | Ages | Covered Teeth/Quad/Arch (If any restrictions exist) | Limitations | Auth? | Documentation Required |
|---|---|---|---|---|---|---|
| D0120 | Periodic Oral Exam-established patient | 19-64 | | one (D0120, D0150) per 6 months | N | |
| D0140 | Limited Oral Evaluation - problem focused | 19-64 | | two per month | N | |
| D0150 | Comprehensive Oral Evaluation - new or established patient | 19-64 | | one (D0120, D0150) per 6 months | N | |
| D0191 | Assessment of a patient | 19-64 | | one per 6 months | N | |
| D0210 | Intraoral - complete series of radiographic images | 19-64 | | one per 5 years | N | |
| D0220 | Intraoral - periapical first radiographic image | 19-64 | | four per month | N | |
| D0230 | Intraoral - periapical each additional radiographic image | 19-64 | | twelve per year | N | |
| D0240 | Intraoral - occlusal radiographic image | 19-21 | | two per 3 years | N | |
| D0270 | Bitewing - single radiographic image | 19-64 | | one (D0270, D0272, D0273, D0274) per year | N | |

| Code | Description | Ages | Covered Teeth/Quad/Arch (If any restrictions exist) | Limitations | Auth? | Documentation Required |
|---|---|---|---|---|---|---|
| D0272 | Bitewing - 2 radiographic images | 19-64 | | one per year | N | |
| D0273 | Bitewing - 3 radiographic images | 19-64 | | one per year | N | |
| D0274 | Bitewing - 4 radiographic images | 19-64 | | one per year | N | |
| D0330 | Panoramic radiographic image | 19-64 | | one per 5 years | N | |
| D1110 | Prophylaxis – Adult | 19-64 | | one (D1110, D1120) per 6 months | N | |
| D1354 | Interim Caries Arresting Medicament Application per tooth | 19-64 | | | N | |
| D2140 | Amalgam - 1 surface, primary or permanent | 19-64 | | one (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 2 years per same tooth/surface | N | |
| D2150 | Amalgam - 2 surfaces, primary or permanent | 19-64 | | one (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 2 years per same tooth/surface | N | |
| D2160 | Amalgam - 3 surfaces, primary or permanent | 19-64 | | one (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 2 years per same tooth/surface | N | |
| D2161 | Amalgam - 4 or > surfaces, primary or permanent | 19-64 | | one (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 2 years per same tooth/surface | N | |
| D2330 | Resin-based composite - 1 surface, anterior | 19-64 | | one (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 2 years per same tooth/surface | N | |

| Code | Description | Ages | Covered Teeth/Quad/Arch (If any restrictions exist) | Limitations | Auth? | Documentation Required |
|---|---|---|---|---|---|---|
| D2331 | Resin-based composite - 2 surfaces, anterior | 19-64 | | one (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 2 years per same tooth/surface | N | |
| D2332 | Resin-based composite - 3 surfaces, anterior | 19-64 | | one (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 2 years per same tooth/surface | N | |
| D2335 | Resin-based composite - 4 or > surfaces or involving incisal angle (anterior) | 19-64 | | one (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 2 years per same tooth/surface | N | |
| D2390 | Resin-based composite crown, - anterior | 19-64 | | one per 2 years per same tooth/surface | N | |
| D2391 | Resin-based composite - 1 surface, posterior | 19-64 | | one (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 2 years per same tooth/surface | N | |
| D2392 | Resin-based composite - 2 surfaces, posterior | 19-64 | | one (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 2 years per same tooth/surface | N | |
| D2393 | Resin-based composite - 3 surfaces, posterior | 19-64 | | one (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 2 years per same tooth/surface | N | |
| D2394 | Resin-based composite - 4 or > surfaces, posterior | 19-64 | | one (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 2 years per same tooth/surface | N | |
| D2710 | Crown - resin based composite (indirect) | 19-21 | | one per 5 years per same tooth/surface | Y | pre-operative x-ray |
| D2712 | Crown - 3/4 resin-based composite (indirect) | 19-21 | | one per 5 years per same tooth/surface | Y | pre-operative x-ray |
| D2910 | Re-cement or re-bond inlay, onlay, veneer or partial coverage restoration | 19-64 | | one per 6 months per same tooth/surface | N | |

| Code | Description | Ages | Covered Teeth/Quad/Arch (If any restrictions exist) | Limitations | Auth? | Documentation Required |
|---|---|---|---|---|---|---|
| D2915 | Re-cement or re-bond indirectly fabricated or prefabricated post and core | 19-21 | | one per 6 months per same tooth/surface | N | |
| D2920 | Re-cement or re-bond crown | 19-64 | | one per 6 months per same tooth/surface | N | |
| D2930 | Prefabricated stainless steel crown – primary tooth | 19-21 | | one per 2 years, same tooth/surface | N | |
| D2931 | Prefabricated stainless steel crown – permanent tooth | 19-21 | | one per 2 years, same tooth/surface | N | |
| D2933 | Prefabricated stainless crown with resin window | 19-21 | | one per 2 years, same tooth/surface | N | |
| D2934 | Prefabricated esthetic coated stainless steel crown – primary tooth | 19-21 | | one per 2 years, same tooth/surface | N | |
| D2940 | Protective restoration | 19-64 | | one per 2 years, same tooth/surface | N | |
| D2950 | Core buildup, including any pins | 19-21 | | only with approved D2710 one per 2 years, same tooth/surface | N | pre-operative x-ray |
| D2951 | Pin retention - per tooth, in addition to restoration | 19-64 | | only with approved D2710 one per 2 years, same tooth/surface | N | pre-operative x-ray |
| D2952 | Cast post and core in addition to crown, indirectly fabricated | 19-21 | | only with approved D2710 one per 2 years, same tooth/surface | N | pre-operative x-ray |
| D2954 | Prefabricated post and core in addition to crown | 19-21 | | only with approved D2710 one per 2 years, same tooth/surface | N | pre-operative x-ray |
| D2999 | Unspecified restorative procedure, by report | 19-64 | | | Y | Narrative of procedure and why it doesn't fit any other code |
| D3110 | Pulp cap – direct (excluding final restoration) | 19-64 | | one per lifetime, same tooth/surface | N | pre-operative x-ray |

| Code | Description | Ages | Covered Teeth/Quad/Arch (If any restrictions exist) | Limitations | Auth? | Documentation Required |
|---|---|---|---|---|---|---|
| D3222 | Partial pulpotomy for apexogenesis – permanent tooth with incomplete root development | 19-21 | | one per lifetime | N | |
| D3310 | Endodontic therapy, anterior tooth (excluding final restoration) | 19-21 | Anterior Teeth | one per lifetime, same tooth/surface | N | |
| D3320 | Endodontic therapy, premolar tooth (excluding final restoration) | 19-21 | Premolar | | N | |
| D3330 | Endodontic therapy, molar (excluding final restoration) | 19-21 | 1st and 2nd Molars | one per lifetime, same tooth/surface | N | |
| D3346 | Retreatment of previous root canal therapy – anterior | 19-21 | Anterior Teeth | one per lifetime , same tooth/surface | Y | pre-operative x-ray |
| D3347 | Retreatment of previous root canal therapy – premolar | 19-21 | Premolar | one per lifetime, same tooth/surface | Y | pre-operative x-ray |
| D3348 | Retreatment of previous root canal therapy – molar | 19-21 | Molar | one per lifetime, same tooth/surface | Y | pre-operative x-ray |
| D3410 | Apicoectomy – anterior | 19-21 | | one per lifetime, same tooth/surface | N | |
| D3421 | Apicoectomy – premolar (first root) | 19-21 | | one per lifetime, same tooth/surface | N | |
| D3425 | Apicoectomy – molar (first root) | 19-21 | | one per lifetime, same tooth/surface | N | |
| D3426 | Apicoectomy (each additional root) | 19-21 | | one per lifetime, same tooth/surface | N | |
| D3430 | Retrograde filling – per root | 19-21 | | one per lifetime, same tooth/surface | N | |
| D3999 | Unspecified endodontic procedure by report | 19-21 | | | Y | Narrative of procedure and why it doesn't fit any other code |

| Code | Description | Ages | Covered Teeth/Quad/Arch (If any restrictions exist) | Limitations | Auth? | Documentation Required |
|---|---|---|---|---|---|---|
| D4355 | Full mouth debridement to enable comprehensive eval & diagnosis on a subsequent visit | 19-64 | | one per year<br>not on same DOS as D1110, D1120 | N | |
| D5110 | Complete denture - Maxillary | 19-64 | | one (D5110, D5130) per 5 years | Y | Full mouth or panoramic x-ray |
| D5120 | Complete denture – Mandibular | 19-64 | | one (D5120, D5140) per 5 years | Y | Full mouth or panoramic x-ray |
| D5130 | Immediate denture - Maxillary | 19-64 | | one (D5110, D5130) per 5 years | Y | Full mouth or panoramic x-ray, and teeth to be extracted at insertion of denture |
| D5140 | Immediate denture – Mandibular | 19-64 | | one (D5120, D5140) per 5 years | Y | Full mouth or panoramic x-ray, and teeth to be extracted at insertion of denture |
| D5211 | Maxillary partial denture - resin base | 19-64 | | one (D5211, D5213, D5225) per 5 years | Y | Full mouth or panoramic x-ray |
| D5212 | Mandibular partial denture - resin base | 19-64 | | one (D5212, D5214, D5226) per 5 years | Y | Full mouth or panoramic x-ray |
| D5213 | Maxillary partial denture - cast metal framework w/ resin base | 19-64 | | one (D5211, D5213, D5225) per 5 years | Y | Full mouth or panoramic x-ray |
| D5214 | Mandibular partial denture - cast metal framework w/ resin base | 19-64 | | one (D5212, D5214, D5226) per 5 years | Y | Full mouth or panoramic x-ray |
| D5225 | Maxillary partial denture - flexible base | 19-64 | | one (D5211, D5213, D5225) per 5 years | Y | Full mouth or panoramic x-ray |
| D5226 | Mandibular partial denture - flexible base | 19-64 | | one (D5212, D5214, D5226) per 5 years | Y | Full mouth or panoramic x-ray |
| D5410 | Adjust complete denture – maxillary | 19-64 | | one per 2 years<br>not payable within 6 months of maxillary dentures D5110, D5130, D5211, D5213, D5225 | N | |

| Code | Description | Ages | Covered Teeth/Quad/Arch (If any restrictions exist) | Limitations | Auth? | Documentation Required |
|---|---|---|---|---|---|---|
| D5411 | Adjust complete denture – mandibular | 19-64 | | one per 2 years not payable within 6 months of mandibular dentures D5120, D5140, D5212, D5214, D5226 | N | |
| D5421 | Adjust partial denture – maxillary | 19-64 | | one per 2 years not payable within 6 months of maxillary dentures D5110, D5130, D5211, D5213, D5225 | N | |
| D5422 | Adjust partial denture – mandibular | 19-64 | | one per 2 years not payable within 6 months of mandibular dentures D5120, D5140, D5212, D5214, D5226 | N | |
| D5511 | Repair broken complete denture base, mandibular | 19-64 | | two per 12 months | N | |
| D5512 | Repair broken complete denture base, maxillary | 19-64 | | two per 12 months | N | |
| D5520 | Replace missing or broken teeth - complete denture per tooth | 19-64 | | two per 12 months, same tooth/surface not payable within 6 months of dentures D5110, D5120, D5130, D5140, D5211, D5212, D5213, D5214, D5225, D5226 | N | |
| D5611 | Repair resin partial denture base, mandibular | 19-64 | | two per 12 months | N | |
| D5612 | Repair resin partial denture base, maxillary | 19-64 | | two per 12 months | N | |
| D5621 | Repair cast partial framework, mandibular | 19-64 | | two per 12 months | N | |
| D5622 | Repair cast partial framework, maxillary | 19-64 | | two per 12 months | N | |
| D5630 | Repair or replace broken clasp – per tooth | 19-64 | | two per 12 months not payable within 6 months of dentures D5110, D5120, D5130, D5140, D5211, D5212, D5213, D5214, D5225, D5226 | N | |

| Code | Description | Ages | Covered Teeth/Quad/Arch (If any restrictions exist) | Limitations | Auth? | Documentation Required |
|---|---|---|---|---|---|---|
| D5640 | Replace broken teeth - per tooth | 19-64 | | two per 12 months, same tooth/surface<br>not payable within 6 months of dentures D5110, D5120, D5130, D5140, D5211, D5212, D5213, D5214, D5225, D5226 | N | |
| D5650 | Add tooth to existing partial denture | 19-64 | | two per 12 months, same tooth/surface<br>not payable within 6 months of dentures D5110, D5120, D5130, D5140, D5211, D5212, D5213, D5214, D5225, D5226 | N | |
| D5660 | Add clasp to existing partial denture – per tooth | 19-64 | | two per 12 months<br>not payable within 6 months of dentures D5110, D5120, D5130, D5140, D5211, D5212, D5213, D5214, D5225, D5226 | N | |
| D5710 | Rebase complete maxillary denture | 19-64 | | one maxillary rebase/reline (D5710, D5720, D5730, D5740, D5750, D5760) per 2 years<br>not payable within 6 months of maxillary dentures D5110, D5130, D5211, D5213, D5225 | N | |
| D5711 | Rebase complete mandibular denture | 19-64 | | one mandibular rebase/reline (D5711, D5721, D5731, D5741, D5751, D5761) per 2 years<br>not payable within 6 months of mandibular dentures D5120, D5140, D5212, D5214, D5226 | N | |
| D5720 | Rebase maxillary partial denture | 19-64 | | one maxillary rebase/reline (D5710, D5720, D5730, D5740, D5750, D5760) per 2 years<br>not payable within 6 months of maxillary dentures D5110, D5130, D5211, D5213, D5225 | N | |
| D5721 | Rebase mandibular partial denture | 19-64 | | one mandibular rebase/reline (D5711, D5721, D5731, D5741, D5751, D5761) per 2 years<br>not payable within 6 months of mandibular dentures D5120, D5140, D5212, D5214, D5226 | N | |
| D5730 | Reline complete maxillary denture (chairside) | 19-64 | | one maxillary rebase/reline (D5710, D5720, D5730, D5740, D5750, D5760) per 2 years<br>not payable within 6 months of maxillary dentures D5110, D5130, D5211, D5213, D5225 | N | |

| Code | Description | Ages | Covered Teeth/Quad/Arch (If any restrictions exist) | Limitations | Auth? | Documentation Required |
|---|---|---|---|---|---|---|
| D5731 | Reline complete mandibular denture (chairside) | 19-64 | | one mandibular rebase/reline (D5711, D5721, D5731, D5741, D5751, D5761) per 2 years<br>not payable within 6 months of mandibular dentures D5120, D5140, D5212, D5214, D5226 | N | |
| D5740 | Reline maxillary partial denture (chairside) | 19-64 | | one maxillary rebase/reline (D5710, D5720, D5730, D5740, D5750, D5760) per 2 years<br>not payable within 6 months of maxillary dentures D5110, D5130, D5211, D5213, D5225 | N | |
| D5741 | Reline mandibular partial denture (chairside) | 19-64 | | one mandibular rebase/reline (D5711, D5721, D5731, D5741, D5751, D5761) per 2 years<br>not payable within 6 months of mandibular dentures D5120, D5140, D5212, D5214, D5226 | N | |
| D5750 | Reline complete maxillary denture (laboratory) | 19-64 | | one maxillary rebase/reline (D5710, D5720, D5730, D5740, D5750, D5760) per 2 years<br>not payable within 6 months of maxillary dentures D5110, D5130, D5211, D5213, D5225 | N | |
| D5751 | Reline complete mandibular denture (laboratory) | 19-64 | | one mandibular rebase/reline (D5711, D5721, D5731, D5741, D5751, D5761) per 2 years<br>not payable within 6 months of mandibular dentures D5120, D5140, D5212, D5214, D5226 | N | |
| D5760 | Reline maxillary partial denture (laboratory) | 19-64 | | one maxillary rebase/reline (D5710, D5720, D5730, D5740, D5750, D5760) per 2 years<br>not payable within 6 months of maxillary dentures D5110, D5130, D5211, D5213, D5225 | N | |

| Code | Description | Ages | Covered Teeth/Quad/Arch (If any restrictions exist) | Limitations | Auth? | Documentation Required |
|---|---|---|---|---|---|---|
| D5761 | Reline mandibular partial denture (laboratory) | 19-64 | | one mandibular rebase/reline (D5711, D5721, D5731, D5741, D5751, D5761) per 2 years<br>not payable within 6 months of mandibular dentures D5120, D5140, D5212, D5214, D5226 | N | |
| D5899 | Unspecified removable prosthodontic procedure, by report | 19-64 | | | Y | Narrative of procedure and why it doesn't fit any other code |
| D6930 | Re-cement or re-bond fixed partial denture | 19-64 | | | N | |
| D7111 | Extraction, coronal remnants – primary tooth | 19-21 | | one per lifetime, same tooth | N | |
| D7140 | Extraction, erupted tooth or exposed root | 19-64 | | one per lifetime, same tooth | N | |
| D7210 | Extraction, erupted tooth requiring removal of bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap if indicated | 19-64 | | one per lifetime, same tooth | N | |
| D7220 | Removal of impacted tooth - soft tissue | 19-64 | | one per lifetime, same tooth | N | |
| D7230 | Removal of impacted tooth - partially bony | 19-64 | | one per lifetime, same tooth | N | |
| D7240 | Removal of impacted tooth - completely bony | 19-64 | | one per lifetime, same tooth | N | |
| D7250 | Removal of residual tooth roots (cutting procedure) | 19-64 | | one per lifetime, same tooth | N | |
| D7260 | Oroantral fistula closure | 19-64 | | one per lifetime | N | |
| D7261 | Primary closure of a sinus perforation | 19-64 | | one per lifetime | N | |

| Code | Description | Ages | Covered Teeth/Quad/Arch (If any restrictions exist) | Limitations | Auth? | Documentation Required |
|---|---|---|---|---|---|---|
| D7270 | Tooth re-implantation and/or stabilization of accidentally evulsed or displaced tooth | 19-21 | | one per lifetime, same tooth | N | |
| D7310 | Alveoloplasty in conjunction w/ extractions - 4 or > teeth or tooth spaces per quadrant | 19-64 | | one per lifetime, same quadrant | N | |
| D7320 | Alveoloplasty not in conjunction w/ extractions – 4 or > teeth or tooth spaces per quadrant | 19-64 | | one per 5 years, same quadrant | N | |
| D7471 | Removal of lateral exostosis (maxilla or mandible) | 19-64 | | one per lifetime, same quadrant | N | |
| D7472 | Removal of torus palatinus | 19-64 | | one per lifetime | N | |
| D7473 | Removal of torus mandibularis | 19-64 | | one per lifetime, same quadrant | N | |
| D7485 | Surgical reduction of osseous tuberosity | 19-64 | | one per lifetime, same quadrant | N | |
| D7510 | Incision and drainage of abscess - intraoral soft tissue | 19-64 | | | N | |
| D7970 | Excision of hyperplastic tissue - per arch | 19-64 | | one per 2 years, same arch | N | |
| D7971 | Excision of pericoronal gingiva | 19-64 | | one per 2 years, same tooth/surface | N | |
| D7972 | Surgical reduction of fibrous tuberosity | 19-64 | | one per 2 years, same quadrant | | |
| D7999 | Unspecified oral surgery procedure, by report | 19-64 | | | Y | Narrative of procedure and why it doesn't fit any other code |
| D9110 | Palliative (emergency) treatment of dental pain - minor procedure | 19-64 | | | N | |

| Code | Description | Ages | Covered Teeth/Quad/Arch (If any restrictions exist) | Limitations | Auth? | Documentation Required |
|---|---|---|---|---|---|---|
| D9222 | Deep sedation/general anesthesia first 15 minutes | 19-64 | | | N | |
| D9223 | Deep sedation/general anesthesia - each subsequent 15 minute increment | 19-64 | | | N | |
| D9239 | Intravenous moderate (conscious) sedation/analgesia - first 15 minutes | 19-64 | | | N | |
| D9243 | Intravenous moderate (conscious) sedation/analgesia - each subsequent 15 minute increment | 19-64 | | | N | |
| D9310 | Dental consultation - diagnostic service provided by dentist or physician other than requesting dentist or physician | 19-64 | | | N | |
| D9420 | Hospital or ambulatory surgical center call | 19-64 | | one per 6 months | N | |
| D9930 | Treatment of complications (post-surgical) – unusual circumstances, by report | 19-64 | | | N | |
| D9999 | Unspecified adjunctive procedure, by report | 19-64 | | | Y | Narrative of procedure and why it doesn't fit any other code |

## Molina Healthcare of Michigan

## Molina Dual Options (MI Health Link) as of 7/1/18

| Code | Description | Ages | Covered Teeth/Quad/Arch (If any restrictions exist) | Limitations | Auth? | Documentation Required |
|---|---|---|---|---|---|---|
| D0120 | Periodic Oral Exam-established patient | 21-999 | | one (D0120, D0150) per 6 months | N | |
| D0140 | Limited Oral Evaluation - problem focused | 21-999 | | two per month | N | |
| D0150 | Comprehensive Oral Evaluation - new or established patient | 21-999 | | one (D0120, D0150) per 6 months | N | |
| D0191 | Assessment of a patient | 21-999 | | one per 6 months | N | |
| D0210 | Intraoral - complete series of radiographic images | 21-999 | | one per 5 years | N | |
| D0220 | Intraoral - periapical first radiographic image | 21-999 | | four per month | N | |
| D0230 | Intraoral - periapical each additional radiographic image | 21-999 | | twelve per year | N | |
| D0270 | Bitewing - single radiographic image | 21-999 | | one (D0270, D0272, D0273, D0274) per year | N | |

| Code | Description | Ages | Covered Teeth/Quad/Arch (If any restrictions exist) | Limitations | Auth? | Documentation Required |
|---|---|---|---|---|---|---|
| D0272 | Bitewing - 2 radiographic images | 21-999 | | one per year | N | |
| D0273 | Bitewing - 3 radiographic images | 21-999 | | one per year | N | |
| D0274 | Bitewing - 4 radiographic images | 21-999 | | one per year | N | |
| D0330 | Panoramic radiographic image | 21-999 | | one per 5 years | N | |
| D1110 | Prophylaxis – Adult | 21-999 | | one (D1110, D1120) per 6 months | N | |
| D1354 | Interim Caries Arresting Medicament Application per tooth | 21-999 | | | N | |
| D2140 | Amalgam - 1 surface, primary or permanent | 21-999 | | one (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 2 years per same tooth/surface | N | |
| D2150 | Amalgam - 2 surfaces, primary or permanent | 21-999 | | one (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 2 years per same tooth/surface | N | |
| D2160 | Amalgam - 3 surfaces, primary or permanent | 21-999 | | one (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 2 years per same tooth/surface | N | |
| D2161 | Amalgam - 4 or > surfaces, primary or permanent | 21-999 | | one (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 2 years per same tooth/surface | N | |
| D2330 | Resin-based composite - 1 surface, anterior | 21-999 | | one (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 2 years per same tooth/surface | N | |

| Code | Description | Ages | Covered Teeth/Quad/Arch (If any restrictions exist) | Limitations | Auth? | Documentation Required |
|---|---|---|---|---|---|---|
| D2331 | Resin-based composite - 2 surfaces, anterior | 21-999 | | one (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 2 years per same tooth/surface | N | |
| D2332 | Resin-based composite - 3 surfaces, anterior | 21-999 | | one (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 2 years per same tooth/surface | N | |
| D2335 | Resin-based composite - 4 or > surfaces or involving incisal angle (anterior) | 21-999 | | one (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 2 years per same tooth/surface | N | |
| D2390 | Resin-based composite crown, - anterior | 21-999 | | one per 2 years per same tooth/surface | N | |
| D2391 | Resin-based composite - 1 surface, posterior | 21-999 | | one (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 2 years per same tooth/surface | N | |
| D2392 | Resin-based composite - 2 surfaces, posterior | 21-999 | | one (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 2 years per same tooth/surface | N | |
| D2393 | Resin-based composite - 3 surfaces, posterior | 21-999 | | one (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 2 years per same tooth/surface | N | |
| D2394 | Resin-based composite - 4 or > surfaces, posterior | 21-999 | | one (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 2 years per same tooth/surface | N | |
| D2910 | Re-cement or re-bond inlay, onlay, veneer or partial coverage restoration | 21-999 | | one per 6 months per same tooth/surface | N | |

| Code | Description | Ages | Covered Teeth/Quad/Arch (If any restrictions exist) | Limitations | Auth? | Documentation Required |
|---|---|---|---|---|---|---|
| D2920 | Re-cement or re-bond crown | 21-999 | | one per 6 months per same tooth/surface | N | |
| D2940 | Protective restoration | 21-999 | | one per 2 years, same tooth/surface | N | |
| D2951 | Pin retention - per tooth, in addition to restoration | 21-999 | | only with approved D2710 one per 2 years, same tooth/surface | N | pre-operative x-ray |
| D2999 | Unspecified restorative procedure, by report | 21-999 | | | Y | Narrative of procedure and why it doesn't fit any other code |
| D3110 | Pulp cap – direct (excluding final restoration) | 21-999 | | one per lifetime, same tooth/surface | N | pre-operative x-ray |
| D4341 | Periodontal scaling and root planing – four or more teeth per quadrant | 21-999 | Tooth range - 4+ | $1,000 Calendar Year Max One (1) per quadrant per 24 months, either D4341 or D4342. Limit to two (2) quadrants per same date of service. | Y | A periodontal treatment plan. Periodontal charting of oral condition and pocket depths with all six surfaces on each tooth charted. Current labeled, readable peri-apical images of the mouth and posterior bitewings. No Panorex images. |
| D4342 | Periodontal scaling and root planing – one to three teeth per quadrant | 21-999 | Tooth range - 1-3 | $1,000 Calendar Year Max One (1) per quadrant per 24 months, either D4341 or D4342. Limit to two (2) quadrants per same date of service. | Y | A periodontal treatment plan. Periodontal charting of oral condition and pocket depths with all six surfaces on each tooth charted. Current labeled, readable peri-apical images of the mouth and posterior bitewings. No Panorex images. |
| D4355 | Full mouth debridement to enable comprehensive eval & diagnosis on a subsequent visit | 21-999 | | one per year not on same DOS as D1110, D1120 | N | |
| D5110 | Complete denture - Maxillary | 21-999 | | one (D5110, D5130) per 5 years | Y | Full mouth or panoramic x-ray |
| D5120 | Complete denture – Mandibular | 21-999 | | one (D5120, D5140) per 5 years | Y | Full mouth or panoramic x-ray |
| D5130 | Immediate denture - Maxillary | 21-999 | | one (D5110, D5130) per 5 years | Y | Full mouth or panoramic x-ray, and teeth to be extracted at insertion of denture |
| D5140 | Immediate denture – Mandibular | 21-999 | | one (D5120, D5140) per 5 years | Y | Full mouth or panoramic x-ray, and teeth to be extracted at insertion of denture |

| Code | Description | Ages | Covered Teeth/Quad/Arch (If any restrictions exist) | Limitations | Auth? | Documentation Required |
|---|---|---|---|---|---|---|
| D5211 | Maxillary partial denture - resin base | 21-999 | | one (D5211, D5213, D5225) per 5 years | Y | Full mouth or panoramic x-ray |
| D5212 | Mandibular partial denture - resin base | 21-999 | | one (D5212, D5214, D5226) per 5 years | Y | Full mouth or panoramic x-ray |
| D5213 | Maxillary partial denture - cast metal framework w/ resin base | 21-999 | | one (D5211, D5213, D5225) per 5 years | Y | Full mouth or panoramic x-ray |
| D5214 | Mandibular partial denture - cast metal framework w/ resin base | 21-999 | | one (D5212, D5214, D5226) per 5 years | Y | Full mouth or panoramic x-ray |
| D5225 | Maxillary partial denture - flexible base | 21-999 | | one (D5211, D5213, D5225) per 5 years | Y | Full mouth or panoramic x-ray |
| D5226 | Mandibular partial denture - flexible base | 21-999 | | one (D5212, D5214, D5226) per 5 years | Y | Full mouth or panoramic x-ray |
| D5410 | Adjust complete denture – maxillary | 21-999 | | one per 2 years not payable within 6 months of maxillary dentures D5110, D5130, D5211, D5213, D5225 | N | |
| D5411 | Adjust complete denture – mandibular | 21-999 | | one per 2 years not payable within 6 months of mandibular dentures D5120, D5140, D5212, D5214, D5226 | N | |
| D5421 | Adjust partial denture – maxillary | 21-999 | | one per 2 years not payable within 6 months of maxillary dentures D5110, D5130, D5211, D5213, D5225 | N | |
| D5422 | Adjust partial denture – mandibular | 21-999 | | one per 2 years not payable within 6 months of mandibular dentures D5120, D5140, D5212, D5214, D5226 | N | |
| D5511 | Repair broken complete denture base, mandibular | 21-999 | | two per 12 months | N | |
| D5512 | Repair broken complete denture base, maxillary | 21-999 | | two per 12 months | N | |
| D5520 | Replace missing or broken teeth - complete denture per tooth | 21-999 | | two per 12 months, same tooth/surface not payable within 6 months of dentures D5110, D5120, D5130, D5140, D5211, D5212, D5213, D5214, D5225, D5226 | N | |

| Code | Description | Ages | Covered Teeth/Quad/Arch (If any restrictions exist) | Limitations | Auth? | Documentation Required |
|---|---|---|---|---|---|---|
| D5611 | Repair resin partial denture base, mandibular | 21-999 | | two per 12 months | N | |
| D5612 | Repair resin partial denture base, maxillary | 21-999 | | two per 12 months | N | |
| D5621 | Repair cast partial framework, mandibular | 21-999 | | two per 12 months | N | |
| D5622 | Repair cast partial framework, maxillary | 21-999 | | two per 12 months | N | |
| D5630 | Repair or replace broken clasp – per tooth | 21-999 | | two per 12 months<br>not payable within 6 months of dentures D5110, D5120, D5130, D5140, D5211, D5212, D5213, D5214, D5225, D5226 | N | |
| D5640 | Replace broken teeth - per tooth | 21-999 | | two per 12 months, same tooth/surface<br>not payable within 6 months of dentures D5110, D5120, D5130, D5140, D5211, D5212, D5213, D5214, D5225, D5226 | N | |
| D5650 | Add tooth to existing partial denture | 21-999 | | two per 12 months, same tooth/surface<br>not payable within 6 months of dentures D5110, D5120, D5130, D5140, D5211, D5212, D5213, D5214, D5225, D5226 | N | |
| D5660 | Add clasp to existing partial denture – per tooth | 21-999 | | two per 12 months<br>not payable within 6 months of dentures D5110, D5120, D5130, D5140, D5211, D5212, D5213, D5214, D5225, D5226 | N | |
| D5710 | Rebase complete maxillary denture | 21-999 | | one maxillary rebase/reline (D5710, D5720, D5730, D5740, D5750, D5760) per 2 years<br>not payable within 6 months of maxillary dentures D5110, D5130, D5211, D5213, D5225 | N | |

| Code | Description | Ages | Covered Teeth/Quad/Arch (If any restrictions exist) | Limitations | Auth? | Documentation Required |
|---|---|---|---|---|---|---|
| D5711 | Rebase complete mandibular denture | 21-999 | | one mandibular rebase/reline (D5711, D5721, D5731, D5741, D5751, D5761) per 2 years not payable within 6 months of mandibular dentures D5120, D5140, D5212, D5214, D5226 | N | |
| D5720 | Rebase maxillary partial denture | 21-999 | | one maxillary rebase/reline (D5710, D5720, D5730, D5740, D5750, D5760) per 2 years not payable within 6 months of maxillary dentures D5110, D5130, D5211, D5213, D5225 | N | |
| D5721 | Rebase mandibular partial denture | 21-999 | | one mandibular rebase/reline (D5711, D5721, D5731, D5741, D5751, D5761) per 2 years not payable within 6 months of mandibular dentures D5120, D5140, D5212, D5214, D5226 | N | |
| D5730 | Reline complete maxillary denture (chairside) | 21-999 | | one maxillary rebase/reline (D5710, D5720, D5730, D5740, D5750, D5760) per 2 years not payable within 6 months of maxillary dentures D5110, D5130, D5211, D5213, D5225 | N | |
| D5731 | Reline complete mandibular denture (chairside) | 21-999 | | one mandibular rebase/reline (D5711, D5721, D5731, D5741, D5751, D5761) per 2 years not payable within 6 months of mandibular dentures D5120, D5140, D5212, D5214, D5226 | N | |
| D5740 | Reline maxillary partial denture (chairside) | 21-999 | | one maxillary rebase/reline (D5710, D5720, D5730, D5740, D5750, D5760) per 2 years not payable within 6 months of maxillary dentures D5110, D5130, D5211, D5213, D5225 | N | |
| D5741 | Reline mandibular partial denture (chairside) | 21-999 | | one mandibular rebase/reline (D5711, D5721, D5731, D5741, D5751, D5761) per 2 years not payable within 6 months of mandibular dentures D5120, D5140, D5212, D5214, D5226 | N | |

| Code | Description | Ages | Covered Teeth/Quad/Arch (If any restrictions exist) | Limitations | Auth? | Documentation Required |
|---|---|---|---|---|---|---|
| D5750 | Reline complete maxillary denture (laboratory) | 21-999 | | one maxillary rebase/reline (D5710, D5720, D5730, D5740, D5750, D5760) per 2 years<br>not payable within 6 months of maxillary dentures D5110, D5130, D5211, D5213, D5225 | N | |
| D5751 | Reline complete mandibular denture (laboratory) | 21-999 | | one mandibular rebase/reline (D5711, D5721, D5731, D5741, D5751, D5761) per 2 years<br>not payable within 6 months of mandibular dentures D5120, D5140, D5212, D5214, D5226 | N | |
| D5760 | Reline maxillary partial denture (laboratory) | 21-999 | | one maxillary rebase/reline (D5710, D5720, D5730, D5740, D5750, D5760) per 2 years<br>not payable within 6 months of maxillary dentures D5110, D5130, D5211, D5213, D5225 | N | |
| D5761 | Reline mandibular partial denture (laboratory) | 21-999 | | one mandibular rebase/reline (D5711, D5721, D5731, D5741, D5751, D5761) per 2 years<br>not payable within 6 months of mandibular dentures D5120, D5140, D5212, D5214, D5226 | N | |
| D5899 | Unspecified removable prosthodontic procedure, by report | 21-999 | | | Y | Narrative of procedure and why it doesn't fit any other code |
| D6930 | Re-cement or re-bond fixed partial denture | 21-999 | | | N | |
| D7140 | Extraction, erupted tooth or exposed root | 21-999 | | one per lifetime, same tooth | N | |

| Code | Description | Ages | Covered Teeth/Quad/Arch (If any restrictions exist) | Limitations | Auth? | Documentation Required |
|---|---|---|---|---|---|---|
| D7210 | Extraction, erupted tooth requiring removal of bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap if indicated | 21-999 | | one per lifetime, same tooth | N | |
| D7220 | Removal of impacted tooth - soft tissue | 21-999 | | one per lifetime, same tooth | N | |
| D7230 | Removal of impacted tooth - partially bony | 21-999 | | one per lifetime, same tooth | N | |
| D7240 | Removal of impacted tooth - completely bony | 21-999 | | one per lifetime, same tooth | N | |
| D7250 | Removal of residual tooth roots (cutting procedure) | 21-999 | | one per lifetime, same tooth | N | |
| D7260 | Oroantral fistula closure | 21-999 | | one per lifetime | N | |
| D7261 | Primary closure of a sinus perforation | 21-999 | | one per lifetime | N | |
| D7310 | Alveoloplasty in conjunction w/ extractions - 4 or > teeth or tooth spaces per quadrant | 21-999 | | one per lifetime, same quadrant | N | |
| D7320 | Alveoloplasty not in conjunction w/ extractions – 4 or > teeth or tooth spaces per quadrant | 21-999 | | one per 5 years, same quadrant | N | |
| D7471 | Removal of lateral exostosis (maxilla or mandible) | 21-999 | | one per lifetime, same quadrant | N | |
| D7472 | Removal of torus palatinus | 21-999 | | one per lifetime | N | |
| D7473 | Removal of torus mandibularis | 21-999 | | one per lifetime, same quadrant | N | |
| D7485 | Surgical reduction of osseous tuberosity | 21-999 | | one per lifetime, same quadrant | N | |

| Code | Description | Ages | Covered Teeth/Quad/Arch (If any restrictions exist) | Limitations | Auth? | Documentation Required |
|---|---|---|---|---|---|---|
| D7510 | Incision and drainage of abscess - intraoral soft tissue | 21-999 | | | N | |
| D7970 | Excision of hyperplastic tissue - per arch | 21-999 | | one per 2 years, same arch | N | |
| D7971 | Excision of pericoronal gingiva | 21-999 | | one per 2 years, same tooth/surface | N | |
| D7972 | Surgical reduction of fibrous tuberosity | 21-999 | | one per 2 years, same quadrant | | |
| D7999 | Unspecified oral surgery procedure, by report | 21-999 | | | Y | Narrative of procedure and why it doesn't fit any other code |
| D9110 | Palliative (emergency) treatment of dental pain - minor procedure | 21-999 | | | N | |
| D9222 | Deep sedation/general anesthesia first 15 minutes | 21-999 | | | N | |
| D9223 | Deep sedation/general anesthesia - each subsequent 15 minute increment | 21-999 | | | N | |
| D9239 | Intravenous moderate (conscious) sedation/analgesia - first 15 minutes | 21-999 | | | N | |
| D9243 | Intravenous moderate (conscious) sedation/analgesia - each subsequent 15 minute increment | 21-999 | | | N | |
| D9310 | Dental consultation - diagnostic service provided by dentist or physician other than requesting dentist or physician | 21-999 | | | N | |
| D9420 | Hospital or ambulatory surgical center call | 21-999 | | one per 6 months | N | |
| D9930 | Treatment of complications (post-surgical) – unusual circumstances, by report | 21-999 | | | N | |

| Code | Description | Ages | Covered Teeth/Quad/Arch (If any restrictions exist) | Limitations | Auth? | Documentation Required |
|---|---|---|---|---|---|---|
| D9999 | Unspecified adjunctive procedure, by report | 21-999 | | | Y | Narrative of procedure and why it doesn't fit any other code |

# Section 20: Appendix - Attachment

# Appendix C – Non-Covered Services Agreement

## Non-Covered Services Agreement

**Provider**_____

**Address**_____**City, State, Zip**_____

**Telephone**_____ **Fax**_____

**Email**_____ **Website**_____

**Provider MA#**_____

I,_____ , understand that the following procedures are excluded under the Molina Healthcare program. I further understand that by signing this agreement, I am agreeing in advance, in writing, to accept full financial responsibility for all costs associated with these non-covered dental services.

| Date of Service | Code | Description of Service | Cost |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| **Total Amount Due by Recipient** | | | |

_____/_____

**Patient Name/Patient MA#**

_____

**Patient/Guardian/Beneficiary Name – Relationship to Patient**

_____

**Patient/Guardian/Beneficiary Signature** **Date**

_____

**Dentist Name**

_____

**Dentist Signature** **Date**

This form must be kept on file and a copy of which available upon request.