



Quarter 1
2020

Dental Provider Manual

Molina Healthcare of Ohio

Medicaid and MyCare Ohio Programs

Contents

- Welcome.....7**

- Fraud, Waste and Abuse Program8**
 - Regulatory Requirements8
 - Examples of Fraud, Waste and Abuse by a Provider9
 - Reporting Fraud, Waste and Abuse9
 - Non-Incentivization Policy 10
 - Deficit Reduction Act: The False Claims Act..... 11
 - Review of Provider 11
 - Review of Provider Claims and Claims System 12
 - Whistleblower Protection..... 12

- Health Insurance Portability and Accountability Act (HIPAA)..... 13**
 - National Provider Identifier (NPI)..... 14
 - Medicaid ID Requirements 14
 - Cybersecurity Requirements 14

- Quick Reference Guide 18**
 - Quick Contacts 18
 - Mailing Addresses 18
 - Quick Reference 19

- Member Rights & Responsibilities 21**
 - Member Rights.....21
 - Member Responsibilities22
 - Member Information and Marketing 23

- Provider Rights & Responsibilities 24**
 - Provider Responsibilities.....24
 - Nondiscrimination24
 - Section 1557 Investigations.....25
 - Child Abuse and Neglect25
 - Facilities, Equipment and Personnel25
 - Provider Data Accuracy and Validation26
 - Compliance26
 - Confidentiality of Member Health Information and HIPAA Transactions27
 - Participation in Grievance and Appeals Programs27
 - Molina Electronic Solutions Requirements27
 - Billing Molina Healthcare Members.....27

Office Site Standards	28
Interpreter Services.....	32
Cultural Competency.....	33
Eligibility & Member Services	37
Medicaid.....	37
Molina Dual Options MyCare Ohio Medicare-Medicaid Plan	37
Member Identification Card.....	38
Verifying Member Eligibility.....	39
Verifying Eligibility via SKYGEN Provider Portal	39
Verifying Eligibility via IVR	40
Specialist Referrals	40
Appointment Availability Standards	40
Missed Appointments	41
Balance Billing.....	41
Payment for Non-Covered Services	41
Credentialing	42
The Credentialing Process.....	43
The Recredentialing Process.....	44
Provider Rights.....	45
Provider Enrollment & Contracting.....	46
Out of Network Providers and Services.....	46
Benefit Plan Details and Authorization Requirements	47
Coverage Details Authorization Requirements	50
Form 03630: Referral Evaluation Criteria for Comprehensive Orthodontic Treatment ..	68
SKYGEN Provider Portal.....	69
SKYGEN Provider Portal Registration	69
Utilization Management.....	70
Community Practice Patterns.....	70
Evaluation	70
Results	70
Prior Authorization & Documentation Requirements	71
Consistent, Transparent Authorization Decisions	71
Prior Authorization for Treatment	71

Authorization Submission Procedures.....	73
Submitting Authorizations via SKYGEN Provider Portal.....	73
Submitting Authorizations via Clearinghouses.....	73
Submitting Authorizations via 837D File.....	74
Attaching Electronic Documents.....	74
American Dental Association Approved Dental Claim Form.....	75
Clinical Criteria.....	77
Medical Necessity.....	77
Prior Authorization of Treatment.....	77
Emergency Treatment.....	77
Clinical Criteria Descriptions.....	78
Claim Submission Procedures	83
Submitting Claims via SKYGEN Provider Portal	83
Submitting Claims via Clearinghouses.....	83
Submitting Claims via HIPAA-Compliant 837D File	84
Attaching Electronic Documents.....	84
Submitting Claims on Paper Forms	84
Coordination of Benefits (COB) and Third Party Liability.....	85
Submitting Updated COB Information	86
Corrected Claim Submission Guidelines.....	86
Prior Authorization of Treatment.....	88
Emergency Treatment.....	89
Receipt and Audit of Claims	89
Claims Adjudication and Payment	89
Overpayments and Refund Requests	90
Refunds.....	90
Electronic Payment	92
Electronic Funds Transfer (EFT)	92
Electronic Remittance Reports.....	93
Providing Services in Hospitals	94
Participating Hospitals.....	94
Appeals and Grievances.....	95
Provider Appeals.....	95
Member Appeals.....	97

Appendix – Attachments	98
Appendix A – Non-Covered Services Agreement	99
Appendix B - Orthodontic Continuation of Care Form	100

Welcome

Welcome to the Molina Healthcare of Ohio Provider network! At Molina, we are committed to providing our Members with the best possible care to keep them healthy, stable and independent. It's our reason for being here. We are pleased to welcome you to our team.

We have partnered with SKYGEN USA, LLC, formerly known as Scion Dental, Inc., a nationwide leader in managed benefits administration, to administer the dental benefit for our Members. Throughout your relationship with Molina, you can refer to this Provider Manual as a reference tool. This manual includes information on contacting Molina, claims and authorization submissions and Covered Benefits for Members.

This Provider Manual shall serve as a supplement as referenced thereto and incorporated therein, to the Molina Healthcare of Ohio, Inc. Dental Provider Services Agreement. Contracted Providers must acknowledge this Provider Manual and any other written materials provided by Molina as proprietary and confidential. The information is not to be copied in whole or in part; nor is the information to be distributed without the express written consent of Molina.

The Provider Manual is reviewed, evaluated and updated as needed and at a minimum annually. Molina retains the right to add to, delete from, or otherwise modify this Provider Manual.

Thank you for your participation in the delivery of quality health care services to Molina Members. We look forward to working with you.

This manual describes policies and procedures that govern our administration of dental benefits for Molina programs. We make every effort to maintain accurate information in this manual, however we will not be held liable for any damages due to unintentional errors. If you discover an error, please report it to Provider Services at (844) 862-4564. If information in this manual differs from your Participating Agreement, the Participating Agreement takes precedence.

Fraud, Waste and Abuse Program

Introduction

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

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

Mission Statement

Molina regards health care fraud, waste and abuse as unacceptable, unlawful and harmful to the provision of quality health care in an efficient and affordable manner. Molina has therefore implemented a plan to prevent, investigate and report suspected health care fraud, waste and abuse in order to reduce health care cost and to promote quality health care.

Regulatory Requirements

Federal False Claims Act

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

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

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

The act does not require proof of a specific intent to defraud the U.S. government. Instead, health care Providers can be prosecuted for a wide variety of conduct that leads to the submission of fraudulent claims to the government, such as knowingly making false statements, falsifying records, double-billing for items or services.

Definitions

Fraud, waste and abuse are defined as:

Fraud: Fraud is intentional deception or misrepresentation made by a person with knowledge the deception could result in some unauthorized benefit to themselves or some other person or entity. It includes any act that constitutes fraud under federal or state law.

Waste: Waste is the unintentional, thoughtless or careless expenditures, consumption, mismanagement, use or squandering of federal or state resources. Waste also includes unnecessary costs incurred as a result of inefficient or ineffective practices, systems or controls.

Abuse: Abuse is defined as practices that are inconsistent with sound fiscal, business or medical practices, and that result in the unnecessary cost to the government health care program or in reimbursement for services medically unnecessary or that fail to meet professionally recognized standards for health care. Abuse includes intentional infliction of physical harm, injury caused by negligent acts or omissions, unreasonable confinement, sexual abuse or sexual assault. Abuse also includes beneficiary practices that result in unnecessary costs to the health care program.

Provider Fraud: Provider fraud is any deception or misrepresentation committed intentionally, or through willful ignorance or reckless disregard, by a person or entity in order to receive benefits or funds to which they are not entitled. This may include deception by improper coding or other false statements by Providers seeking reimbursement or false representations or other violations of federal health care program requirements, its associates or contractors.

Examples of Fraud, Waste and Abuse by a Provider

- Billing for services, procedures and/or supplies that have not actually been rendered
- Providing services to patients that are not Medically Necessary
- Balance billing a Medicaid Member for Medicaid Covered Services (e.g. asking the patient to pay the difference between the discounted fees, negotiated fees and the Provider's usual and customary fees)
- Intentional misrepresentation or manipulation of the benefits payable for services, procedures and/or supplies, dates on which services and/or treatments were rendered, medical record of services, condition treated or diagnosed, charges or reimbursement, identity of Provider/Practitioner or the recipient of services, "unbundling" of procedures, non-covered treatments, "up-coding" or billing for services not provided
- Concealing a patient's misuse of Molina identification card
- Failure to report a patient's forgery/alteration of a prescription
- Knowingly and willfully soliciting/receiving payment of kickbacks or bribes in exchange for the referral of Medicaid patients
- Knowingly and willfully referring Medicaid patients to health care facilities in which or with which the physician has a financial relationship (The Stark Law)

Reporting Fraud, Waste and Abuse

If you suspect cases of fraud, waste or abuse, you must report it by contacting the Molina AlertLine. AlertLine is an external telephone and web-based reporting system hosted by NAVEX Global, a leading Provider of compliance and ethics hotline services. AlertLine telephone and web-based reporting is available 24 hours a day, seven days a week, 365 days a year.

When you make a report, you can choose to remain confidential or anonymous. If you choose to call AlertLine, a trained professional at NAVEX Global will note your concerns and provide

them to the Molina Compliance Department for follow-up. If you elect to use the web-based reporting process, you will be asked a series of questions concluding with the submission of your report. Reports to AlertLine can be made from anywhere within the United States with telephone or Internet access.

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

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

Molina Healthcare of Ohio
Attn: Compliance
P.O. Box 349020
Columbus, OH 43234

Remember to include the following information when reporting:

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

Suspected fraud and abuse may also be reported directly to the state. If you suspect that a Medicaid recipient has committed fraud or abuse and would like to report it, please contact the County Department of Job and Family Services (CDJFS) in which the beneficiary resides. The number can be found in the CDJFS directory at www.ifs.ohio.gov/county/county_directory.pdf or in the telephone book under "County Government." If you are unable to locate the number, please call the Ohio Department of Job and Family Services General Information Customer Service number at (877) 852-0010 for assistance.

If you suspect a Provider to have committed fraud or abuse of the Medicaid program, or have specific knowledge of corrupt or deceptive practices by a Provider, you should contact the Ohio Attorney General's Medicaid Fraud Control Unit at (614) 466-0722 or the Attorney General's Help Center at (800) 282-0515.

Non-Incentivization Policy

It is Molina's 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 SKYGEN Utilization Management team bases decisions solely on appropriateness of care, service and existence of coverage. Molina and SKYGEN do 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.

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.

Review of Provider

The SKYGEN Credentialing Department is responsible for monitoring Practitioners through the various government reports, including:

- Federal and state Medicaid sanction reports
- Federal and state lists of excluded individuals and entities, including the U.S. Department of Health and Human Services Office of the Inspector General Exclusion Database and the Ohio Department of Medicaid Provider Exclusion and Suspension List
- List of parties excluded from Federal Procurement and Non-procurement Programs
- Medicaid suspended and ineligible Provider list
- Monthly review of state Medical Board sanctions list
- Review of license reports from the appropriate specialty board

If a match is found, the SKYGEN Credentialing staff will request copies of relevant information from the appropriate government entity. Upon receiving this information, the documents are presented to the SKYGEN Credentialing Committee for review and potential action. The SKYGEN Credentialing staff will also present the list of physicians found on the Medicaid sanctions report to Molina for review and potential oversight of action.

Provider/Practitioner Education

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

The Molina Provider Relations Representative will inform the Provider's office that an on-site meeting is required in order to educate the Provider on certain issues identified as inappropriate or deficient.

Review of Provider Claims and Claims System

Molina and SKYGEN Claims Examiners are trained to recognize unusual billing practices and to detect fraud, waste and abuse. If the Claims Examiner suspects fraudulent, abusive or wasteful billing practices, the billing practice is documented and reported to the Molina Compliance Department.

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

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

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.

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 or will go into effect as indicated in the final publications of the various rules covered by HIPAA.

Molina and SKYGEN 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.

Providers, Molina and SKYGEN agree to conduct their respective activities in accordance with the applicable provisions of HIPAA and such implementing regulations.

Maintenance of adequate dental/medical, financial and administrative records related to covered dental services are rendered by the Provider in accordance with federal and state law.

The safeguarding of all information about Members will adhere to applicable state and federal laws and regulations. All material and information, in particular information relating to Members or potential Members, which is provided to or obtained by or through a Provider, whether verbal, written, tape or otherwise, shall be reported as confidential information to the extent confidential treatment is provided under state and federal laws.

Neither Molina, SKYGEN nor Providers shall share confidential information with a Member's employer without the Member's consent for such disclosure.

Providers agree to comply with the requirements of HIPAA relating to the exchange of information and shall cooperate with SKYGEN in its efforts to ensure compliance with the privacy regulations promulgated under HIPAA and other related privacy laws.

When you contact Provider Services, you will be asked to supply your Tax ID Number (TIN) or National Provider Identifier (NPI) number. When you call regarding Member inquiries, you will be asked to supply specific Member identification such as Member ID, 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 (Current Dental Terminology [CDT]-) recognized by the American Dental Association (ADA). Molina and SKYGEN 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 current American Dental Association Claim Form.

To request copies of Molina and SKYGEN HIPAA policies, call Provider Services at (855) 322-4079 after selecting the appropriate plan choose option 7 for dental inquiries.

Note: To report a potential security issue, call the Molina Healthcare AlertLine: (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 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, Providers were required to have enrolled or applied for enrollment with the Ohio Department of Medicaid (ODM) at both the group practice and individual levels by Jan. 1, 2019. Providers without a Medicaid ID number will need to submit an application to ODM. Enrollment is available through the Medicaid Information Technology System (MITS) portal or Providers can start the process at <http://medicaid.ohio.gov>. Reach out to your Molina Provider Services Representative with questions.

Upon future notice by ODM, Molina will begin denying Claims for Providers that are not registered and known to the state.

Cybersecurity Requirements

Note: *This section is only applicable to Providers who are delegated Providers and have been delegated by Molina as a health plan function.*

1. Provider shall comply with the following requirements and permit Molina to audit such compliance as required by law or any enforcement agency.
2. The following terms are defined as follows:
 - I. “Consumer” means an individual who is a resident of Ohio, whose Nonpublic Information is in Molina’s possession, custody or control and which Provider maintains, processes, stores or otherwise has access to such Nonpublic Information.
 - II. “Cybersecurity Event” means an event resulting in unauthorized access to or the disruption or misuse of an Information System or Nonpublic Information stored on an Information System that has a reasonable likelihood of materially harming any Consumer residing in the state of Ohio or any material part of the normal operation of Molina. The term “Cybersecurity Event” does not include the unauthorized acquisition of encrypted Nonpublic Information if the encryption, process or key is not also acquired, released or used without authorization. The term “Cybersecurity Event” also

does not include an event in which Provider has determined that the Nonpublic Information accessed by an unauthorized person has not been used or released and has been returned or destroyed.

III. “Information System” or “Information Systems” means a discrete set of electronic information resources organized for the collection, processing, maintenance, use, sharing, dissemination or disposition of electronic Nonpublic Information, as well as any specialized system such as industrial or process controls systems, telephone switching and private branch exchange systems, and environmental control systems.

IV. “Nonpublic Information” means information that is not publicly available information and is one of the following:

- a. business related information of Molina the tampering with which, or unauthorized disclosure, access, or use of which, would cause a material adverse impact to the business, operations or security of Molina;
- b. any information concerning a Consumer that because of the name, number, personal mark, or other identifier contained in the information can be used to identify such Consumer, in combination with any one or more of the following data elements:
 - i. social security number;
 - ii. driver’s license number, commercial driver’s license or state identification card number;
 - iii. account number, credit or debit card number;
 - iv. security code, access code, or password that would permit access to a Consumer’s financial account; or
 - v. biometric records;
- c. any information or data, except age or gender, in any form or medium created by or derived from a health care Provider or a Consumer, that can be used to identify a particular Consumer, and that relates to any of the following:
 - i. the past, present, or future physical, mental or behavioral health or condition of a Consumer or a Member of the Consumer’s family;
 - ii. the provision of health care to a Consumer; or
 - iii. payment for the provision of health care to a Consumer.

3. As soon as possible, but no later than March 19, 2021, Provider shall implement appropriate administrative, technical, and physical measures to protect and secure the Information Systems and Nonpublic Information, as defined herein, that are accessible to, or held by, the Provider. Implementation of the foregoing measures shall incorporate guidance issued by the Ohio Department of Insurance, as appropriate.
4. Provider agrees to comply with all applicable laws governing Cybersecurity Events. Molina will decide on notification to affected individuals or government entities. Upon Molina’s prior written request, Provider agrees to assume responsibility for informing all such individuals in accordance with applicable law.
5. In the event of a Cybersecurity Event, Provider shall notify Molina’s Chief Information Security Officer of such Cybersecurity Event by telephone and email (as provided below) as promptly as possible, but in no event later than three (3) business days from a determination that a Cybersecurity Event has occurred. A follow-up notification shall be provided by mail, at the address indicated below.

Notification to Molina’s Chief Information Security Officer shall be provided to:

Molina Chief Information Security Officer

Telephone: (844) 821-1942
Email: CyberIncidentReporting@molinahealthcare.com

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

6. Upon Provider's notification to Molina of a determination of a Cybersecurity Event, Provider must promptly provide Molina any documentation required and requested by Molina to complete an investigation, or, upon written request by Molina, Provider shall complete an investigation pursuant to the following requirements:
 - (a) determine whether a Cybersecurity Event occurred;
 - (b) assess the nature and scope of the Cybersecurity Event;
 - (c) identify Nonpublic Information that may have been involved in the Cybersecurity Event; and
 - (d) perform or oversee reasonable measures to restore the security of the Information Systems compromised in the Cybersecurity Event to prevent further unauthorized acquisition, release, or use of the Nonpublic Information.
7. Provider shall maintain records concerning all Cybersecurity Events for a period of at least five (5) years from the date of the Cybersecurity Event or such longer period as required by applicable laws and produce those records upon request of Molina.
8. Provider must provide to Molina the documentation required and requested by Molina in electronic form. Provider shall have a continuing obligation to update and supplement the initial and subsequent notifications to Molina concerning the Cybersecurity Event. The information provided to Molina in the initial and subsequent notices must include as much of following information known to Provider at the time of the notification:
 - (a) the date of the Cybersecurity Event;
 - (b) a description of how the information was exposed, lost, stolen, or breached, including the specific roles and responsibilities of Provider, if any;
 - (c) how the Cybersecurity Event was discovered;
 - (d) whether any lost, stolen, or breached information has been recovered and if so, how this was done;
 - (e) the identity of the source of the Cybersecurity Event;
 - (f) whether Provider has filed a police report or has notified any regulatory, governmental or law enforcement agencies and, if so, when such notification was provided;
 - (g) a description of the specific types of information acquired without authorization, which means particular data elements including, for example, types of medical information, types of financial information, or types of information allowing identification of the Consumer;
 - (h) the period during which the Information System was compromised by the Cybersecurity Event;
 - (i) the number of total Consumers in Ohio affected by the Cybersecurity Event;
 - (j) the results of any internal review identifying a lapse in either automated controls or internal procedures, or confirming that all automated controls or internal procedures were followed;
 - (k) a description of efforts being undertaken to remediate the situation which permitted the Cybersecurity Event to occur;

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- (l) a copy of Provider's privacy policy and if requested by Molina, the steps that Provider will take to notify Consumers affected by the Cybersecurity Event; and
 - (m) the name of a contact person who is both familiar with the Cybersecurity Event and authorized to act on behalf of Provider.

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

Quick Reference Guide

Quick Contacts

- Molina Healthcare AlertLine: (866) 606-3889
- Molina Healthcare Member Services (Medicaid): (800) 642-4168
- Molina MyCare Ohio Medicare-Medicaid Plan Member Services (opt-in/full benefits): (855) 665-4623
- Molina MyCare Ohio Medicaid Member Services (opt-out): (855) 687-7862
- Molina Healthcare Provider Services: (855) 322-4079
- SKYGEN Provider Portal: (844) 621-4589 URL: <https://pwp.skygenusystems.com>

Mailing Addresses

- Appeals and Grievances Mailing Address:
Molina Healthcare Appeals and Grievances Department
P.O. Box 349020
Columbus, OH 43234-9020
- Claim Dispute Mailing Address:
Molina Healthcare Provider Disputes
P.O. Box 649
Milwaukee, WI 53201
- Claims Mailing Address:
Molina Healthcare Claims
P.O. Box 2136
Milwaukee, WI 53201
- Corrected Claims Mailing Address:
Molina Healthcare Corrected Claims
P.O. Box 641
Milwaukee, WI 53201

Quick Reference

Quick Reference to Common Questions

Member Eligibility:

- To verify Member eligibility:
 - Log in to SKYGEN Provider Portal: <https://pwp.skygenusasystems.com>
 - Call Interactive Voice Response (IVR) eligibility hotline: (855) 322-4079
 - Call Provider Services: (855) 322-4079

Authorization Submission:

- Submit authorizations in one of the following formats:
 - SKYGEN Provider Portal at <https://pwp.skygenusasystems.com>
 - Electronic submission via clearinghouse, Payer ID: SKYGN
 - HIPAA-compliant 837D file
- For help submitting authorizations via SKYGEN Provider Portal, call (844) 621-4587.

Claims Submission:

- The timely filing requirement is 180 calendar days.
- Submit Claims in one of the following formats:
 - SKYGEN Provider Portal at <https://pwp.skygenusasystems.com>
 - Electronic submission via clearinghouse, Payer ID: SKYGN
 - HIPAA-compliant 837D file
 - Paper American Dental Association Dental Claim Form, sent by mail:
Molina Healthcare Claims
P.O. Box 2136
Milwaukee, WI 53201
- For help submitting Claims via SKYGEN Provider Portal, call (844) 621-4587.

Appeals and Grievances:

- To file an appeal:
 - Call Provider Services at (855) 322-4079
 - Send by mail to:
Molina Healthcare
ATTN: Appeals and Grievances Department
P.O. Box 349020
Columbus, OH 43234-9020

Provider Appeals – Authorizations:

- Authorization appeals must be filed within 60 calendar days from the original determination date. Molina issues a decision within 15 calendar days if an extension was not requested and granted. Expedited resolution is 72 hours.
- To request reconsideration of a denied authorization, a Provider may:
 - Call Provider Services at (855) 322-4079
 - Send by mail to:
Molina Healthcare Appeals Department
P.O. Box 349020

Columbus, OH 43234-9020

Provider – Claims Reconsiderations:

- Claim appeals must be filed within 120 calendar days following the date the denial letter was mailed. A decision is issued within 30 calendar days if an extension was not requested and granted. Expedited resolution is 72 hours.
- To request a reconsideration of a Claims denial, a Provider may:
 - Call Provider Services at (855) 322-4079
 - Send by mail to:
Molina Healthcare Provider Disputes
P.O. Box 649
Milwaukee, WI 53201

Member Appeals:

- Send by mail to:
Molina Healthcare Appeals and Grievances Department
P.O. Box 349020
Columbus, OH 43234-9020

Electronic Funds Transfer:

- SKYGEN Provider Portal: <https://pwp.skygenusystems.com>
- Phone: 844-621-4587
- Email: providerportal@skygenusa.com

SKYGEN Provider Portal:

- For training or help registering for or using the SKYGEN Provider Portal, contact the SKYGEN Provider Portal Team at (844) 621-4587 from 9 a.m. to 6 p.m. Monday through Friday.

Additional Provider Resources:

- For information about additional Provider resources:
 - Call Provider Services at (855) 322-4079
 - Access the SKYGEN Provider Portal at <https://pwp.skygenusystems.com>

Member Rights & Responsibilities

Molina Members have certain rights and responsibilities to ensure that they get the most out of their health care experience. Rights and responsibilities are communicated to Members through the Molina Member Handbook, the Molina website and an annual mailing to all Members. Providers and their staff are encouraged to be familiar with these rights and responsibilities.

Member Rights

Members of Molina have the following rights:

1. To receive all services that Molina must provide.
2. To be treated with respect and with regard for a Member's dignity and privacy.
3. To be sure that the Member's medical record information will be kept private.
4. To be given information about a Member's health. This information may also be available to someone the Member has legally authorized to have the information, or to someone the Member has said should be reached in an emergency when it is not in the best interest of the Member's health to give it to him or her.
5. To be able to take part in decisions about a Member's health care and to get information on any medical treatment in a way that the Member can follow.
6. To be sure others cannot hear or see the Member when the Member is getting medical care.
7. To be free from any form of restraint or seclusion used as a means of force, discipline, ease or revenge.
8. To ask and get a copy of the Member's medical records and to be able to ask that the record be changed/corrected if needed.
9. To be able to say "yes" or "no" to having any information about the Member given out unless Molina has to by law.
10. To be able to say "no" to treatment or therapy. If the Member says "no," the doctor or Managed Care Plan (MCP) must talk to him or her about what could happen, and the Provider must put a note in the Member's medical record about it.
11. To be able to file an appeal, grievance (complaint) or state hearing. (See the [Appeals and Grievances](#) section for information.)
12. To be able to get all MCP written Member information from the MCP:
 - a. At no cost to the Member;
 - b. In the prevalent non-English languages of Members in the MCP's service area;
 - c. In other ways that help with the special needs of Members who may have trouble reading the information for any reason
13. To be able to get help free of charge from Molina and its Providers if the Member does not speak English or needs help in understanding information.
14. To be able to get help with sign language at no cost.
15. To be told if the health care Provider is a student and to be able to refuse his/her care.
16. To refuse to be part of experimental care.
17. To make Advance Directives (a living will); see the Provider Responsibilities section or contact Provider Services for more information.
18. To file any complaint about not following the Member advance directives with the Ohio Department of Health.

19. To know that the MCP must follow all federal and state laws and other laws about privacy that apply.
20. To choose the Provider that gives the Member care whenever possible and appropriate.
21. To be able to get a second opinion from a qualified Provider on Molina's panel. If a qualified Provider is not able to see the Member, Molina must set up a visit with a Provider not on our panel at no cost to the Member.
22. To get information about Molina from us.
23. To contact the United States Department of Health and Human Services Office of Civil Rights and/or the Ohio Department of Job and Family Services Bureau of Civil Rights at the addresses listed below with any complaint of discrimination based on race, color, religion, sex, sexual orientation, age, disability, national origin, veteran status, ancestry, health status or need for health services.

Office for Civil Rights

United States Department of Health and Human Services
233 N. Michigan Ave. – Suite 240
Chicago, IL 60601
(312) 886-2359; (312) 353-5693 TTY

Bureau of Civil Rights

Ohio Department of Job and Family Services
30 E. Broad St., 30th Floor
Columbus, OH 43215
(614) 644-2703; (866) 227-6353; (866) 221-6700 TTY
Fax: (614) 752-6381

Member rights also include the right to:

- Receive information about Molina, Covered Benefits and the Providers contracted to provide services.
- Openly discuss treatment options, regardless of cost or benefit coverage, in a way that is easy to understand.
- Receive information about Member rights and responsibilities.
- Make recommendations about Molina's Member rights and responsibilities policies.
- Get a second opinion from a qualified Provider on Molina's panel. Molina must set up a visit with a Provider not on our panel at no cost to the Member if a qualified panel Provider is not able to see the Member.

Member Responsibilities

As a Member of Molina, Members have the responsibility to:

1. Always carry their Molina ID card, and not let anyone else use their ID card.
2. Keep appointments and be on time.
3. Call Molina at least two business days in advance if they need transportation, whenever possible.
4. Call their Provider 24 hours in advance if they are going to be late or if they cannot keep their appointment.
5. Share important health information (to the extent possible) with Providers and Molina to get appropriate care.

6. Understand their health conditions (to the extent possible) and be active in decisions about their health care.
7. Work with their Provider to develop treatment goals and follow the care plan that their Provider has developed with them.
8. Ask questions if they do not understand their benefits.
9. Call Molina within 24 hours of a visit to the emergency department or an unexpected stay in the hospital.
10. Inform Molina and the their county caseworker if the they change their name, address or telephone number, or if there are any changes that could affect their eligibility.
11. Let Molina and their health care Providers know if they or any family members have other health insurance coverage.
12. Report any fraud or wrongdoing to Molina or the proper authorities.

Member Information and Marketing

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

Please contact your Provider Services representative for information and review of proposed materials.

Provider Rights & Responsibilities

Provider Responsibilities

Participating Providers have the following responsibilities:

- If a recommended treatment plan is not covered (not approved by Molina), 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 [Payment for Non-Covered Services](#) on page 36).
- A Provider wishing to terminate participation with the Molina network must follow the termination guidelines stipulated in the Molina 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 for 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 Program.
- It is important for Participating Providers to ensure Molina has accurate practice and business information. 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
 - Any other information that may impact Member access to care

All contracted Providers to participate in and comply with SKYGEN'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's Provider Portal (Provider Portal).

Nondiscrimination

Molina complies with the guidance set forth in the final rule for Section 1557 of the Affordable Care Act (ACA), which includes notification of nondiscrimination and instructions for accessing language services in all significant Member materials, physical locations that serve our Members, and all Molina website home pages. All Providers who join the Molina Provider network must also comply with the provisions and guidance set forth by the Department of Health and Human Services (HHS) and the Office for Civil Rights (OCR). Molina requires Providers to deliver services to Molina Members without regard to race, color, national origin, age, disability, religion, genetic information, military status, ancestry, health status, sex or need

for health services. This includes gender identity, sexual orientation, pregnancy and sex stereotyping. Providers must post a nondiscrimination notification in a conspicuous location in the Provider's office along with translated non-English taglines in the top fifteen (15) languages spoken in the state to ensure Molina Members understand their rights, how to access language services and the process to file a complaint if they believe discrimination has occurred.

Participating Providers or contracted Medical Groups/Independent Physician Associations (IPAs) may not limit their practices because of a Member's medical (physical or mental) 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 from a state Medicaid program.

Providers can refer Molina Members who are complaining of discrimination to the Molina Civil Rights Coordinator at: (866) 606-3889, or TTY 711.

Members can also email the complaint to civil.rights@molinahealthcare.com.

Should you or a Molina Member need more information you can refer to the Health and Human Services website at: www.federalregister.gov/d/2016-11458.

Section 1557 Investigations

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

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

Toll Free: (866) 606-3889
TTY/TDD: 711
On Line: <https://MolinaHealthcare.AlertLine.com>
Email: civil.rights@MolinaHealthcare.com

Child Abuse and Neglect

Under Ohio law, Providers are mandated to report any suspicion of child abuse or neglect to local children services agencies or law enforcement agencies. Providers should be knowledgeable in recognizing cases of child abuse and neglect and the proper methods of handling evaluation and referral.

Facilities, Equipment and Personnel

The Provider's facilities, equipment, personnel and administrative services must be at a level and quality necessary to perform duties and responsibilities to meet all applicable legal

requirements including the accessibility requirements of the Americans with Disabilities Act (ADA).

Provider Data Accuracy and Validation

It is important for Providers to ensure Molina has accurate practice and business information. Accurate information allows us to better support and serve our Provider network and Members.

Maintaining an accurate and current Provider Directory is a state and federal regulatory requirement, as well as a National Committee for Quality Assurance (NCQA[®]) required element. Invalid information can negatively impact Member access to care, Member assignments and referrals. 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, 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 practice name, 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 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 if your information needs to be updated or corrected.

Note: Some changes may impact credentialing. Providers are required to notify Molina of changes to credentialing information in accordance with the requirements outlined in the [Credentialing](#) section of this Provider Manual.

Molina is required to audit and validate our Provider Network data and Provider Online Directories on a routine basis. As part of our validation efforts, we may reach out to our network of Providers through various methods, such as letters, phone campaigns, face-to-face contact, fax and fax-back verification, etc. Molina also may use a vendor to conduct routine outreach to validate data that impacts its Provider Directory or otherwise impacts its membership or ability to coordinate Member care. Providers are required to provide timely responses to such communications.

Compliance

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

Confidentiality of Member Health Information and HIPAA Transactions

Molina requires that Providers respect the privacy of Molina Members (including Molina Members who are not patients of the Provider) and comply with all applicable laws and regulations regarding the privacy of patient and Member Protected Health Information (PHI).

Participation in Grievance and Appeals Programs

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

Molina Electronic Solutions Requirements

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

Molina requires all contracted Providers to participate in and comply with Molina's Electronic Solution Requirements, which include, but are not limited to, electronic submission of prior authorization requests, prior authorization status inquiries, health plan access to electronic medical records (EMR), electronic Claims submission, electronic fund transfers (EFT), electronic remittance advice (ERA), electronic Claims Appeal and registration for and use of Molina's Provider Portal.

Electronic Claims include Claims submitted via a clearinghouse using the EDI process and Claims submitted through the Molina Provider Portal.

Any Provider entering the network as a Contracted Provider will be encouraged to comply with Molina's Electronic Solution Policy by enrolling for EFT/ERA payments and registering for Molina's Provider Portal within thirty (30) days of entering the Molina network.

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

Billing Molina Members

- Providers contracted with Molina 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 to the Provider.
- Provider agrees to accept payment from Molina as payment in full, or bill the appropriate responsible party.

In accordance with [OAC 5160-26-05 Managed Health Care Programs: Provider Panel and Subcontracting Requirements](#), a Provider may only bill a Molina Member for:

- Non-covered services
- Services determined not to be Medically Necessary by SKYGEN's Utilization Management Department if both the Member and the Provider sign a payment agreement **prior** to the services being rendered. The agreement must be specific to the services being rendered and clearly state:
 - The service is not covered by ODM or Molina.
 - The service is determined not to be Medically Necessary by SKYGEN's Utilization Management Department.
 - The Member is choosing to receive the service and agrees to pay for it, even though the service may have been determined by SKYGEN and Molina to be not Medically Necessary.
 - The Member is under no obligation to pay the Provider if the service is later found to be a Covered Benefit, even if the Provider is not paid because of non-compliance with Molina's billing and/or prior authorization requirements.
 - For Members with limited English proficiency, the agreement must be translated or interpreted into the Member's primary language to be valid and enforceable. This interpretation/translation service is the responsibility of the Provider to supply.
 - The written notification must be specific to the services to be provided and clearly state the Member is financially responsible for the specific service. A general patient liability statement signed by all patients at your practice does not meet this requirement.
 - The written notification must be signed and dated by the Member and the date must be prior to date of service.

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

Office Site Standards

All Providers are expected to comply with the office site standards listed below.

Facilities

Facilities are reviewed for accessibility and safety standards.

- The parking area and walkways demonstrate appropriate maintenance.
- The office appearance demonstrates that housekeeping and maintenance are performed.
- The parking area is reasonably accessible and has adequate handicapped parking available.
- The building and exam rooms are accessible with wide doorways and an incline ramp or flat entryway.
- The restroom is handicapped accessible with wide doorways and grab bars.

- The waiting area has adequate seating, lighting and space for the average number of patients in an hour.
- The office has clearly marked containers for hazardous waste materials, and provides evidence of contracts or appropriate alternative methods for hazardous waste management.
- Fire extinguishers are checked annually with tags showing review dates.
- Basic emergency equipment is located in an easily accessible area. This includes any medications or equipment appropriate to the practice.
- Exit signs are clearly visible.
- Evacuation routes are posted in a visible location.
- Disclosure of privacy practices is posted to comply with HIPAA regulations.

Member Accessibility

Appointment schedules, policies and procedures are reviewed to evaluate how the Provider meets the accessibility standards.

- Standards for appointments and wait times are reasonable for dentistry and comply with Medicaid guidelines and standards.
- After-hours contact information is available or emergency referral information is provided.
- Hours of operation for Molina Members are no less than those offered to other managed care Members.

Administration

The following areas are evaluated through review of policies and procedures, interviews with staff, inspection of equipment and cabinets, observation of patient flow (when practical) and review of appropriate documentation.

- A current Clinical Laboratory Improvement Amendments (CLIA) waiver is in place when the appropriate lab work is run in the office.
- X-ray certificate and maintenance records are posted in the department.
- Radiology operator licenses are posted in the department.
- Prescription pads are not kept in the exam rooms.
- All prescription medications, needles and syringes are isolated from patient areas and preferably locked.
- Narcotics are inaccessible to patients.
- All drugs, including samples and emergency medications, are checked routinely for outdated drugs.
- Patient check-in systems provide confidentiality.
- Medical records are inaccessible to patients.

Medical Record Keeping and Documentation

A confidential medical record must be maintained for each Member that includes all pertinent information regarding medical services rendered. Providers must maintain established standards for accurate medical record keeping.

The following categories are reviewed during on-site office visits.

- Medical records are secured from patient and public access and are restricted to identified staff.

- Medical record release procedures are compliant with state and federal regulations.
- Patient records are available for each encounter.
- There is an individual record for each patient.
- Forms and methodology for filing within a chart is consistent.
- Allergies, reactions or no known allergies are clearly indicated on each chart.
- The patient's name appears on each sheet in the chart.
- There is a date and signature/initial on each entry/report in chart.

Complete medical record reviews may be conducted to support Molina's Quality Improvement Program. Providers must demonstrate an overall 80 percent compliance in medical record documentation. Molina uses the guidelines below when evaluating medical record documentation.

- A complete medical history is easily identified for patients. Allergies are listed on the front cover of the record or prominently in the inside front page. If the patient has no known allergies, this is appropriately noted.
- A working diagnosis is recorded with the clinical findings.

Subjective Objective Assessment Plan

- The plan of action and treatment is documented for the diagnosis.
- There is no evidence that the patient is placed at inappropriate risk by a diagnostic or therapeutic procedure.
- Patient name or identifying number is on each page of the record.
- The registration form or computer printout contains address, home and work phone numbers, employer, gender and marital status. An emergency contact should also be designated.
- All staff and Provider notes are signed with initials or first initial, last name and title.
- All entries are dated.
- The record is legible to someone in the office other than the Provider. Dictation is preferred.
- Pertinent history for presenting problem is included.
- Record of pertinent oral exam for the presenting problem is included.
- Lab results and other studies are ordered as appropriate.
- There are notations regarding follow-up care, calls or visits. The specific time of return is noted as needed. Include the preventive care visit when appropriate.
- Previous unresolved problems are addressed in subsequent visits.
- Evidence of appropriate use of specialists.
- Notes from specialists are included in the record.
- All reports show initials of Provider who ordered them.
- All consult and abnormal lab/imaging results show explicit follow-up plans.
- There is documentation of appropriate dental health promotion and disease prevention education.
- Preventive services are appropriately used/offered in accordance with accepted practice guidelines.

Medical Record Organization

- The medical record is legible to someone other than the writer.
- Each patient has an individual medical record.
- Chart pages are bound, clipped or attached to the file (labeled lab, consults, progress notes, etc.).

Medical Record Retrieval

- The medical record is available to the Provider at each patient encounter.
- The medical record is available to Molina for quality improvement purposes.
- Medical record retention is at least ten years.
- Data recovery process is in place in the event of data loss, etc.

Please remember the following about the medical record:

- It is a medical record that must be treated confidentially, as defined by HIPAA regulations.
- It is a legal document you may have to defend in court much later, after your memory has faded.
- It is a historical record of the event from which a bill of service will be generated.

Physical Access/Safety Survey Criteria

- Accommodations for persons with disabilities are guided by Americans with Disabilities Act of 1990 (ADA) standards, evidenced by designated parking, loading zones, an external ramp and/or public transportation within close proximity to the building. Reviewer to consider regional site characteristics.
- Parking areas and walkways demonstrate appropriate maintenance.
- Reasonable accommodations guided by ADA standards for persons with disabilities include all of the following:
 - Automatic entry option or alternative access method.
 - Elevator for public use (if applicable).
 - Restroom equipped with large stall and safety bars or other reasonable accommodation.
- At least one exam room can accommodate physically challenged patients.
- Fire protection equipment (fire extinguisher, smoke detector, fire alarm or sprinkler system) is accessible, in working order and inspected on a yearly basis.
- Emergency medications are available on-site and current (i.e. have not expired).
- A medication dosage chart (or other method for determining dosage) is kept with emergency medications.
- A procedure for the management of non-medical emergencies.
- A procedure for handling medical emergencies appropriate to the patient population.

Physical Appearance

- Exam rooms are in good condition with protective barriers as needed.
- Office appearance demonstrates that housekeeping and maintenance are performed appropriately on a regular basis.
- Office has a well-lit waiting area and entry way.

Adequacy of Waiting and Exam Room Space

- Adequate seating is provided in the waiting room for an average number of patients in an hour.
- Exam rooms provide adequate space for oral assessment and treatment.

Interpreter Services

Members with Limited English Proficiency

All Molina Providers are required to comply with Title VI of the Civil Rights Act of 1964 in the provision of Covered Services to Members. Compliance with this provision includes providing interpretation and translation services for Members requiring such services, including Members with Limited English Proficiency (LEP). A Member with LEP has a limited ability or inability to read, speak or write English, to understand and communicate effectively. This can result from language, cognitive or physical limitations. Written procedures are to be maintained by each office or facility regarding the process for obtaining such services. Documentation of such services shall be kept in the Member's chart.

Arranging for Interpreter Services

If a Member has LEP, the Provider may call Member Services for assistance with locating translation services. If a Member requires an on-site interpreter for sign language or foreign interpretation, the Provider may call Provider Services to request assistance with locating interpreter services. Pursuant to Title VI of the Civil Rights Act of 1964, services provided for Members with LEP, limited reading proficiency (LRP), or limited hearing or sight are the responsibility of the Provider. Under no circumstances are Molina's Members responsible for the cost of such services.

- If a Member cannot hear or has limited hearing ability, use the Ohio Relay Service/TTY at (800) 750-0750 or 711.
- If a Member has limited or no vision, documents in large print, Braille or audio can be obtained by calling Molina Member Services.
- If a Member has LRP, contact Molina Member Services. The representatives will verbally explain the information, up to and including reading the document to the Member, or provide the documents in audio version.

Provider Guidelines for Accessing Interpreter Services

When Molina Members need interpreter services for health care services, the Provider should:

- Verify the Member's eligibility and medical benefits.
- Inform the Member that interpreter services are available.
- Contact Molina immediately if assistance in locating interpreter services is needed.

Cultural Competency

Background

Molina works to ensure all Members receive culturally competent care across the service continuum to reduce health disparities and improve health outcomes. The Culturally and Linguistically Appropriate Services in Health Care (CLAS) standards published by the US Department of Health and Human Services (HHS), Office of Minority Health (OMH) guide the activities to deliver culturally competent services. Molina complies with Title VI of the Civil Rights Act, the Americans with Disabilities Act (ADA) Section 504 of the Rehabilitation Act of 1973, Section 1557 of the Affordable Care Act (ACA) and other regulatory/contract requirements. Compliance ensures the provision of linguistic access and disability-related access to all Members, including those with LEP and Members who are deaf, hard of hearing or have speech or cognitive/intellectual impairments. Policies and procedures address how individuals and systems within the organization will effectively provide services to people of all cultures, races, ethnic backgrounds, gender, gender identity, sexual orientation, age and religions as well as those with disabilities in a manner that recognizes values, affirms and respects the worth of the individuals and protects and preserves the dignity of each.

Additional information on cultural competency and linguistic services is available at [MolinaHealthcare.com/OhioProviders](https://www.MolinaHealthcare.com/OhioProviders), from your local Provider Services Representative and by calling Molina Provider Services at (855) 322-4079 after selecting the option for the correct line of business, press 7 for dental inquiries.

Cultural Competency

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

Provider and Community Training

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

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

1. Written materials
2. On-site cultural competency training delivered by Provider Services Representatives
3. Access to enduring reference materials available through health plan representatives and the Molina website
4. Integration of cultural competency concepts and nondiscrimination of service delivery into Provider communications

Integrated Quality Improvement – Ensuring Access

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

Molina develops Member materials according to Plain Language Guidelines. Members or Providers may also request written Member materials in alternate languages and formats, leading to better communication, understanding and Member satisfaction. Online materials found on [MolinaHealthcare.com/OhioProviders](https://www.MolinaHealthcare.com/OhioProviders) and information delivered in digital form meet Section 508 accessibility requirements to support Members with visual impairments.

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

Program and Policy Review Guidelines

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

- Annual collection and analysis of race, ethnicity and language data from:
 - Eligible individuals to identify significant culturally and linguistically diverse populations within plan's membership
 - Contracted Providers to assess gaps in network demographics
- Revalidate data at least annually
- Local geographic population demographics and trends derived from publicly available sources (Group Needs Assessment)
- Applicable national demographics and trends derived from publicly available sources
- Assessment of Provider Network
- Collection of data and reporting for the Diversity of Membership HEDIS® measure
- Annual determination of threshold languages annually and processes in place to provide Members with vital information in threshold languages
- Identification of specific cultural and linguistic disparities found within the plan's diverse populations
- Analysis of HEDIS® and CAHPS®/Qualified Health Plan Enrollee Experience Survey results for potential cultural and linguistic disparities that prevent Members from obtaining the recommended key chronic and preventive services
- Comparison with selected measures such as those in Healthy People 2020

24 Hour Access to Interpreter Services

Molina serves a diverse population of Members with specific cultural needs and preferences. Providers must support Member access to telephonic interpreter services by offering a telephone with speaker capability or a telephone with a dual headset. Providers may offer Molina Members interpreter services if the Members do not request them on their own. It is never permissible to ask a family Member, friend or minor to interpret.

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

Molina Members are entitled to:

- Be provided with effective communications with medical Providers as established by the Americans with Disabilities Act of 1990, the Rehabilitation Act of 1973, and the Civil Rights Act of 1964.
- Be given access to Care Managers trained to work with cognitively impaired individuals.
- Be notified by the medical Provider that interpreter services are available at no cost to the client.
- Decide, with the medical Provider, to use an interpreter and receive unbiased interpretation.
- Be assured of confidentiality, as follows:
 - Interpreters must adhere to Health and Human Service Commission (HHSC) policies and procedures regarding confidentiality of client records.
 - Interpreters may, with client written consent, share information from the client's records only with appropriate medical professionals and agencies working on the client's behalf.
 - Interpreters must ensure that this shared information is similarly safeguarded.
- Have interpreters, if needed, during appointments with the Member's Providers and when talking to the health plan.

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

Pursuant to Title VI of the Civil Rights Act of 1964, services provided for Members with LEP, LRP or limited hearing or sight are the financial responsibility of the Provider. Under no circumstances are Molina Members responsible for the cost of such services. Written procedures are to be maintained by each office or facility regarding their process for obtaining such services.

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

- Verify the Member's eligibility and medical benefits.
- Inform the Members that an interpreter, limited hearing and/or limited reading services are available.
- Molina is available to assist Providers with locating these services if needed. Providers needing assistance finding on-site interpreter services may call Molina Member Services.
 - Providers needing assistance finding translation services may call Molina Member Services.
 - Providers with Members who cannot hear or have limited hearing ability may use the Ohio Relay service (TTY) at 711.
 - Providers with Members with limited vision may contact Molina Member Services for documents in large print, Braille or audio version.
 - Providers with Members with limited reading proficiency (LRP) may contact Molina

Member Services. The Molina Member Service Representative will verbally explain the information, up to and including reading the documentation to the Members or offer the documents in audio version

- Contact Molina Member Services at:
 - Medicaid: (800) 642-4168 (TTY/Ohio Relay (800) 750-0750 or 711), Monday through Friday from 7 a.m. to 7 p.m.
 - Molina Dual Options (full benefits): (855) 665-4623 (TTY 711), Monday through Friday from 8 a.m. to 8 p.m.
 - Molina MyCare Ohio Medicaid (opt-out): (855) 687-7862 (TTY 711), Monday through Friday from 8 a.m. to 8 p.m.

Providers using interpreter services shall document such services. Documentation of these services shall be kept in the Member's chart, which may be audited by Molina.

Molina asks Providers to inform us when providing interpreter services to Molina Members. This information will be added to the Member's record for future reference if needed. Providers may report this information to Molina by calling Molina Member Services.

Eligibility & Member Services

Medicaid

Medicaid is funded by both the federal government and the State of Ohio and is administered by the Ohio Department of Medicaid (ODM).

ODM contracts with managed care plans (MCPs) to provide health care to Ohio Medicaid consumers. The State of Ohio is divided into three Medicaid managed care service areas. Molina is contracted with ODM to serve the Medicaid population across Ohio.

A person must qualify for Medicaid benefits before he or she can enroll with a MCP. Each County Department of Job and Family Services (CDJFS) accepts applications and makes eligibility determinations. Applications are accepted online, in person and by mail.

To qualify for Medicaid, a person must meet basic requirements:

- Be a U.S. citizen or meet Medicaid citizenship requirements.
- Be an Ohio resident
- Have or get a social security number
- Meet financial requirements

Ohio has a Medicaid programs for three different populations:

1. Covered Families and Children (CFC)
 - Healthy Families
 - Children up to age 19
 - Pregnant women
 - Families with children under age 19
2. Aged, Blind or Disabled (ABD)
 - Age 65 or older
 - Legally blind
 - Disabled (as classified by the Social Security Administration)
3. Adult Extension (AEP)
 - Adults between the ages of 19 to 64, who are between 0 to 138 percent of the Federal Poverty Level (FPL)
 - Are not eligible under another category of Medicaid
 - Parents who are between 91 to 138 percent of the Federal Poverty Level (FPL) are now eligible

Molina Dual Options MyCare Ohio Medicare-Medicaid Plan

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

- Age 18 or older at the time of enrollment
- Entitled to benefits under Medicare Part A and enrolled under Medicare Parts B and D, and receiving full time Medicaid benefits

- Individuals eligible for full Medicaid per the spousal impoverishment rule codified at section 1924 of the Social Security Act
- Reside in the applicable MyCare Ohio demonstration counties: Franklin, Delaware, Union, Madison, Pickaway, Clark, Greene, Montgomery, Clinton, Warren, Butler, Hamilton and Clermont
- Molina Dual Options will accept all Members who meet the above criteria and elect to join the Molina Dual options plan during appropriate enrollment periods

Member Identification Card

Molina Members receive ID cards at the time of enrollment. 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 ID card does not guarantee a Member’s eligibility, nor does it guarantee Provider payment.


Molina recommends each dental office make a photocopy of the Member’s ID card each time treatment is provided. Please be aware that the Molina ID 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, call Provider Services: (855) 322-4079.

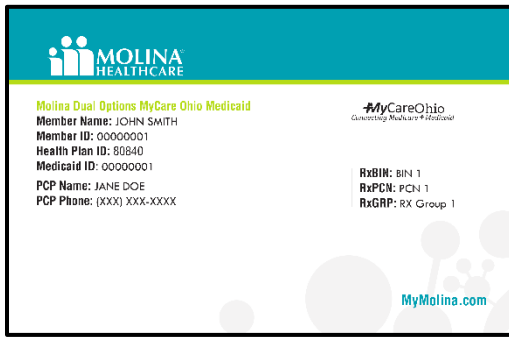
Sample ID Cards:

Molina Healthcare Medicaid

	
<p>Member: JOHN SMITH Identification #: 00000001 Date of Birth: xx/xx/xxxx Effective Date: xx/xx/xxxx</p>	<p>Molina Medicaid</p>
<p>Primary Care Provider: JANE DOE Primary Care Provider Phone: (xxx) xxx-xxxx MMIS#: 00000001 Issue Date: xx/xx/xxxx</p>	<p>RxBIN: BIN 1 RxPCN: PCN 1 RxGRP: RXGroup 1</p>
<p>MyMolina.com</p>	

<p>MEMBER SERVICES: (800) 642-4168 TTY: (800) 750-0750 or 711 7 a.m. to 7 p.m., Monday to Friday</p>	<p>TRANSPORTATION: (866) 642-9279 24 hours a day, 7 days a week Call 2 business days before your appointment</p>
<p>24-HOUR NURSE ADVICE LINE: English: (888) 275-8750 Español: (866) 648-3537 TTY: (866) 735-2929</p>	<p>EMERGENCY SERVICES: Call 911 or go to the nearest emergency room (ER). If you're not sure if you should go to the ER, call your Primary Care Provider or our Nurse Advice Line.</p>
<p>Providers/Hospitals: Visit http://Provider.MolinaHealthcare.com or call (855) 322-4079 for prior authorization, eligibility, claims or benefits. Hospitals must have authorization prior to all non-emergency admissions.</p>	
<p>Pharmacists: For questions, call (855) 322-4079.</p>	
<p>Claims Submissions: P.O. Box 22712, Long Beach, CA 90801 EDI Claims: WebMD-Payor #20149</p>	
<p>MolinaHealthcare.com</p>	

Molina MyCare Ohio Medicaid only (opt-out)



Molina Dual Options MyCare Ohio Medicaid

Member Name: JOHN SMITH
 Member ID: 00000001
 Health Plan ID: 80840
 Medicaid ID: 00000001
 PCP Name: JANE DOE
 PCP Phone: (XXX) XXX-XXXX

MyCareOhio
 Connecting Medicare + Medicaid

RxBIN: BIN 1
 RxPCN: PCN 1
 RxGRP: RX Group 1

MyMolina.com

IN CASE OF AN EMERGENCY: Call 911 or go to the nearest emergency room (ER) or other appropriate setting. If you are not sure if you need to go to the ER, call your PCP or the 24-Hour Nurse Advice Line.

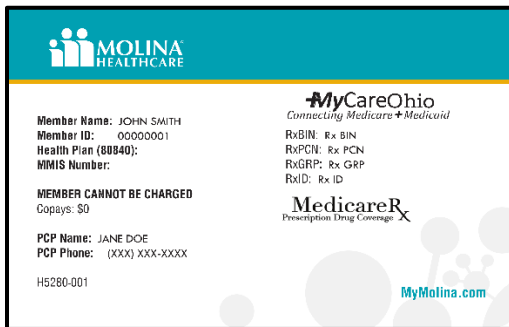
Member Services: (855) 687-7862 TTY 711 Monday - Friday 8 a.m. to 8 p.m.
Care Management: (855) 687-7862, TTY 711 Monday - Friday 8 a.m. to 5 p.m.
24-Hour Nurse Advice Line: (855) 895-9986, TTY 711
24-Hour Behavioral Health Crisis: (855) 895-9986, TTY 711
24-Hour Care Management: (855) 895-9986, TTY 711
Website: www.MolinaHealthcare.com/Duals

Pharmacists/Pharmacy Help Desk: (800) 364-6331 (for Pharmacist use only)
Providers/Hospitals: For prior authorization, eligibility, claims or benefits, visit the Molina Web Portal at www.MolinaHealthcare.com or call **(855) 322-4079**

Hospital Admissions: Authorization must be obtained by the hospital prior to all non-emergency admissions.
 Send claims to: **P.O. Box 22712, Long Beach, CA 90801**
 EDI Submissions: **Payer ID #20149**

MolinaHealthcare.com

Molina Dual Options MyCare Ohio (opt-in/full benefits)



Molina Dual Options MyCare Ohio

Member Name: JOHN SMITH
 Member ID: 00000001
 Health Plan (80840):
 MMIS Number:
 MEMBER CANNOT BE CHARGED
 Copays: \$0
 PCP Name: JANE DOE
 PCP Phone: (XXX) XXX-XXXX
 H5280.001

MyCareOhio
 Connecting Medicare + Medicaid

RxBIN: Rx BIN
 RxPCN: Rx PCN
 RxGRP: Rx GRP
 RxID: Rx ID

MedicareRx
 Prescription Drug Coverage

MyMolina.com

In an emergency, call 9-1-1 or go to the nearest emergency room (ER) or other appropriate setting. If you are not sure if you need to go to the ER, call your PCP or the 24-Hour Nurse Advice line.

Member Services: (855) 665-4623 TTY 711
Eligibility Verification: (855) 665-4623 **Pharmacy Help Desk:** (855) 665-4623
Behavioral Health Crisis: (855) 895-9986
Transportation Reservation: (844) 491-4761

Care Management: (855) 665-4623
24-Hour Nurse Advice: (855) 895-9986 TTY 711

Website: MolinaHealthcare.com/Duals
Send claims to: P.O. Box 22712, Long Beach, CA 90801
 EDI Submission Payer ID: 20149

MolinaHealthcare.com/Duals

Verifying Member Eligibility

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

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

- Log in to SKYGEN Provider Portal at <https://pwp.skygenusystems.com>
- Call the Interactive Voice Response (IVR) system eligibility line at (855) 322-4079

Eligibility information received from these sources will contain the same information you would receive by calling Provider Services. The SKYGEN Provider Portal and IVR system are both available 24 hours a day, seven days a week to provide you with quick access to information without requiring you to wait for an available Provider 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 SKYGEN Provider Portal

SKYGEN's Provider Portal allows quick, accurate verification of Member's eligibility for Covered Benefits, on the date of service. Log in using your ID and password at <https://pwp.skygenusystems.com>. First-time users should call the SKYGEN Provider Portal Team for assistance with registering at (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.

To use the IVR system, call Provider Services at (855) 322-4079. 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 representative. You also have the option of transferring to a representative after completing eligibility checks, if you have additional questions.

Specialist Referrals

A patient who requires a referral to a dental specialist can be referred directly to any specialist contracted with Molina without authorization. The dental specialist is responsible for obtaining prior authorization (PA) for services, as defined in the [Benefit Plan Details and Authorization Requirements](#) section of this Provider Manual, beginning on page 42. If you are unfamiliar with the Molina contracted specialty network or need help locating a specialist Provider, call Provider Services at (855) 322-4079.

Appointment Availability Standards

Molina has established appointment time requirements to ensure Members receive dental services within a time period appropriate to their health condition. We expect our dental Providers to meet these appointment standards for a number of important reasons, such as to:

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

Molina contracted dentists are expected to meet the following minimum standards for appointment availability.

- Routine dental care must be scheduled within 60 calendar days for non-urgent symptomatic care.
- Urgent care must be available within 48 hours.
- Emergent care must be scheduled within 24 hours.

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

Missed Appointments

Per [OAC 5160-26-05 Managed Health Care Programs: Provider Panel and Subcontracting Requirements](#), Participating Providers may not bill Members.

The Centers for Medicare and Medicaid Services (CMS) interpret federal law to prohibit a Provider from billing any Molina Member for a missed appointment. In addition, your missed appointment policy for Members enrolled in Molina cannot be stricter than your policy for private or commercial patients.

Balance Billing

Providers contracted with Molina cannot bill the Member for any Covered Services beyond applicable copayments, deductibles or coinsurance. 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 to the Provider. Balance billing a Molina Member for services covered by Molina is prohibited. This includes asking the Member to pay the difference between the discounted and negotiated fees, and the Provider's usual and customary fees.

For additional information please refer to the Compliance and Claims and Compensation sections of this Provider Manual.

Payment for Non-Covered Services

Enrolled Participating Providers shall hold Members and Molina harmless for the payment of non-covered services except as provided in this paragraph.

Per [OAC 5160-26-05 Managed Health Care Programs: Provider Panel and Subcontracting Requirements](#), Providers may not bill Members the difference between the amount a primary carrier paid and the covered amount, even if that balance involves a copayment, coinsurance or plan deductible unless a signed waiver is on file for a non-covered Medicaid service. Should Providers choose not to bill Molina as a secondary, the balance due after primary carrier has paid must be written off by the Provider, which includes a Member copayment, coinsurance and plan deductible.

The Non-Covered Services Agreement can be found on the SKYGEN Provider Portal within the Documents tab at <https://pwp.skygenusasystems.com>.

Note: Providers must inform Members in advance and in writing when the Member is responsible for non-covered services.

Credentialing

As required by law, any dentist (DDS or DMD) who is interested in participating with Molina is invited to apply and submit a credentialing application for review by SKYGEN's Credentialing Committee. Molina does not differentiate or discriminate in the treatment of Providers seeking credentialing on the basis of race, color, ethnicity, gender, gender identity, sexual orientation, disability, military status, genetic information, ancestry, health status, age, national origin or religion.

Providers must be credentialed before participating in the Molina network. Providers accepted into the Molina network are recredentialed at least every 36 months.

The SKYGEN credentialing process follows the National Committee for Quality Assurance (NCQA[®]) credentialing guidelines and state and federal law for dentistry. All credentialing applications must satisfy NCQA[®] standards of credentialing as they apply to dental services. Molina has the sole right to determine which dentists it accepts and continues to allow as Participating Providers in its 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 Credentialing Committee may recommend other actions it deems appropriate. SKYGEN notifies Molina 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.

SKYGEN's credentialing process is designed to meet the standards of the National Committee for Quality Assurance (NCQA[®]). In accordance with those standards, Molina Members will not be referred and/or assigned to Participating Providers until both the credentialing and contracting processes are completed.

Molina credentials the following types of Practitioners:

- Health care Providers who are licensed, certified or registered by the state to practice independently
- Doctors or masters level psychologists (Ed.D, Ph.D, Psy.D, Me.D)
- Masters level clinical nurse specialists (CNS) practicing independently in a practice in which there is no physician
- Dentists (DDS and DMD)
- Oral surgeons (DDS and DMD)

Molina credentials the following health delivery organizations:

- Ambulatory surgical centers
- Hospitals
- Independent diagnostic testing facilities
- Laboratories (freestanding or cardiac catheterization)

- Outpatient clinics (if not covered by hospital accreditation)

Providers who meet any of the following criteria do not need to be credentialed:

- Providers who do not provide care for Members in a treatment setting (board certified consultants)
- Covering Providers (e.g., *locum tenens* who will be covering for less than 60 days)

As an applicant, whether being credentialed or recredentialed, Providers are required to submit adequate information for a proper evaluation of:

- Experience
- Background
- Education and training
- Demonstrated ability and capability to perform as a Provider without limitation, including physical and mental health status as allowed by law

Molina contracts with some Provider groups who have been delegated credentialing privileges. Prior to delegating this activity, Molina conducts a thorough review of the group's credentialing and recredentialing processes and procedures, including reviews of files and credentialing committee minutes. For Providers affiliated with a delegated Provider group, the collection and verification of information is performed by the group and the Provider names are submitted to the Molina Peer Review Committee as described below for review.

Molina does not make credentialing decisions based on an applicant's race, color, religion, ethnic/national origin, gender, gender identity, age, disability, military status, genetic information, ancestry, sexual orientation, health status or the types of procedures or types of patients within the Provider's discipline of care.

The Credentialing Process

Practitioners who are not a part of a Provider group delegated for credentialing must follow the following steps before the Provider can see Molina Members.

At the time of initial credentialing, the applicant must complete a state required Practitioner Application, which is the Council for Affordable Quality Healthcare (CAQH) credentialing application for physicians and the Ohio Department of Insurance Standard Credentialing Form for all other Providers, plus all applicable attachments to the application. The correct application must be completed per the instructions on the front of the form. All practice sites must be provided (the entire form need not be duplicated for each site - submit only Section III: Office/Practice Information).

1. The following documents must be submitted:
 - Current, unrestricted license to practice
 - Current, valid Drug Enforcement Administration (DEA) certificate
 - Education, training locations and dates
 - Work history from the time of graduation
 - Board certification
 - Clinical admitting hospital privileges in good standing
 - Current, adequate malpractice liability coverage for all practice sites

- All professional liability claims history
 - References
 - Evidence of 24-hour coverage
2. If a Provider participates with the online CAQH process, the CAQH number must be submitted to Molina, the online CAQH file must be current and the Provider must indicate that Molina and SKYGEN has permission to access the application.
 3. Upon receipt of the completed forms and all of the required documents, SKYGEN will query the National Practitioner Data Bank (NPDB)/Healthcare Integrity and Protection Data Bank (HIPDB) to verify education, work history, hospital privileges, board certification and malpractice history and coverage, and will check for sanctions and other disciplinary actions.
 4. If any of the forms are incomplete, or if any of the required documents are missing, the Provider will be contacted and the corrected/required document will be requested.
 5. After all information has been verified, either the SKYGEN Director or the SKYGEN Credentialing Committee reviews and approves all applicants prior to their contracts becoming effective. The SKYGEN Credentialing Committee is made up of peer Providers. Molina has delegated the authority to recommend approval or denial of applicants to the SKYGEN Credentialing Committee. The SKYGEN Credentialing Committee is required to meet no less than quarterly, but generally meets on a bi-weekly basis to facilitate timely processing of applicant files.

The Recredentialing Process

Recredentialing is performed at least every 36 months. Requests for recredentialing application information are sent out approximately six months before the current credentialing period is to expire.

If a Provider participated with CAQH during his or her previous credentialing/recredentialing cycle, a letter will be mailed to that Provider to indicate that the CAQH online application will be accessed by Molina in order to obtain required recredentialing information.

If a Provider did not participate with CAQH during his or her previous credentialing/recredentialing cycle, instructions for obtaining a CAQH Provider ID number or for completing a hard copy of the CAQH paper application (or the Ohio Department of Insurance Standard Credentialing Form for all other Providers, if applicable) is mailed to the Provider.

All recredentialing information should be verified and returned to Molina within the specified timeframe so that the recredentialing process meets the timeliness requirements of the State of Ohio and NCQA®. Failure to return the information within that specified timeframe could result in administrative termination from the Molina network as a non-compliant Provider.

In addition to verifying that contracted Providers continue to meet the basic qualifications, SKYGEN also performs ongoing monitoring of Provider Medicare or Medicaid sanctions, license sanctions or limitations, Member complaints and quality of care concerns. Adverse events discovered through this ongoing monitoring may result in a limitation or termination of the Provider's participation in the Molina network.

Provider Rights

Provider's Right to Review

Providers have the right to review their credentials file at any time.

The Provider must notify the SKYGEN Credentialing Department and request an appointed time to review their file, allowing up to seven days for coordination of schedules. A SKYGEN dental director and a credentialing representative will be present. The Provider has the right to review all information in the credentialing file except peer references or recommendations protected by law from disclosure.

The only items in the file that may be copied by the Provider are documents that the Provider sent to Molina and SKYGEN (e.g., the application, the license and the DEA certificate). Providers may not copy documents that include pieces of information that are confidential in nature, such as the Practitioner credentialing checklist, the responses from monitoring organizations (i.e. National Practitioner Data Bank, Department of Health/Medical Quality Assurance Commission) and verification of hospital privileges letters.

Provider's Right to Notification and Correction of Erroneous Information

SKYGEN will notify the Provider if information is received during the credentialing process that conflicts with information given by the Provider. Examples of these errors include, but are not limited to, actions on a license, malpractice claims history or board certification decisions. The credentialing/recredentialing process cannot be completed until the erroneous information is corrected and received by SKYGEN.

Provider's Right to be Informed of Application Status

Providers have a right, upon request, to be informed of the status of their application. The Provider can request to be informed of the status of the application by telephone. SKYGEN will respond to the request within two working days.

Provider Appeal Rights

In cases where the Credentialing Committee suspends or terminates a Provider's contract based on professional conduct, a certified letter is sent to the Provider describing the adverse action taken and the reason for the action, including notification to the Provider of the right to a fair hearing. A copy of the fair hearing plan and notification of the right to be represented by an attorney or another person of the Provider's choice are included in the letter. Upon receipt of the notice, the Provider is given 30 calendar days to request a fair hearing.

If the fair hearing upholds SKYGEN's initial adverse action or if the Provider does not request a fair hearing, a report summarizing the adverse action will be submitted to the National Practitioner Data Bank (NPDB) and/or the Healthcare Integrity and Protection Data Bank (HIPDB).

Provider Enrollment & Contracting

If you have any questions about the contracting or credentialing process, please contact Molina at (844) 862-4564 or email Denta.VisionDevelopment@MolinaHealthCare.Com.

Out of Network Providers and Services

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

“Emergency Services” means covered inpatient and outpatient services furnished by a Provider who is qualified to furnish these services and such services are needed to evaluate or stabilize an emergency medical condition.

Benefit Plan Details and Authorization Requirements

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

- Medicaid
- Molina MyCare Ohio

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.

Please note that orthodontic treatment requires submission of **Form 03630, Referral Evaluation Criteria for Comprehensive Orthodontic Treatment**. A copy of the form is included in this Provider Manual. You can also download an electronic copy of the form from the Ohio Department of Job and Family Services:

<http://medicaid.ohio.gov/Portals/0/Resources/Publications/Forms/ODM03630fillx.pdf>.

Continuation of Care Process

The Continuation of Care (COC) Form is needed to change Providers during active orthodontic treatment. The form is to be submitted along with a current American Dental Association (ADA) Dental Claim Form. On the ADA Claim Form, the Current Dental Terminology (CDT) code D8999 must be the first requested line item. Next list the D8670 (periodic orthodontic treatment visit) and the quantity of visits remaining to complete the orthodontic treatment. List D8680 (orthodontic retention) and the quantity needed to complete the orthodontic treatment. A narrative explaining the current state of treatment and what is required to complete treatment should also be included. A copy of the COC form is included in this manual.

The COC form is located below:



Orthodontic Continuation of Care Request Form

Date: _____

Patient Name: _____

Member ID: _____

Member DOB: _____

Code(s) Requiring COC: _____

Current Provider Name: _____

Current Provider NPI#: _____

Banding Date: _____

Total Dollars Paid for Case to Date: _____

Remaining Visits: _____

Balance Requested for Remainder of Case: _____

Previous Carrier (if applicable): _____

Previous Provider Name: _____

Previous Provider Phone #: _____

Previous Provider Address: _____

Procedure:

- Complete this form and submit, along with required clinical documentation outlined below in **Required Documentation**, as a prior authorization for code D8999 and all applicable orthodontic codes.
- All documentation should be submitted to:
Molina Healthcare Authorizations
P.O. Box 2154
Milwaukee, WI 53201
- The case will be reviewed and approved or denied for the continuation of care. If approved, an approved reimbursement amount will be determined as well.

Required Documentation:

- This form completed.
- Completed 2019 ADA Dental Claim Form listing D8999 code and all applicable orthodontic codes.
- 6-8 Intraoral/Extraoral photos.
- Narrative that includes: reason for leaving previous treating Provider, previous Provider contact information, additional treatment needed and the approximate amount of additional time needed for treatment.

Coverage Details | Authorization Requirements

In the following table, if **Yes** is indicated in the **Auth Req** column, then a service requires a prior authorization (PA). 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 PA is required, a copy of the signed request for treatment must be submitted with the PA request (along with any required documentation) to SKYGEN 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. For an item that requires multiple fittings and special construction (e.g., dentures), the first visit date is the date of service for purposes of PA or Claims submission. Payment for the item will not be made until it has been delivered to the Member.

Code	Description	Age	Tooth / Quad / Arch	Limitations	Auth Req	Requirement
D0120	Periodic Oral Evaluation - Established Patient	0-20		One D0120, per six months (180 days) per Provider. Not on the same DOS as D0140, D0150 or D0180.	No	
D0120	Periodic Oral Evaluation - Established Patient	21-999		One D0120, per six months per Provider. Not on the same DOS as D0140, D0150 or D0180.	No	
D0140	Limited Oral Evaluation - Problem Focused	0-999		No payment is made if the evaluation is performed solely for the purpose of adjusting dentures, except as specified in Chapter 5160-28 of the Administrative Code. Not on the same DOS in conjunction with D0120, D0150 or D0180.	No	
D0150	Comprehensive Oral Evaluation - New or Established Patient	0-999		One D0150 per five years per Provider, per patient. No payment is made in conjunction with D0120.	No	
D0180	Comprehensive Periodontal Evaluation – New or Established Patient	0-20		One D0180 per 365 days. Not on the same DOS as D0120, D0150 or D0140.	Yes	Narrative of Medical Necessity with Claim.
D0180	Comprehensive Periodontal Evaluation – New or Established Patient	21-999		One D0180 per 365 days. Not on same DOS as D0120, D0140 or D0150.	No	

Code	Description	Age	Tooth / Quad / Arch	Limitations	Auth Req	Requirement
D0210	Intraoral - Complete Series of Radiographic Images	0-999		One D0210 per 60 months per Provider and not in conjunction with D0330.	No	All radiographic images must be at diagnostic quality, properly exposed, clearly focused, clearly readable, properly mounted (if applicable) and free from defect for the relevant area of the mouth.
D0220	Intraoral - Periapical First Radiographic Image	0-999	All Teeth (1-32, A-T)	One per DOS. Twelve per 12 months per Provider. Not on the same DOS as D0250, D0210, D0240 or D0330.	No	All radiographic images must be at diagnostic quality, properly exposed, clearly focused, clearly readable, properly mounted (if applicable) and free from defect for the relevant area of the mouth.
D0230	Intraoral – Periapical Each Additional Image	0-999	All Teeth (1-32, A-T)	Three per DOS. Eight per 12 months per Provider. Not on the same DOS as D0250, D0210, D0240 or D0330.	No	All radiographic images must be at diagnostic quality, properly exposed, clearly focused, clearly readable, properly mounted (if applicable) and free from defect for the relevant area of the mouth.
D0240	Intraoral – Occlusal Radiographic Image	0-999		Two per DOS. Four per 12 months per Provider. Not on the same DOS as D0210, D0220, D0230 or D0330.	No	All radiographic images must be at diagnostic quality, properly exposed, clearly focused, clearly readable, properly mounted (if applicable) and free from defect for the relevant area of the mouth.
D0250	Extraoral – First Radiographic Image	0-999		One D0250 per 60 months.	No	All radiographic images must be at diagnostic quality, properly exposed, clearly focused, clearly readable, properly mounted (if applicable) and free from defect for the relevant area of the mouth.
D0270	Bitewing - Single Radiographic Image	0-999		One D0270 per six months. Not in conjunction with D0210, D0272, D0273, D0274, D0330 or D0340.	No	All radiographic images must be at diagnostic quality, properly exposed, clearly focused, clearly readable, properly mounted (if applicable) and free from defect for the relevant area of the mouth.
D0272	Bitewings - Two Radiographic Images	0-999		One D0272 per six months. Not in conjunction with D0210, D0270, D0273, D0274, D0330 or D0340.	No	All radiographic images must be at diagnostic quality, properly exposed, clearly focused, clearly readable, properly mounted (if applicable) and free from defect for the relevant area of the mouth.
D0273	Bitewings - Three Radiographic Images	0-999		One D0273 per six months. Not in conjunction with D0210, D0270, D0272, D0274, D0330 or D0340.	No	All radiographic images must be at diagnostic quality, properly exposed, clearly focused, clearly readable, properly mounted (if applicable) and free from defect for the relevant area of the mouth.
D0274	Bitewings - Four Radiographic Images	0-999		One D0274 per six months. Not in conjunction with D0210, D0270, D0272, D0273, D0330 or D0340.	No	All radiographic images must be at diagnostic quality, properly exposed, clearly focused, clearly readable, properly mounted (if applicable) and free from defect for the relevant area of the mouth.

Code	Description	Age	Tooth / Quad / Arch	Limitations	Auth Req	Requirement
D0321	Other Temporomandibular Joint Radiographic Images, By Report	0-999		In conjunction with D7899. One D0321 per 60 months.	No	Four to six images, must include submission of patient history and treatment plan. All radiographic or magnetic images must be at diagnostic quality, properly exposed, clearly focused, clearly readable, properly mounted (if applicable) and free from defect for the relevant area of the mouth.
D0330	Panoramic Radiographic Image	6-999		One D0330 per 60 months and not in conjunction with D0210.	No	All radiographic images must be of diagnostic quality, properly exposed, clearly focused, clearly readable, properly mounted (if applicable) and free from defect for the relevant area of the mouth.
D0330	Panoramic Radiographic Image	0-5		One D0330 per 60 months and not in conjunction with D0210.	Yes	All radiographic images must be of diagnostic quality, properly exposed, clearly focused, clearly readable, properly mounted (if applicable) and free from defect for the relevant area of the mouth.
D0340	Cephalometric Radiographic Image	0-999		One D0340 per 12 months. In conjunction with D5913, D5915, D5916, D5931, D5932, D5934, D5935, D5955, D5999, D7450, D7451, D7460, D7461, D8080.	No	All radiographic images must be of diagnostic quality, properly exposed, clearly focused, clearly readable, properly mounted (if applicable) and free from defect for the relevant area of the mouth.
D0350	Oral/Facial Photographic Images	0-999		One D0350 per 12 months. Three D0350 per 12 months per location for oral surgeons only. In conjunction with D4210, D4211, D5913, D5915, D5916, D5934, D5935, D5955, D5999, D7471, D7472, D7473, D7960, D7970, D8080.	No	All Oral/Facial images must be of diagnostic quality, properly exposed, clearly focused, clearly readable, properly mounted (if applicable) and free from defect for the relevant area of the mouth.
D0470	Diagnostic Images of Casts	0-999		Two D0470, one per arch, per 12 months . In conjunction with D4210, D4211, D7471, D7472, D7473, D7899, D7960, D7970, D8080, D8999.	No	
D1110	Prophylaxis - Adult	14-999		One D1110 per six months, per patient.	No	
D1120	Prophylaxis - Child	0-13		One D1120 per six months, per patient.	No	

Code	Description	Age	Tooth / Quad / Arch	Limitations	Auth Req	Requirement
D1206	Topical Fluoride Varnish	0-20		One D1206 or D1208 per six months, per patient.	No	
D1208	Topical Application of Fluoride	0-20		One D1206 or D1208 per six months, per patient.	No	
D1320	Tobacco Cessation Counseling	0-999		Two D1320 per 365 days.	No	Coverage limited to patients with history of tobacco use. This service must be in conjunction with another dental service. Documentation of tobacco use, extent of counseling session and provision of cessation assistance or referral must be maintained in the clinical record.
D1351	Sealant - Per Tooth	0-17	Teeth (14, 15, 18, 19, 2, 3, 30, 31)	One D1351 per patient, per tooth, per lifetime. Occlusal surfaces only with no restorations or caries present.	No	
D1354	Interim Carries Arresting Medicament Application	0-999	All Teeth	Four treatments per tooth per lifetime.	No	No payment is made in conjunction with a fluoride treatment, restoration or crown. Payment is limited to one unit per tooth. May bill up to four teeth per date of service. Tooth numbers required on Claim.
D1510	Space Maintainer - Fixed – Unilateral – Per Quadrant	0-20	Teeth (2-15, 18-31, A-T)	Payment may be made for a passive type of appliance only. Limit one D1510 per tooth, per lifetime. Max four teeth.	No	
D1516	Space Maintainer - Fixed – Bilateral, Maxillary	0-20	Teeth (2-15, A-J)	Payment may be made for a passive type of appliance only. Limit one D1516 per tooth, per lifetime. Max four teeth.	No	
D1517	Space Maintainer - Fixed – Bilateral, Mandibular	0-20	Teeth (18-31, K-T)	Payment may be made for a passive type of appliance only. Limit one D1517 per tooth, per lifetime. Max four teeth.	No	
D1520	Space Maintainer - Removable – Unilateral – Per Quadrant	0-20	Teeth (2-15, 18-31, A-T)	Payment may be made for a passive type of appliance only. Limit one D1520 per tooth, per lifetime. Max four teeth.	No	
D1526	Space Maintainer - Removable – Bilateral, Maxillary	0-20	Teeth (2-15, A-J)	Payment may be made for a passive type of appliance only.	No	

Code	Description	Age	Tooth / Quad / Arch	Limitations	Auth Req	Requirement
				Limit one D1526 per tooth, per lifetime. Max four teeth.		
D1527	Space Maintainer - Removable – Bilateral, Mandibular	0-20	Teeth (18-31, K-T)	Payment may be made for a passive type of appliance only. Limit one D1527 per tooth, per lifetime. Max four teeth.	No	
D2140	Amalgam - One Surface, Primary or Permanent	0-999	All Teeth (1-32, A-T)	One amalgam/resin restoration per tooth, per surface, per 12 months (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394).	No	If a tooth has decay on three surfaces on which separate restorations can be performed, separate payments may be made for each restoration performed up to a maximum of three restorations, per OAC: 5160-5-08. A tooth surface can be named only once, whether alone or in combination with restorations on other surfaces. On maxillary first and second molars, the occlusal surface can be named twice, whether performed alone or in combination with restorations of another surface.
D2150	Amalgam - Two Surfaces, Primary or Permanent	0-999	All Teeth (1-32, A-T)	One amalgam/resin restoration per tooth, per surface, per 12 months (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394).	No	If a tooth has decay on three surfaces on which separate restorations can be performed, separate payments may be made for each restoration performed up to a maximum of three restorations, per OAC: 5160-5-08. A tooth surface can be named only once, whether alone or in combination with restorations on other surfaces. On maxillary first and second molars, the occlusal surface can be named twice, whether performed alone or in combination with restorations of another surface.
D2160	Amalgam - Three Surfaces, Primary or Permanent	0-999	All Teeth (1-32, A-T)	One amalgam/resin restoration per tooth, per surface, per 12 months (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394).	No	If a tooth has decay on three surfaces on which separate restorations can be performed, separate payments may be made for each restoration performed up to a maximum of three restorations, per OAC: 5160-5-08. A tooth surface can be named only once, whether alone or in combination with restorations on other surfaces. On maxillary first and second molars, the occlusal surface can be named twice, whether performed alone or in combination with restorations of another surface.

Code	Description	Age	Tooth / Quad / Arch	Limitations	Auth Req	Requirement
D2161	Amalgam - Four or More Surfaces, Primary or Permanent	0-999	All Teeth (1-32, A-T)	One amalgam/resin restoration per tooth, per surface, per 12 months (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394).	No	If a tooth has decay on three surfaces on which separate restorations can be performed, separate payments may be made for each restoration performed up to a maximum of three restorations, per OAC: 5160-5-08. A tooth surface can be named only once, whether alone or in combination with restorations on other surfaces. On maxillary first and second molars, the occlusal surface can be named twice, whether performed alone or in combination with restorations of another surface.
D2330	Resin-Based Composite - One Surface, Anterior	0-999	Anterior Teeth (6-11, 22-27, C-H, M-R)	One amalgam/resin restoration per tooth, per surface, per 12 months (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394).	No	If a tooth has decay on three surfaces on which separate restorations can be performed, separate payments may be made for each restoration performed up to a maximum of three restorations, per OAC: 5160-5-08. A tooth surface can be named only once, whether alone or in combination with restorations on other surfaces. On anterior teeth, the facial and lingual surfaces can be named twice, whether performed alone or in combination with restorations of another surface. If the incisal angle on an anterior tooth is involved, then only one four-surface restoration can be claimed for the tooth and no additional surfaces or restorations will be allowed.
D2331	Resin-Based Composite - Two Surfaces, Anterior	0-999	Anterior Teeth (6-11, 22-27, C-H, M-R)	One amalgam/resin restoration per tooth, per surface, per 12 months (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394).	No	If a tooth has decay on three surfaces on which separate restorations can be performed, separate payments may be made for each restoration performed up to a maximum of three restorations, per OAC: 5160-5-08. A tooth surface can be named only once, whether alone or in combination with restorations on other surfaces. On anterior teeth, the facial and lingual surfaces can be named twice, whether performed alone or in combination with restorations of another surface. If the incisal angle on an anterior tooth is involved, then only one four-surface restoration can be claimed for the tooth and no additional surfaces or restorations will be allowed.

Code	Description	Age	Tooth / Quad / Arch	Limitations	Auth Req	Requirement
D2332	Resin-Based Composite - Three Surfaces, Anterior	0-999	Anterior Teeth (6-11, 22-27, C-H, M-R)	One amalgam/resin restoration per tooth, per surface, per 12 months (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394).	No	If a tooth has decay on three surfaces on which separate restorations can be performed, separate payments may be made for each restoration performed up to a maximum of three restorations, per OAC: 5160-5-08. A tooth surface can be named only once, whether alone or in combination with restorations on other surfaces. On anterior teeth, the facial and lingual surfaces can be named twice, whether performed alone or in combination with restorations of another surface. If the incisal angle on an anterior tooth is involved, then only one four-surface restoration can be claimed for the tooth and no additional surfaces or restorations will be allowed.
D2335	Resin-Based Composite - Four or More Surfaces or Involving Incisal Angle	0-999	Anterior Teeth (6-11, 22-27, C-H, M-R)	One amalgam/resin restoration per tooth, per surface, per 12 months (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394).	No	Payment is for one restoration only.
D2390	Resin-Based Composite Crown, Anterior	0-20	Anterior Teeth (6-11, 22-27, C-H, M-R)	One D2390 per 60 months, per patient, per anterior tooth.	No	
D2391	Resin-Based Composite - One Surface, Posterior	0-999	Posterior Teeth (1-5, 12-21, 28-32, A, B, I, J, K, L, S, T)	One amalgam/resin restoration per tooth, per surface, per 12 months (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394).	No	If a tooth has decay on three surfaces on which separate restorations can be performed, separate payments may be made for each restoration performed up to a maximum of three restorations, per OAC: 5160-5-08. A tooth surface can be named only once, whether alone or in combination with restorations on other surfaces. On maxillary first and second molars, the occlusal surface can be named twice, whether performed alone or in combination with restorations of another surface.
D2392	Resin-Based Composite - Two Surfaces, Posterior	0-999	Posterior Teeth (1-5, 12-21, 28-32, A, B, I, J, K, L, S, T)	One amalgam/resin restoration per tooth, per surface, per 12 months (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394).	No	If a tooth has decay on three surfaces on which separate restorations can be performed, separate payments may be made for each restoration performed up to a maximum of three restorations, per OAC: 5160-5-08. A tooth surface can be named only once, whether alone or in combination with restorations on other surfaces.

Code	Description	Age	Tooth / Quad / Arch	Limitations	Auth Req	Requirement
						On maxillary first and second molars, the occlusal surface can be named twice, whether performed alone or in combination with restorations of another surface.
D2393	Resin-Based Composite - Three Surfaces, Posterior	0-999	Posterior Teeth (1-5, 12-21, 28-32, A, B, I, J, K, L, S, T)	One amalgam/resin restoration per tooth, per surface, per 12 months (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394).	No	If a tooth has decay on three surfaces on which separate restorations can be performed, separate payments may be made for each restoration performed up to a maximum of three restorations, per OAC: 5160-5-08. A tooth surface can be named only once, whether alone or in combination with restorations on other surfaces. On maxillary first and second molars, the occlusal surface can be named twice, whether performed alone or in combination with restorations of another surface.
D2394	Resin-Based Composite - Four or More Surfaces, Posterior	0-999	Posterior Teeth (1-5, 12-21, 28-32, A, B, I, J, K, L, S, T)	One amalgam/resin restoration per tooth, per surface, per 12 months (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394).	No	If a tooth has decay on three surfaces on which separate restorations can be performed, separate payments may be made for each restoration performed up to a maximum of three restorations, per OAC: 5160-5-08. A tooth surface can be named only once, whether alone or in combination with restorations on other surfaces. On maxillary first and second molars, the occlusal surface can be named twice, whether performed alone or in combination with restorations of another surface.
D2740	Crown - Porcelain/Ceramic Subs	0-999	Permanent Anterior Teeth (6-11, 22-27)	One D2740, D2751, D2752 per 60 months, per patient, per anterior tooth.	Yes	Pre-operative x-rays of tooth.
D2751	Crown - Porcelain Fused to Base Metal	0-999	Permanent Anterior Teeth (6-11, 22-27)	One D2740, D2751, D2752 per 60 months, per patient, per anterior tooth.	Yes	Pre-operative x-rays of tooth.
D2752	Crown - Porcelain Fused to Noble Metal	0-999	Permanent Anterior Teeth (6-11, 22-27)	One D2740, D2751, D2752 per 60 months, per patient, per anterior tooth.	Yes	Pre-operative x-rays of tooth.
D2929	Prefab Porcelain/Ceramic Crown-Anterior Primary Tooth	0-20	Primary Anterior Teeth (C-H, M-R)	One D2929 per 36 months, per tooth	No	A prefabricated porcelain/ceramic – primary tooth is reimbursed at different maximum fees for primary anterior and posterior teeth.
D2929	Prefab Porcelain/Ceramic Crown-Posterior Primary Tooth	0-20	Primary Posterior Teeth (A,B, I-L, S,T)	One D2929 per 36 months, per tooth	No	A prefabricated porcelain/ceramic – primary tooth is reimbursed at different maximum fees for primary anterior and posterior teeth

Code	Description	Age	Tooth / Quad / Arch	Limitations	Auth Req	Requirement
D2930	Prefabricated Stainless Steel Crown - Primary Tooth	0-20	Primary Teeth (A-T)	One D2930 per 36 months, per tooth.	No	
D2931	Prefabricated Stainless Steel Crown - Permanent Tooth	0-999	All Permanent Teeth (1-32)	One D2931 per 60 months, per tooth.	No	
D2933	Prefabricated Stainless Steel Crown With Resin Window	0-20	Primary Anterior (C-H, M-R)	One D2933 per 36 months, per anterior tooth.	No	Payment for a crown with resin window includes any necessary restoration.
D2934	Prefabricated Steel Crown - Primary Tooth	0-20	Primary Teeth (A-T)	One D2934 per 36 months, per tooth.	No	
D2950	Core Buildup, Including Pins	0-999	Teeth (1-32), Super-numerary	One per tooth.	No	Coverage is limited to permanent teeth. This service must be provided in preparation for or in conjunction with an adult crown procedure.
D2951	Pin Retention - Per Tooth, in Addition to Restoration	0-999	All Permanent Teeth (1-32)	Three D2951 per lifetime per tooth.	No	
D2952	Post and Core in Addition to Crown, Indirectly Fabricated	0-999	Permanent Anterior Teeth (6-11, 22-27)	One D2952 per 60 months, per anterior tooth.	Yes	Pre-operative x-rays of endodontically treated tooth.
D2954	Prefabricated Post and Core in Addition to Crown	0-999	Permanent Anterior Teeth (6-11, 22-27)	One D2954 per 60 months, per anterior tooth.	Yes	Pre-operative x-rays of endodontically treated tooth.
D3220	Therapeutic Pulpotomy	0-20	All Teeth (1-32, A-T)	Pulpotomy and pulpectomy not payable as separate procedures in combination with root canal therapy. One D3220 per lifetime, per tooth.	No	
D3310	Endodontic Therapy, Anterior Tooth (Excluding Final Restoration)	0-999	Permanent Anterior (6-11, 22-27)	One D3310 per lifetime, per tooth.	No	
D3320	Endodontic Therapy, Bicuspid Tooth (Excluding Final Restoration)	0-999	Bicuspids (4, 5, 12, 13, 20, 21, 28, 29)	One D3320 per lifetime, per tooth.	No	
D3330	Endodontic Therapy, Molar (Excluding Final Restoration)	0-999	Permanent Molars (1-3, 14-19, 30-32)	One D3330 per lifetime, per tooth.	No	
D3351	Apexification / Recalcification - Initial Visit	0-999	All Permanent Teeth	One D3351 per lifetime, per tooth.	No	Pre-operative x-rays (excluding bitewings).

Code	Description	Age	Tooth / Quad / Arch	Limitations	Auth Req	Requirement
			(1-32)			
D3352	Apexification / Recalcification - Interim	0-999	All Permanent Teeth (1-32)	One D3352 per lifetime, per tooth.	No	Date of initial apexification visit with Claim.
D3353	Apexification / Recalcification - Final Visit	0-999	All Permanent Teeth (1-32)	One D3353 per lifetime, per tooth.	No	Date of initial apexification visit, fill x-ray with Claim.
D3410	Apicoectomy - Anterior	0-999	Permanent Anterior (6-11, 22-27)	One D3410 per lifetime, per tooth.	No	Pre-operative x-rays of tooth.
D4210	Gingivectomy or Gingivoplasty - Four or More Contiguous Teeth	0-999	Quadrants (LL, LR, UR, UL)	One D4210, D4211 per 24 months, per quadrant, per patient. Not payable in conjunction with D1110, D1120, D4341, D4342 and D4910.	Yes	Pre-op x-rays, narrative of Medical Necessity, diagnostic images of casts or photos.
D4211	Gingivectomy or Gingivoplasty – One to Three Contiguous Teeth	0-999	Quadrants (LL, LR, UR, UL)	One D4210, D4211 per 24 months, per quadrant, per patient. Not payable in conjunction with D1110, D1120, D4341, D4342 and D4910.	Yes	Pre-op x-rays, narrative of Medical Necessity, diagnostic images of casts or photos.
D4341	Periodontal scaling, Four or More Teeth	0-999	Quadrants (LL, LR, UR, UL)	One D4341, D4342 per 24 months, per quadrant, per patient. Not payable in conjunction with D1110, D1120, D4210, D4211 and D4910.	Yes	A periodontal treatment plan. A 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, One to Three Teeth	0-999	Quadrants (LL, LR, UR, UL)	One D4341, D4342 per 24 months, per quadrant, per patient. Not payable in conjunction with D1110, D1120, D4210, D4211 and D4910.	Yes	A periodontal treatment plan. A 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.
D4910	Periodontal Maintenance	0-999	Quadrants (LL, LR, UR, UL)	One D4910 per 12 months. No payment made in conjunction with prophylaxis or within 30 days of root planning within last 24 months.	No	

Code	Description	Age	Tooth / Quad / Arch	Limitations	Auth Req	Requirement
D5110	Complete Denture - Maxillary	0-999		One D5110, D5130 per 96 months.	Yes	Full mouth x-rays or panorex for initial dentures only, date of prior placement or narrative of Medical Necessity if edentulous. When a prior authorization is submitted, for complete or partial dentures, for a resident of a long-term care facility it must be accompanied by the following: A copy of the resident's most recent nursing care plan, a copy of a consent form signed by resident or guardian and a dentist's narrative assessing resident's ability to wear dentures.
D5120	Complete Denture - Mandibular	0-999		One D5120, D5140 per 96 months.	Yes	Full mouth x-rays or panorex for initial dentures only, date of prior placement or narrative of Medical Necessity if edentulous. When a prior authorization is submitted, for complete or partial dentures, for a resident of a long-term care facility it must be accompanied by the following: A copy of the resident's most recent nursing care plan, a copy of a consent form signed by resident or guardian and a dentist's narrative assessing resident's ability to wear dentures.
D5130	Immediate Denture- Maxillary	0-999		One D5110, D5130 per 96 months.	Yes	Full mouth x-rays or panorex of teeth PRIOR to extraction. When a prior authorization is submitted, for complete or partial dentures, for a resident of a long-term care facility it must be accompanied by the following: A copy of the resident's most recent nursing care plan, a copy of a consent form signed by resident or guardian and a dentist's narrative assessing resident's ability to wear dentures.

Code	Description	Age	Tooth / Quad / Arch	Limitations	Auth Req	Requirement
D5140	Immediate Denture-Mandibular	0-999		One D5120, D5140 per 96 months.	Yes	Full mouth x-rays or panorex of teeth PRIOR to extraction. When a prior authorization is submitted, for complete or partial dentures, for a resident of a long-term care facility it must be accompanied by the following: A copy of the resident's most recent nursing care plan, a copy of a consent form signed by resident or guardian and a dentist's narrative assessing resident's ability to wear dentures.
D5211	Maxillary Partial Denture - Resin Base (including, conventional clasps, rests and teeth)	0-18		One D5211, D5213 per 96 months.	Yes	Full mouth x-rays or panorex. When a prior authorization is submitted, for complete or partial dentures, for a resident of a long-term care facility it must be accompanied by the following: A copy of the resident's most recent nursing care plan, a copy of a consent form signed by resident or guardian and a dentist's narrative assessing resident's ability to wear dentures.
D5212	Mandibular Partial Denture - Resin Base (including, conventional clasps, rests and teeth)	0-18		One D5212, D5214 per 96 months.	Yes	Full mouth x-rays or panorex. When a prior authorization is submitted, for complete or partial dentures, for a resident of a long-term care facility it must be accompanied by the following: A copy of the resident's most recent nursing care plan, a copy of a consent form signed by resident or guardian and a dentist's narrative assessing resident's ability to wear dentures.
D5213	Maxillary Partial Denture - Cast Metal Framework With Resin Denture Bases (including retentive/clasping materials, rests and teeth)	0-999		One D5211, D5213 per 96 months.	Yes	Full mouth x-rays or panorex. When a prior authorization is submitted, for complete or partial dentures, for a resident of a long-term care facility it must be accompanied by the following: A copy of the resident's most recent nursing care plan, a copy of a consent form signed by resident or guardian and a dentist's narrative assessing resident's ability to wear dentures.
D5214	Mandibular Partial Denture - Cast Metal Framework With Resin Denture Bases (including retentive/clasping	0-999		One D5212, D5214 per 96 months.	Yes	Full mouth x-rays or panorex. When a prior authorization is submitted for complete or partial dentures for a resident of a long-term care facility it must be accompanied by the following: A copy of the resident's most recent nursing care plan; a copy

Code	Description	Age	Tooth / Quad / Arch	Limitations	Auth Req	Requirement
	materials, rests and teeth)					of a consent form signed by resident or guardian; and a dentist's narrative assessing resident's ability to wear dentures.
D5511	Repair Broken Complete Denture Base, Mandibular	0-999	Arch – LA	One per 36 months.	No	
D5512	Repair Broken Complete Denture Base, Maxillary	0-999	Arch - UA	One per 36 months.	No	
D5520	Replace Missing or Broken Teeth - Complete Denture (Each Tooth)	0-999	All Permanent Teeth (1-32)	One D5520 per permanent tooth, per 24 months.	No	
D5611	Repair Resin Partial Denture Base, Mandibular	0-999	Arch – LA	One per 36 months.	No	
D5612	Repair Resin Partial Denture Base, Maxillary	0-999	Arch – UA	One per 36 months.	No	
D5621	Repair Cast Partial Framework, Mandibular	0-999	Arch – LA	One per 36 months.	No	
D5622	Repair Cast Partial Framework, Maxillary	0-999	Arch – UA	One per 36 months.	No	
D5630	Repair or Replace Broken Clasp	0-999	All Permanent Teeth (1-32)	Two D5630 per 24 months.	No	
D5640	Replace Broken Teeth - Per Tooth	0-999	All Permanent Teeth (1-32)	One D5640 per permanent tooth, per 24 months, maximum eight teeth.	No	
D5650	Add Tooth to Existing Partial Denture	0-999	All Permanent Teeth (1-32)	One D5650 per permanent tooth, per 24 months, maximum eight teeth.	No	
D5660	Add Clasp to Existing Partial Denture	0-999		One D5660 per 24 months.	No	
D5750	Reline Complete Maxillary Denture (Laboratory)	0-999		One D5750 per 36 months. Not covered within 36 months of placement.	No	
D5751	Reline Complete Mandibular Denture (Laboratory)	0-999		One D5751 per 36 months. Not covered within 36 months of placement.	No	
D5760	Reline Maxillary Partial Denture (Laboratory)	0-999		One D5760 per 36 months. Not covered within 36 months of placement.	No	

Code	Description	Age	Tooth / Quad / Arch	Limitations	Auth Req	Requirement
D5761	Reline Mandibular Partial Denture (Laboratory)	0-999		One D5761 per 36 months. Not covered within 36 months of placement.	No	
D5899	Unspecified Removable Prosthodontic Procedure, By Report	0-999	Arches (UA, LA)	Covered only in conjunction with D5211-D5214. Approved denture required for authorization. Maximum of two per denture covered.	Yes	Description of procedure and narrative of Medical Necessity.
D5913	Nasal Prosthesis	0-999		One D5913 per 96 months.	Yes	Narrative of Medical Necessity with Claim.
D5915	Orbital Prosthesis	0-999		One D5915 per 96 months.	Yes	Narrative of Medical Necessity with Claim.
D5916	Ocular Prosthesis	0-999		One D5916 per 96 months.	Yes	Narrative of Medical Necessity with Claim.
D5931	Obturator Prosthesis, Surgical	0-999		One D5931 per 96 months.	Yes	Narrative of Medical Necessity with Claim.
D5932	Obturator Prosthesis, Definitive	0-999		One D5932 per 96 months.	Yes	Narrative of Medical Necessity with Claim.
D5934	Mandibular Resection Prosthesis With Guide Flange	0-999		One D5934 per lifetime.	Yes	Narrative of Medical Necessity with Claim.
D5935	Mandibular Resection Prosthesis Without Guide Flange	0-999		One D5935 per lifetime.	Yes	Narrative of Medical Necessity with Claim.
D5955	Palatal Lift Prosthesis, Definitive	0-999		One D5955 per lifetime.	Yes	Narrative of Medical Necessity with Claim.
D5999	Unspecified Maxillofacial Prosthesis, By Report	21-999		One D5999 per 96 months.	Yes	Description of procedure and narrative of Medical Necessity.
D7140	Extraction, Erupted Tooth or Exposed Root	0-999	All Teeth (1-32, A-T, SN)		No	
D7210	Surgical Extraction	0-999	Teeth (1-32, Super-numerary)	One D7210 per tooth, per lifetime.	No	.
D7220	Removal of Impacted Tooth - Soft Tissue	0-999	Teeth (1, 16, 17, 32, Super-numerary)	One D7220 per tooth, per lifetime.	No	

Code	Description	Age	Tooth / Quad / Arch	Limitations	Auth Req	Requirement
D7220	Removal of Impacted Tooth - Soft Tissue	0-999	Teeth (2-15, 18-31, A-T, Supernumerary)	One D7220 per tooth, per lifetime.	Yes	Pre-op x-ray (periapical, no bitewings) and narrative of Medical Necessity.
D7230	Removal of Impacted Tooth - Partially Bony	0-999	Teeth (1, 16, 17, 32, Supernumerary)	One D7230 per tooth, per lifetime.	No	
D7230	Removal of Impacted Tooth - Partially Bony	0-999	Teeth (2-15, 18-31, A-T, Supernumerary)	One D7230 per tooth, per lifetime.	Yes	Pre-op x-ray (periapical, no bitewings) and narrative of Medical Necessity.
D7240	Removal of Impacted Tooth - Completely Bony	0-999	All Teeth (1-32, A-T, SN)	One D7240 per tooth, per lifetime.	Yes	Pre-op x-rays (excluding bitewings) and narrative of Medical Necessity.
D7241	Removal of Impacted Tooth - Completely Bony, Unusual Surgical Complications	0-999	All Teeth (1-32, A-T, SN)	One D7241 per tooth, per lifetime.	Yes	Pre-op x-rays (excluding bitewings) and narrative of Medical Necessity.
D7250	Surgical Removal of Residual Tooth (Cutting Procedure)	0-999	All Teeth (1-32, A-T, SN)	One D7250 per tooth, per lifetime.	Yes	Pre-op x-rays (excluding bitewings) and narrative of Medical Necessity.
D7260	Oroantral Fistula Closure	0-999		Four D7260 per lifetime.	Yes	Pre-op x-rays (excluding bitewings) and narrative of Medical Necessity with Claim.
D7270	Reimplantation and/or Stabilization of Accidentally Evulsed/ Displaced Tooth	0-999	All Permanent Teeth (1-32)	One D7270 per tooth, per lifetime.	No	Images of the area and a detailed explanation of the findings and treatment must be maintained in patient's clinical record.
D7280	Surgical Access of an Unerrupted Tooth	0-999	Teeth 2-15, 18-31	In conjunction with D8080. One per permanent tooth, per lifetime.	Yes	Pre-operative X-ray and orthodontic treatment approval.
D7283	Placement of device to facilitate eruption of impacted tooth	0-20	Teeth 2-15, 18 - 31	Limit one per permanent tooth, per lifetime. In conjunction with D7280.	Yes	Pre-operative X-ray and orthodontic treatment approval.
D7285	Incisional Biopsy of Oral Tissue - Hard (Bone, Tooth)	0-999		One D7285 per 12 months.	No	
D7286	Incisional Biopsy of Oral Tissue - Soft	0-999		One D7286 per 12 months.	No	

Code	Description	Age	Tooth / Quad / Arch	Limitations	Auth Req	Requirement
D7310	Alveoloplasty in Conjunction with Extractions - Four or More Teeth	0-999	Quadrants (LL, LR, UR, UL)	D7310 and D7320 are covered only in conjunction with the construction of a prosthodontic appliance.	No	
D7320	Alveoloplasty Not in Conjunction with Extractions - Four or More Teeth	0-999	Quadrants (LL, LR, UR, UL)	D7310 and D7320 are covered only in conjunction with the construction of a prosthodontic appliance.	No	
D7450	Removal of Benign Odontogenic Cyst or Tumor - Dia Up to 1.25 Cm	0-999		Removal of periradicular cyst and curettage post extraction is not covered. One D7450 per 12 months.	No	Images of the area and a detailed explanation of the findings and treatment must be maintained in patient's clinical record.
D7451	Removal of Benign Odontogenic Cyst or Tumor - Dia Greater Than 1.25 Cm	0-999		Removal of periradicular cyst and curettage post extraction is not covered. One D7451 per 12 months.	No	Images of the area and a detailed explanation of the findings and treatment must be maintained in patient's clinical record.
D7460	Removal of Benign Nonodontogenic Cyst or Tumor - Dia Up To 1.25 Cm	0-999		Removal of periradicular cyst and curettage post extraction is not covered. One D7460 per 12 months.	No	Images of the area and a detailed explanation of the findings and treatment must be maintained in patient's clinical record.
D7461	Removal Of Benign Nonodontogenic Cyst or Tumor - Dia Greater Than 1.25 Cm	0-999		Removal of periradicular cyst and curettage post extraction is not covered. One D7461 per 12 months.	No	Images of the area and a detailed explanation of the findings and treatment must be maintained in patient's clinical record.
D7471	Removal of Lateral Exostosis (Maxilla or Mandible)	0-999	Arches (UA, LA)	One D7471 per lifetime, per patient, per arch.	No	A diagnostic image of casts or photograph of the mouth with the area of surgery outlined must be maintained in the patient's clinical record.
D7472	Removal of Torus Palatinus	0-999		One D7472 per lifetime, per patient, per arch.	No	A diagnostic image of casts or photograph of the mouth with the area of surgery outlined must be maintained in the patient's clinical record.
D7473	Remove Torus Mandibularis	0-999	Quadrants (LL,LR)	One D7473 per lifetime, per patient, per quadrant.	No	A diagnostic image of casts or photograph of the mouth with the area of surgery outlined must be maintained in the patient's clinical record.

Code	Description	Age	Tooth / Quad / Arch	Limitations	Auth Req	Requirement
D7510	Incision and Drainage of Abscess - Intraoral Soft Tissue	0-999	Quadrants (LL,LR)	One D7510 per 12 months.	No	Images of the area and a detailed explanation of the findings and treatment must be maintained in the patients clinical records.
D7520	Incision and Drainage of Abscess - Extraoral Soft Tissue	0-999		One D7520 per 12 months.	No	Images of the area and a detailed explanation of the findings and treatment must be maintained in the patients clinical records.
D7670	Alveolus – Closed Reduction)	0-999			No	Narrative of Medical Necessity, x-ray or photos optional. Images of the area and a detailed explanation of the findings and treatment must be maintained in the patient’s clinical records.
D7671	Alveolus - Open Reduction, May Include Stabilization of Teeth	0-999		One D7671 per 12 months.	No	Narrative of Medical Necessity, x-rays or photos optional. Images of the area and a detailed explanation of the findings and treatment must be maintained in the patients clinical records.
D7899	Unspecified TMD Therapy, By Report	0-999		One D7899 per 12 months.	Yes	Description of procedure and narrative of Medical Necessity, panoramic images and diagnostic images of casts.
D7960	Frenulectomy - Also Known as Frenectomy or Frenotomy - Separate Procedure	0-999		Three D7960 per lifetime.	No	A diagnostic image of casts or photograph of the mouth with the area of surgery outlined must be maintained in the patient’s clinical record.
D7970	Excision of Hyperplastic Tissue - Per Arch	0-999	Arches (UA, LA)	Once per arch, per lifetime.	No	A diagnostic image of casts or photograph of the mouth with the area of surgery outlined must be maintained in the patient’s clinical record.
D8080	Comprehensive Orthodontic Treatment of the Adolescent Dentition	0-20		One course of orthodontic treatment per lifetime. Payment includes first calendar quarter of treatment.	Yes	Six items must be submitted with each PA request: <ol style="list-style-type: none"> 1. Diagnostic photos (5-7) which include lateral & frontal photographs of the patient with lips together. 2. Cephalometric film and tracing with lips together. 3. Complete series of intraoral images or panorex image must be of diagnostic quality. 4. Diagnostic models. 5. Treatment plan to include length of time of treatment. 6. Completed evaluation and referral form ODM 3630 (1/2016).
D8210	Removable Appliance Therapy	0-999		One appliance per arch (upper arch and lower arch), per 60 months.	No	Panorex and/or ceph x-ray and narrative of Medical Necessity.

Code	Description	Age	Tooth / Quad / Arch	Limitations	Auth Req	Requirement
D8220	Fixed Appliance Therapy	0-999		One D8220 per lifetime.	Yes	Panorex and/or cephalometric x-ray and narrative of Medical Necessity.
D8670	Periodic Orthodontic Treatment Visit	0-20		Seven quarterly D8670 per lifetime.	Yes	History of initial banding required.
D8680	Orthodontic Retention (Removal of Appliances, Place Retainers)	0-20		Two D8680, one per arch (upper arch and lower arch), per lifetime.	Yes	Submitted in conjunction with orthodontic approval, covered after active orthodontic treatments have been completed.
D8999	Unspecified Orthodontic Procedure, By Report	0-20		One D8999 per lifetime.	Yes	Description of procedure and narrative of Medical Necessity.
D9222	Deep Sedation/ General Anesthesia- first 15 minutes	0-999		One D9222 per day, per patient. Not in conjunction with D9239 and D9243.	No	.
D9223	Deep Sedation/ General Anesthesia – each subsequent 15 minute increment	0-999		Limit four D9223 increments per patient per date of service. Not in conjunction with D9239 and D9243.	No	.
D9239	Intravenous Moderate (Conscious) Sedation/ Analgesia – first 15 minutes	0-999		One D9239 per day, per patient. Not in conjunction with D9222 and D9223.	No	.
D9243	Intravenous Moderate (Conscious) Sedation – each subsequent 15 minute increment	0-999		Limit four D9243 increments per patient per date of service. Not in conjunction with D9222 and D9223.	No	.
D9610	Therapeutic Parenteral Drug, Single Administration	0-999		One D9610 per day, per patient. Not in conjunction with D9612.	No	.
D9612	Therapeutic Parenteral Drugs, Two or More Administrations, Different Medications	0-999		One D9612 per day, per patient. Not in conjunction with D9610.	No	.
D9944	Occlusal Guard – Hard Appliance, Full Arch	21-999	Either upper or lower arch	Either D9944, D9945, or D9946 per 36 months	No	Removable dental appliance to minimize effects of bruxism or other occlusal factors. Not to be used for any type of sleep apnea, snoring or TMD appliance.
D9945	Occlusal Guard – Soft Appliance, Full Arch	21-999	Either upper or lower arch	Either D9944, D9945, or D9946 per 36 months	No	Removable dental appliance to minimize effects of bruxism or other occlusal factors. Not to be used for any type of sleep apnea, snoring or TMD appliance.

Code	Description	Age	Tooth / Quad / Arch	Limitations	Auth Req	Requirement
D9946	Occlusal Guard – Hard Appliance, Partial Arch	21-999	Either upper or lower arch	Either D9944, D9945, or D9946 per 36 months	No	Removable dental appliance to minimize effects of bruxism or other occlusal factors. Not to be used for any type of sleep apnea, snoring or TMD appliance.
D9999	Unspecified Adjunctive Procedure, By Report	0-999		Limited to procedures that require hospitalization.	Yes	Description of procedure, narrative of Medical Necessity. Entails unusual or specialized treatment required to safeguard the health and welfare of the patient. Detailed information on the difficulty and complications of the service is required. Submit complete images of the mouth, if indicated.

Form 03630: Referral Evaluation Criteria for Comprehensive Orthodontic Treatment

Please note that orthodontic treatment requires submission of Form 03630, Referral Evaluation Criteria for Comprehensive Orthodontic Treatment.

You can download an electronic copy of the form from the Ohio Department of Medicaid:
<http://medicaid.ohio.gov/Portals/0/Resources/Publications/Forms/ODM03630fillx.pdf>.

SKYGEN Provider Portal

Everything You Need, When You Need It, 24/7 and 365

The SKYGEN Provider Portal offers quick access to easy-to-use self-service tools for managing daily administration tasks. The SKYGEN Provider 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 24 hours a day, seven days a week.

For help getting started with the SKYGEN Provider Portal, contact the Provider Portal Team at (844) 621-4587. A web browser, an Internet connection, and a valid user ID and password are required for online access. From the SKYGEN Provider Portal, Providers and authorized office staff can log in for secure access anytime, anywhere and handle a variety of day-to-day tasks like:

- Verifying Member eligibility
- Reviewing patient treatment history
- Setting up office appointment schedules that automatically verify eligibility and pre-populate Claim forms for online submission
- Submitting Claims and authorizations using pre-populated electronic forms and data entry shortcuts
- Stepping through clinical guidelines as part of submitting authorizations for a quick indication of whether a service request is likely to be approved
- Attaching and securely send supporting documents such as digital x-rays, Explanation of Benefits (EOBs) and treatment plans for no extra charge
- Generating a quick pricing estimate before submitting a Claim
- Checking the real-time status of in-process Claims and authorizations and review historical payment records
- Reviewing Provider clinical profiling data relative to your peers
- Downloading and printing Provider Manuals, remittance reports and more

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

SKYGEN Provider Portal Registration

The SKYGEN Provider 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.

First-time users should call the SKYGEN Provider Portal Team for assistance with registering at (844) 621-4587.

To access the SKYGEN Provider Portal, click this link: <https://pwp.skygenusystems.com>

Utilization Management

Community Practice Patterns

To ensure fair and appropriate reimbursement, the SKYGEN 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, SKYGEN's 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 analyses, evaluations and outcomes are related to these community practice patterns. SKYGEN's 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, Utilization Management evaluates specialty dentists as a separate group and not with general dentists, since the types and nature of treatment may differ.

Evaluation

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 SKYGEN 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). SKYGEN is contractually obligated to report suspected fraud, waste, abuse or misuse by Members and participating dental Providers to Molina.

Prior Authorization & Documentation Requirements

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 SKYGEN Provider 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](#) beginning on page 70.

Prior Authorization for Treatment

SKYGEN has specific utilization criteria, as well as a prior authorization (PA) review process, to manage the utilization of services. Whether PA is required for a particular service and whether supporting documentation is also required, is defined in this Provider Manual in [Benefit Plan Details and Authorization Requirements](#) beginning on page 42.

Non-emergency services requiring PA should not be started until the authorization request is reviewed and approved. Non-emergency 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.

Requests for PA should be entered online through the SKYGEN Provider Portal at <https://pwp.skygenusystems.com>, submitted electronically in a HIPAA-compliant data file. (See [Authorization Submission Procedures](#) beginning on page 66. Any Claims or authorizations submitted without the required documentation will be denied and must be resubmitted to obtain reimbursement.

SKYGEN will make a decision on a request for PA within 10 calendar days from the date the 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 48 hours via the SKYGEN Provider Portal. PAs will be honored for 180 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 PA decision, call Provider Services at (855) 322-4079 dental inquiries press 7.

If SKYGEN 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.

To appeal an authorization decision, submit the appeal in writing along with any necessary documentation within 60 calendar days of the original determination date to:

Molina Healthcare
Appeals and Grievances Department
P.O. Box 349020
Columbus, OH 43234-9020

Authorization Submission Procedures

SKYGEN accepts authorizations submitted in any of the following formats:

- SKYGEN Provider Portal at <https://pwp.skygenusystems.com>
- Electronic submission via clearinghouse (Payer ID: SKYGN)
- HIPAA-compliant 837D file

Submitting Authorizations via SKYGEN Provider Portal

Providers may submit authorizations through the SKYGEN Provider Portal at <https://pwp.skygenusystems.com>.

Submitting authorizations via the SKYGEN Provider 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 guides 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, the status is instantly updated online and available for review. Approval notifications are available via the SKYGEN Provider Portal.

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

Submitting Authorizations via Clearinghouses

Providers may submit electronic Claims and authorizations 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.

SKYGEN 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.

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 SKYGEN Provider Portal or a clearinghouse, SKYGEN will work with you individually to receive electronic files submitted using the HIPAA Compliant 837D transaction set format. To inquire about this option, call SKYGEN at (844) 621-4587

Attaching Electronic Documents

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

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

American Dental Association Approved Dental Claim Form

ADA American Dental Association® Dental Claim Form																																																																																																																																				
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<table border="1" style="width: 100%; border-collapse: collapse; text-align: center;"> <thead> <tr> <th style="width: 5%;">#</th> <th style="width: 10%;">24. Procedure Date (MM/DD/CCYY)</th> <th style="width: 5%;">25. Area of Oral Cavity</th> <th style="width: 5%;">26. Tooth System</th> <th style="width: 10%;">27. Tooth Number(s) or Letter(s)</th> <th style="width: 5%;">28. Tooth Surface</th> <th style="width: 5%;">29. Procedure Code</th> <th style="width: 5%;">29a. Diag. Pointer</th> <th style="width: 5%;">29b. Ctx</th> <th style="width: 20%;">30. Description</th> <th style="width: 10%;">31. Fee</th> </tr> </thead> <tbody> <tr><td>1</td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr> <tr><td>2</td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr> <tr><td>3</td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr> <tr><td>4</td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr> <tr><td>5</td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr> <tr><td>6</td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr> <tr><td>7</td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr> <tr><td>8</td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr> <tr><td>9</td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr> <tr><td>10</td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr> </tbody> </table>												#	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. Ctx	30. Description	31. Fee	1											2											3											4											5											6											7											8											9											10										
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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. <input checked="" type="checkbox"/> Patient/Guardian Signature _____ Date _____						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) <input type="checkbox"/>																																																																																																																														
37. I hereby authorize and direct payment of the dental benefits otherwise payable to me, directly to the below named dentist or dental entity. <input checked="" type="checkbox"/> Subscriber Signature _____ Date _____						40. Is Treatment for Orthodontics? <input type="checkbox"/> No (Skip 41-42) <input type="checkbox"/> Yes (Complete 41-42)		41. Date Appliance Placed (MM/DD/CCYY)																																																																																																																												
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						45. Treatment Resulting from <input type="checkbox"/> Occupational illness/injury <input type="checkbox"/> Auto accident <input type="checkbox"/> Other accident																																																																																																																														
						46. Date of Accident (MM/DD/CCYY)		47. Auto Accident State																																																																																																																												
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						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. <input checked="" type="checkbox"/> Signed (Treating Dentist) _____ Date _____																																																																																																																														
49. NPI		50. License Number		51. SSN or TIN		54. NPI		55. License Number																																																																																																																												
52. Phone Number () -						52a. Additional Provider ID		56. Address, City, State, Zip Code		56a. Provider Specialty Code																																																																																																																										
57. Phone Number () -						57. Additional Provider ID		58. Additional Provider ID																																																																																																																												

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 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"

Clinical Criteria

Medical Necessity

Molina 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 oral facial 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. Molina must provide consistent methodical documentation of Medical Necessity for coding.

Medical Necessity does not supersede benefit coverage.

Prior Authorization of Treatment

Some procedures require prior authorization (PA) before treatment is started. When submitting these procedures for PA, also submit supporting documentation, if required. PA requirements and documentation requirements are summarized in this Provider Manual in [Benefit Plan Details and Authorization Requirements](#) beginning on page 42.

For information about submitting PA and required documentation, see [Prior Authorization & Documentation Requirements](#) beginning on page 64.

Dental surgery services must be performed in participating hospitals and require PA. See [Providing Services in Hospitals](#) on page 86.

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. SKYGEN uses the same clinical criteria (and require the same supporting documentation) for Claims submitted after emergency treatment as they would use to determine prior authorization (PA) for the same services.

Clinical Criteria for Prior Authorization of Treatment and Emergency Treatment

A number of procedures require prior authorization (PA) before initiating treatment. When submitting PA for these procedures, please note the documentation requirements when sending the information.

Clinical Criteria Descriptions

Clinical criteria used for 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 (PA) before initiating treatment. When submitting PA for these procedures, please note the documentation requirements. The criteria used to approve the request is listed below.

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 will require the same documentation be provided (with the Claim for payment) and the same criteria be met to receive payment for the treatment.

Clinical oral evaluations

- Documentation describing Medical Necessity

Porcelain fused to metal crowns and porcelain/ceramic substrate crowns

- Anterior Teeth only
- Minimum of 50% bone support
- No evidence of periapical pathology on non-endodontically treated teeth (vital)
- No Subcrestal caries or caries within 2mm of pulp on non-endodontically treated teeth (vital)
- Clinically acceptable Root Canal Therapy (RCT) if present
- 50% incisal edge missing/4+ surfaces involved/ or large restorations

Core buildup, including any pins when required

- Permanent teeth only
- Used in preparation for or in conjunction with an adult crown procedure

Cast posts and cores/prefabricated posts and cores

- Anterior teeth only
- Minimum of 50% bone support
- No subcrestal caries
- Clinically acceptable RCT
- 50% or more of clinical crown missing
- Clinically sufficient amount of tooth structure remaining to support a crown

Apexification

- Minimum of 50% bone support
- Evidence of apical pathology/fistula
- Evidence of deep caries/restoration, fracture, near pulpal exposure with open apex
- Pain from percussion or temperature with open apex
- File x-ray with claim

Apicoectomy / periradicular services

- Minimum of 50% bone support
- History of RCT
- Apical pathology
- No caries below bone level

Gingivectomy or gingivoplasty

- Hyperplasia or hypertrophy from drug therapy, hormonal disturbances or congenital defects
- Generalized 5mm or more pocketing indicated on the periodontal charting
- Photos/models of teeth

Scaling and root planning**D4341**

- Four or more teeth in the quadrant
- 5mm or more pocketing on two 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 8mm and above

D4342

- One to three teeth in the quadrant
- 5mm or more pocketing on two 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 8mm and above

Full dentures

- Existing denture greater than eight years old
- Remaining teeth do not have adequate bone support or are non-restorable
- Additional documentation for residents in a long-term care facility

Partial dentures

- Replacing one or more anterior teeth
- Replacing three or more posterior teeth (excluding third molars)
- Existing partial denture greater than eight years old
- Resin based (flipper) only for patients younger than 19 years of age
- Proper orientation of teeth to construct a stable partial
- Remaining teeth have greater than 50% bone support and are restorable
- Additional documentation for residents in a long-term care facility

Maxillofacial prosthetics

- Documentation describes accident, facial trauma, disease, facial reconstruction or other Medical Necessity

Impacted teeth (asymptomatic impactions will not be approved)

- Documentation describes pain, swelling, etc. around tooth (must be symptomatic) and documentation noted in patient record for at least one impaction
- Tooth impinges on the root of an adjacent tooth, is horizontally impacted or is tilted such that 50% of the occlusal surface is in bone, or shows a documented enlarged tooth follicle

or potential cystic formation and documentation noted in patient record for at least one impaction

- X-rays match type of impaction code described

Surgical extraction

- Documentation supporting need for surgical removal (dense bone, curved roots, minimal clinical crown remaining, etc.)
- Procedure will require elevation of mucoperiosteal flap, removal of bone and/or sectioning of the tooth and suturing

Surgical removal of residual tooth roots

- Tooth root is completely covered by tissue on x-ray
- Documentation describes pain, swelling, etc. around tooth (must be symptomatic) and documentation noted in patient record
- Procedure would require removal of bone to extract the residual root

Tooth reimplantation and/or stabilization

- Documentation describes accident and Medical Necessity
- Images of the area, a detailed explanation of the findings and treatment plan must be maintained in the patient's clinical record

Surgical access of an unerupted tooth

- Documentation supports impacted/unerupted tooth
- Tooth is beyond one year of normal eruption pattern

Biopsy

- Copy of pathology report must be maintained in the patient's clinical records

Excision of lesion/tumor (PA Not Required)

- Images of the area, a detailed explanation of the findings and treatment plan must be maintained in the patient's clinical record

Excision of bone tissue

- Necessary for fabrication of a prosthesis

Incision/drain abscess

- Images of the area, if applicable, and a detailed explanation of the findings and treatment plan must be maintained in the patient's clinical record

Fractures – simple/compound (PA not required)

- Documentation describes accident, operative report and Medical Necessity
- Images of the area, a detailed explanation of the findings and treatment plan must be maintained in the patient's clinical record

Frenulectomy (PA not required)

- Documentation describes tongue tied, diastema or tissue pull condition
- Images of the mouth with the area of surgery outlined must be maintained in the patient's clinical record

Excision of hyperplastic tissue

- Documentation describes Medical Necessity due to ill-fitting denture
- Images of the mouth with the area of surgery outlined must be maintained in the patient's clinical record

General anesthesia/IV sedation (dental office setting) - one or more of the criteria below (PA not required)

- Extractions of impacted or unerupted cuspids or wisdom teeth or surgical exposure of unerupted cuspids
- Two or more extractions in two or more quadrants
- Four or more extractions in one quadrant
- Excision of lesions greater than 1.25cm
- Surgical recovery from the maxillary antrum
- Documentation that patient is less than nine years old with extensive treatment (described)
- Documentation of failed local anesthesia and documentation noted in patient record
- Documentation of situational anxiety and documentation noted in patient record
- Documentation and narrative of Medical Necessity supported by submitted medical records (cardiac, cerebral palsy, epilepsy or condition that would render patient noncompliant)

Therapeutic drug injection

- Description of drugs (antibiotics, steroids, anti-inflammation or other therapeutic medication) and parental administration
- Documentation must be maintained in the patient's clinical record

Unspecified procedures, by report

- Procedure cannot be adequately described by an existing code
- Temporomandibular Joint Disorder (TMJ) therapy requires additional diagnosis and cannot solely be bruxism

Operating room (hospital operating room or outpatient facility) request – use D9999

- Patient under six years of age with extensive treatment needed
- Documentation supports indication of patient with a medical condition (cardiac, cerebral palsy, epilepsy) or other condition that would render the patient noncompliant

Fixed or removable appliance therapy

- Documentation of treatment for thumb and finger sucking, tongue thrusting, or other similar condition
- Documentation of a condition requiring treatment of interceptive orthodontics, retention appliance or occlusal guard

Comprehensive orthodontic services

- Documentation shows deep impinging overbite that shows palatal impingement of the majority of lower incisors
- Documentation shows true anterior open bite (not including one or two teeth slightly out of occlusion or where the incisors have not fully erupted)
- Documentation shows a large anterior-posterior discrepancy (Class II and Class III malocclusions that are virtually a full tooth Class II or Class III)
- Documentation shows anterior cross bite (involves more than two teeth in cross bite)

- Documentation shows posterior transverse discrepancies (involves several posterior teeth in cross bite, not a single tooth in cross bite)
- Documentation shows significant posterior open bites (not involving partially erupted teeth or one or two teeth slightly out of occlusion)
- Documentation shows impacted canines that will not erupt into the arch without orthodontic or surgical intervention (does not include cases where canines are going to erupt ectopically)
- Documentation shows majority of primary posterior teeth have exfoliated and orthodontic treatment is not expected to exceed 24 months; if necessary, interceptive orthodontics has been completed
- Documentation on **ODM Form 03630: Referral Evaluation Criteria for Comprehensive Orthodontic Treatment** shows at least five symptoms and signs of physical conditions checked, two of which fall under “dentofacial abnormality”

Placement of device to facilitate eruption of impacted tooth

Complete images must be submitted with each PA request **Occlusal Guard**

- Removable dental appliance to minimize effects of bruxism or other occlusal factors.
- Not to be used for any type of sleep apnea, snoring or TMD appliance.

Claim Submission Procedures

Claims can be submitted in any of the following formats:

- SKYGEN Provider Portal at <https://pwp.skygenusystems.com>
- Electronic submission via clearinghouse (Payer ID: SKYGN)
- HIPAA-compliant 837D file
- Paper American Dental Association 2019 Dental Claim Form

Submitting Claims via SKYGEN Provider Portal

Providers may submit Claims directly to SKYGEN through our SKYGEN Provider Portal at <https://pwp.skygenusystems.com>.

- Claims are paid and/or denied accurately and timely in accordance with organizational policies and regulatory requirements
- 90% of clean Medicaid Claims must be paid within 30 days of receipt, with 99.5% of all Claims paid within 60 days of receipt
- 95% of clean Medicare Claims must be paid within 30 days of receipt, with 100% of all Claims paid within 60 days of receipt
- 95% of clean Claims from non-contracted Providers must be paid within 30 calendar days of receipt

Submitting Claims via the SKYGEN Provider 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 submitting a Claim
- Before submitting a Claim, you can generate an online payment estimate
- Claims enter the benefits administration system faster, which means you receive payment faster
- As soon as a Claim is paid, the 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 SKYGEN Provider Portal, call the Provider Portal Team at (855) 434-9239.

Submitting Claims via Clearinghouses

Providers may submit electronic Claims and authorizations to SKYGEN 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.

SKYGEN 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.

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 SKYGEN Provider Portal or a clearinghouse, SKYGEN will work with you individually to receive electronic files submitted using the HIPAA Compliant 837D transaction set format. To inquire about this option, call SKYGEN (855) 434-9239.

Attaching Electronic Documents

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

SKYGEN, in conjunction with National Electronic Attachment, Inc. (NEA), 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 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 current American Dental Association 2019 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 American Dental Association dental codes, as published in the current dental terminology (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 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 will result in the Claim being rejected to the submitting Provider's office, causing a delay in payment. Use the proper postage when bulk mailing documentation. Mail with postage due will be returned. Mail paper claims to:

Molina Healthcare Claims
P.O. 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. 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 of said entitlement.

When Molina is the secondary insurance carrier, a copy of the primary carrier's Explanation of Benefits (EOB) must be submitted with the Claim within 90 days from the date of the primary carrier's explanation/denial of payment. For electronic Claim submissions, the payment 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 will consider the Claim paid in full and no further payment will be made on the Claim.

Providers will not require Members who have a primary carrier to submit secondary Claims to Molina themselves. [Per OAC 5160-26-05 Managed Health Care Programs; Provider Panel and Subcontracting Requirements](#), Providers may not bill Members the difference between the amount a primary carrier paid and the covered amount, even if that balance involves a copayment, coinsurance or plan deductible unless a signed waiver is on file for a non-covered Medicaid service. Should Providers chose not to bill Molina as secondary, the balance due after the primary carrier has paid must be written off by the Provider, which includes any Member copayment, coinsurance and plan deductible.

Molina follows the applicable regulatory guidance associated with COB. These include:

- [OAC 3901-8-01](#) Coordination of benefits
- [OAC 5160-1-05](#) Medicaid coordination of benefits with the Medicare program (Title XVIII).
- [OAC 5160-1-05.1](#) Payment for Medicare Part C Cost Sharing
- [OAC 5160-1-05.3](#) Payment for Medicare Part B Cost Sharing
- [OAC 5160-1-08](#) Coordination of benefits

- [OAC 5160-2-25](#) Coordination of benefits: hospital services
- [OAC 5160-3-64.1](#) Nursing facilities (NFs): payment for cost-sharing other than Medicare Part A
- [OAC 5160-26-09.1\(C\)](#) Managed Health Care Programs: Third Party Liability and Recovery/Coordination of Benefits

Claims received with an explanation of benefits (EOB) from the primary carrier attached must be submitted to Molina within 90 days of the date listed on the EOB from the other carrier.

Submitting Updated COB Information

Complete and accurate COB information is necessary for Molina to pay Claims timely and accurately. Molina streamlined the COB process so that it is easier for you to communicate the information with Molina.

If COB information has changed or terminated, please submit the updated COB information directly to Molina by sending a secure email to MHOEnrollment@MolinaHealthcare.com for Medicaid Members, OHMMP_EnrollmentAccountingMHI@MolinaHealthcare.com for MyCare Ohio Dual Options Members or by sending a fax to (855) 714-2414 to the attention of the Enrollment Department.

Remember to include:

- Molina ID number
- A front and back copy of the other insurance ID card
- Verification of eligibility, including the Member ID number and the coverage dates from the other insurance carrier or third party vendor

Health plans use the ODM Health Insurance Fact Request ODM 06614 available at <https://Medicaid.ohio.gov> to verify COB information.

Once you submit the COB information, Molina will verify and adjust impacted Claims that meet the standard 120-day time frame within 60 days of the submission date. Claims denied prior to 120 days of the COB update will not be reprocessed.

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 American Dental Association (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
P.O. 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 were 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 page 87 for the proper method for submitting an appeal or reprocess request.

What happens if I submit a Corrected Claim to the wrong P.O. 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 with additional information that has been denied previously, follow the standard Claim submission process. Corrections to denied Claims should not be submitted as a Corrected Claim.

Medical Necessity

Molina and SKYGEN define 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 oral facial 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. Molina must provide consistent methodical documentation of Medical Necessity for coding.

Medical Necessity does not supersede benefit coverage.

Prior Authorization of Treatment

Some procedures require prior authorization (PA) before treatment is started. When submitting these procedures for PA, also submit supporting documentation, if required. PA requirements and documentation requirements are summarized in this Provider Manual in Benefit Plan Details and Authorization Requirements beginning on page 42.

For information about submitting PA and required documentation, see Prior Authorization & Documentation Requirements beginning on page 64

Dental surgery services must be performed in participating hospitals and require PA. See Providing Services in Hospitals on page 86.

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 uses the same clinical criteria (and require the same supporting documentation) for Claims submitted after emergency treatment as they would use to determine prior authorization (PA) for the same services.

Clinical Criteria for Prior Authorization of Treatment and Emergency Treatment

A number of procedures require prior authorization (PA) before initiating treatment. When submitting PA for these procedures, please note the documentation requirements when sending the information.

Submitting a Corrected Claim

To reverse and correct a payment that should not have been made, submit a Corrected Claim on the 2019 ADA Dental Claim Form and send paper forms and documents to:

Molina Dental Services Corrected Claims
P.O. Box 641
Milwaukee, WI 53201

Note: Refer to the Corrected Claim process for additional details.

Receipt and Audit of Claims

To ensure timely, accurate payment to each participating Provider, SKYGEN 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. Call Provider Services at (855) 322-4079 dental inquiries option 7 with questions about Claims submissions or remittances.

Claims Adjudication and Payment

The SKYGEN benefits administration software system imports Claim and authorization data, evaluates and edits the data for completeness and correctness, analyzes the data for clinical appropriateness and coding correctness, audits against plan and benefit limits, calculates the

appropriate payment amounts and generates payments and remittance summaries. The system also evaluates and automatically matches Claims and services that require prior authorization (PA) 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 SKYGEN Provider Portal at <https://pwp.skygenusystems.com>.

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

Claim Dispute Mailing Address:
Molina Healthcare Provider Disputes
P.O. Box 649
Milwaukee, WI 53201

Overpayments and Refund Requests

In the event SKYGEN finds an overpayment on a Claim or must recoup money, a letter requesting the refund may be mailed to the Provider. The Provider has 60 days to submit the refund by check or an accounts receivable will be established and the amount of the overpayment will be deducted from the Provider's next check(s). All recovery activity will appear on the remittance advice.

Recoupment/refund checks should be sent to:
Molina Healthcare
P.O. Box 641
Milwaukee, WI 53201

Refunds

Refund checks received at SKYGEN are investigated, processed and applied to the appropriate paid services. Refunds with the appropriate documentation are processed and sent to the Provider with the original check to be deposited, the documentation submitted with the check and a copy of the refund documentation from SKYGEN's system.

Refunds with partial information are investigated and the Provider/billing office will be contacted to get additional information to process the refund check. If SKYGEN is unable to obtain the necessary information, a letter will be sent to with a request for the missing information.

When refunds are received with no documentation, two attempt(s) will be made to contact the Provider, if no response is received, the refund will be mailed back with a letter detailing the information needed to process the refund.

Refunds submitted for Claim(s) services that have already been adjusted and recouped are returned to the Provider with a letter stating the date of the adjustment.

In the event the Provider receives a check that is not theirs or finds an overpayment, please send the refund with a copy of the remittance advice and Claim information to:

Molina Healthcare
P.O. Box 541
Milwaukee, WI 53201

Electronic Payment

Electronic Funds Transfer (EFT)

SKYGEN 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 SKYGEN Provider Portal <https://pwp.skygenusystems.com>.

Add EFT Information
✕

Account Type

Routing Number

Account Number

John Doe
123 Main St.
City, State, ZIP

Date

Pay to the Order Of \$

Dollars

Memo

Routing Number

Account Number

EFT Authorization Agreement 📄

I hereby authorize Scion Dental, on behalf of itself and its affiliates, to initiate credit entries, and if necessary, debit entries and adjustments to my Checking Account/Savings Account indicated above at the financial institution listed.

I agree that transactions authorized herein shall comply with all applicable U.S. laws. I accept responsibility for any resulting loss of payment and release Company from any liability for or arising from my failure to submit accurate or updated information to Scion Dental.

I agree

Allow up to six weeks for the EFT program to be implemented after your completed paperwork is received. 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 SKYGEN Provider Portal as soon as your Claims are paid. (Navigate to the SKYGEN Provider Portal from <https://pwp.skygenusystems.com>).

Once you are enrolled in the EFT Program, notify SKYGEN 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. SKYGEN is not responsible for delays in payment if Providers do not properly notify SKYGEN 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 SKYGEN Provider Portal. For help registering for the portal or accessing your Remittance Reports, call the SKYGEN Provider Portal Team: (844) 621-4587.

Providing Services in Hospitals

Molina 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 (PA) request and receive approval for the planned services.

Note: When you submit a prior authorization request for hospital services, include a note in the “**Remarks**” section that indicates your purpose is to obtain approval for **inpatient dental surgery services**.

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

- SKYGEN Provider Portal at <https://pwp.skygenusystems.com>
- Electronic submission via clearinghouse (Payer ID: SKYGN)
- HIPAA-compliant 837D file

Participating Hospitals

Molina Providers are encouraged to use the Provider Online Directory located on our website to find Molina network Providers and specialists. Visit MolinaHealthcare.com/OhioProviders and click “Find a Provider,” “Find a Hospital” or “Find a Pharmacy.”

Appeals and Grievances

Molina is 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 grievances and appeals.

Our procedures for handling and resolving 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 appeals in a satisfactory and acceptable manner within the Molina protocol
- Comply with all regulatory guidelines and policies with respect to Member grievances and appeals
- Efficiently monitor the resolution of Provider-related Member grievances to allow for tracking and identifying unacceptable patterns of care over time

Provider Appeals

Differences sometimes arise between dental Providers and insurers/benefit administrators regarding prior authorization (PA) 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. For assistance, call Provider Services at (855) 322-4079 dental inquiries option 7.

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

Participating Providers who disagree with authorization decisions (not Claim disputes) made by Molina reviewers or dental consultants may submit a written appeal within 60 days of the original authorization denial date.

Submit appeals to:

Molina Healthcare Appeals Department
P.O. Box 349020
Columbus, OH 43234-9020

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, SKYGEN will use nationally recognized guidelines, which include but are not limited to, third party guidelines, Center for Medicaid and Medicare Services (CMS) guidelines, state guidelines, recognized guidelines from 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 2019 ADA Claim Form with appropriate ICD-10 and CDT codes for the services rendered and as defined by MCL 400.111i.) or submission of Claim through the SKYGEN Provider Portal.

Administrative Denials

Molina 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 Provider must submit a written appeal within 90 calendar days of the Claim denial notification along with the explanation of payment.
- 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.
 - Reason authorization was not obtained
 - Full clinical notes
 - Any required supporting documentation (x-rays, photos, etc.)
- 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.
- 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 line of business 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 to schedule a call with a licensed dental consultant. 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 within 5 business days.

Submit complaints and disputes to in writing to:
Molina Healthcare Provider Disputes
P.O. Box 649
Milwaukee, WI 53201

Member Appeals

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

Appeals regarding authorization determinations must be filed within 60 days of the authorization denial date.

Molina will review the appeal and render a decision within 15 calendar days if an extension is not requested and granted. Molina will deliver resolutions meeting expedited review criteria within 72 hours.

Member appeals may also submit in writing to:

Molina Healthcare Appeals and Grievances Department
P.O. Box 349020
Columbus, OH 43234-9020

Appendix – Attachments

Appendix A – 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.

Appendix B - Orthodontic Continuation of Care Form

Additional information on the Orthodontic Continuation of Care Form is available on page 61 of the manual.



Orthodontic Continuation of Care Request Form

Date: _____

Patient Name: _____

Member ID: _____

Member DOB: _____

Code(s) Requiring COC: _____

Current Provider Name: _____

Current Provider NPI#: _____

Banding Date: _____

Total Dollars Paid for Case to Date: _____

Remaining Visits: _____

Balance Requested for Remainder of Case: _____

Previous Carrier (if applicable): _____

Previous Provider Name: _____

Previous Provider Phone #: _____

Previous Provider Address: _____