DENTAL PROVIDER MANUAL
(Provider Handbook)

Molina Healthcare of Illinois, Inc.
(Molina Healthcare or Molina)

Medicaid Program
2026

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

Last Updated 02/2026

MOLINA® HEALTHCARE

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1. Contact Information

Molina Healthcare of Illinois, Inc.
2001 Butterfield Rd., Suite 750
Downers Grove, IL 60515

Plan Types

Medicaid Plan

In Illinois, Molina offers two Medicaid health programs, a Dual-Eligible Special Needs Plan (D-SNP), multiple Marketplace Plans, and a Medicare Plan (MAPD). This Provider Manual is for the Medicaid Plan.

HealthChoice Illinois

The Molina HealthChoice Illinois health plan offers free medical coverage to seniors and people with disabilities, children, pregnant women, families, and adults who qualify for Illinois Medicaid. The program was previously known as Family Health Plan and Integrated Care Program.

HealthChoice Illinois MLTSS

The HealthChoice Illinois Managed Long-Term Support and Services (MLTSS) plan provides waiver and other services to individuals who qualify for both Medicare and Medicaid, but who are not part of the Medicare-Medicaid Alignment Initiative (MMAI).

Provider Services

The Molina Provider Contact Center handles telephone inquiries from Providers regarding Claims, appeals, authorizations, eligibility, and general concerns. Molina Provider Contact Center representatives are available Monday through Friday from 8 a.m. to 5 p.m. Central Time, excluding state and federal holidays.

Molina strongly encourages participating Providers to submit Claims electronically via a clearinghouse or the SKYGEN Essentials (SKYGEN) portal whenever possible.

EDI Payer ID Number: SKYGN WITHOUT THE E

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

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

Phone: (855) 994-1817
Hearing Impaired (TTY/TDD): 711
SKYGEN portal: https://www.dentalhub.com/molina

Provider Relations

The Provider Relations department manages Provider issue resolution, Provider education and Provider training. The department has Provider Relations representatives who serve all of Molina's Provider network and are available via email, phone and fax at the following:

- MDVSProviderServices@MolinaHealthcare.com
- **Phone:** (844) 862-4564
- **Hearing Impaired:** 711
- **Fax:** (855) 297-3304

Member Services

The Molina Member Contact Center handles all telephone inquiries regarding benefits, eligibility/identification, pharmacy inquiries, and Member complaints. Molina Member Contact Center representatives are available 8 a.m. to 5 p.m. Central Time, Monday through Friday, excluding state and federal holidays.

- **Phone:** (855) 687-7861 (English & Spanish)
- **Hearing Impaired (TTY/TDD):** 711

Claims

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

- **SKYGEN portal**
- **EDI Payer ID SKYGN WITHOUT THE E**

To verify the status of your Claims, please use the SKYGEN portal. Claims questions can be submitted through the Secure Messaging feature via the Claim Status module on the SKYGEN portal or by contacting the Molina Provider Contact Center. For additional information please refer to the **Claims and Compensation** section of this Provider Manual.

- **Phone:** (855) 994-1817

Claims Recovery

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

Provider Disputes	SKYGEN Claims Recovery Department PO Box 649 Milwaukee, WI 53201
Refund Checks Lockbox	Molina Healthcare of Illinois, Inc. PO Box 631264 Cincinnati, OH 45263-1264
Phone:	(866) 642-8999

Compliance and Fraud Alertline

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

Confidential Compliance Officer
Molina Healthcare, Inc.
200 Oceangate
Suite 100
Long Beach, CA 90802

Phone: (866) 606-3889
Online: MolinaHealthcare.Alertline.com

Credentialing

In accordance with 42 CFR 438.214, Provider enrollment in the Illinois Medicaid Program Advanced Cloud Technology (IMPACT) system constitutes Illinois' Medicaid managed care uniform credentialing and recredentialing process. To participate in Molina's Provider Network, Molina must verify that practitioner is enrolled in IMPACT. Molina will submit monthly reports to the Illinois Department of Healthcare and Family Services (HFS) indicating which practitioners have completed the credentialing process and the results of the process. For additional information about Molina's credentialing program please refer to the Credentialing and Recredentialing section of this Provider Manual.

24-Hour Nurse Advice Line

This telephone-based nurse advice line is available to all Molina Members. Members may call any time they are experiencing symptoms or need health care information. Registered nurses are available 24/7 year-round.

- **English Phone**: (888) 275-8750 **English TTY**: (888) 735-2929
- **Spanish Phone**: (866) 648-3537 **Spanish TTY**: (866) 833-4703

Health Care Services (HCS)

The Health Care Services (HCS) department conducts concurrent review on inpatient cases and processes prior authorizations/service requests. The HCS department also performs care management for Members who will benefit from care management services. Participating Providers are **required** to interact with Molina's HCS department electronically whenever possible. Prior authorizations/service requests and status checks can be easily managed electronically. For additional information please refer to the Health Care Services section of this Provider Manual.

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

- Easy to access 24/7 online submission and status checks.
- Ensures Health Insurance Portability and Accountability Act (HIPAA) compliance.
- Ability to receive real-time authorization status.
- Ability to upload dental records.
- Increased efficiencies through reduced telephonic interactions.
- Reduce costs associated with fax and telephonic interactions.

Pharmacy

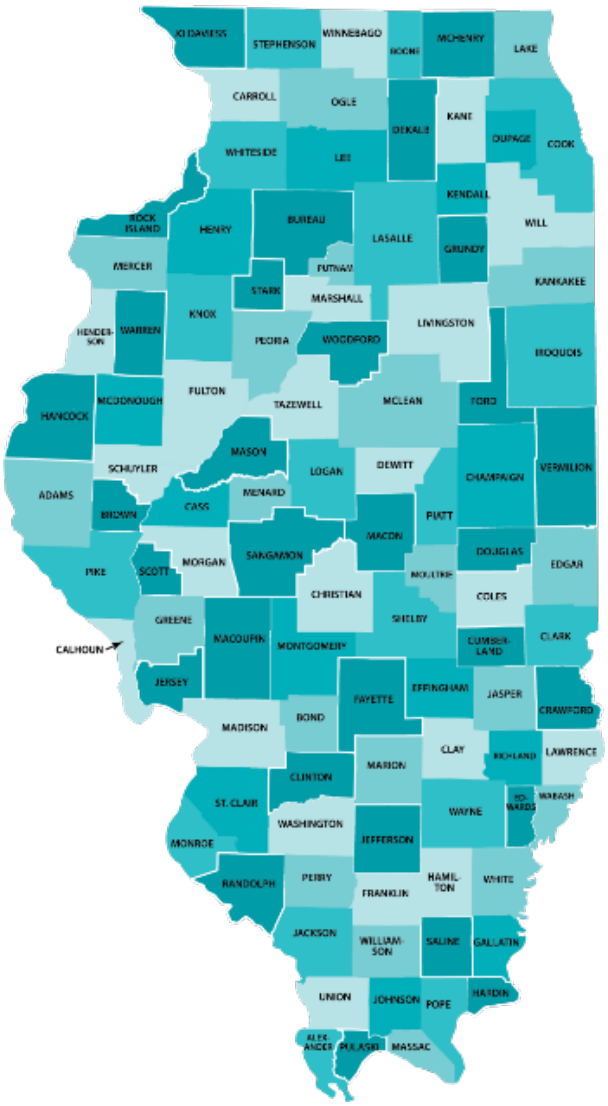
Prescription drug benefits are administered through the pharmacy benefit manager CVS Caremark. A list of in-network pharmacies is available in the Provider Online Directory on Molina's website or by contacting Molina. For additional information, please refer to the Pharmacy section of this Provider Manual. For pharmacy services, contact:
Phone: (855) 866-5462
Hearing Impaired (TTY/TDD): 711

Quality

Molina maintains a Quality Improvement (QI) department to work with Members and Providers in administering the Molina Quality Improvement Program. For additional information, please refer to the Quality section of this Provider Manual.

- **Phone:** (855) 866-5462
- **Fax:** (855) 556-2074
- **Email:** quality-healthcampaigns@molinahealthcare.com

Molina Healthcare of Illinois, Inc. Service Area



2. Provider Responsibilities

Nondiscrimination in Oral Health Care Service Delivery

Providers must comply with the nondiscrimination in health care service delivery requirements as outlined in the Culturally and Linguistically Appropriate Services section of this Provider Manual.

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

Section 1557 Investigations

All Molina Providers shall disclose all investigations conducted pursuant to Section 1557 of the Patient Protection and Affordable Care Act to Molina's Civil Rights Coordinator.
Molina Healthcare, Inc.
Civil Rights Coordinator
200 Oceangate, Suite 100
Long Beach, CA 90802

Phone: (866) 606-3889
Hearing Impaired (TTY/TDD): 711
Online: MolinaHealthcare.AlertLine.com
Email: civil.rights@MolinaHealthcare.com
For more information, Providers and Members can refer to the HHS website: federalregister.gov/documents/2020/06/19/2020-11758/nondiscrimination-in-health-andhealth-education-programs-or-activities-delegation-of-authority.

Facilities, Equipment, Personnel, and Administrative Services

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

Provider Data Accuracy and Validation

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

Maintaining an accurate and current Provider Directory is a state and federal regulatory requirement, as well as a National Committee for Quality Assurance (NCQA)-required element. Invalid information can negatively impact Member access to care, Member/PCD assignments and referrals. Additionally, current information is critical for timely and accurate claims processing.

Providers must validate their Provider information on file with Molina at least once every 90 days for correctness and completeness. Provider information that must be validated includes, but is not limited to:

- Provider or practice name
- Location(s)/address(es)
- Specialty(ies)
- Phone number, fax number, and email
- Digital contact information
- Whether your practice is open to new patients (PCDs only)
- Tax ID and/or National Provider Identifier (NPI)

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

- Change in office location(s)/address(es), office hours, phone, fax, or email.
- Addition or closure of office location(s).
- Addition of Provider(s) (within an existing clinic/practice).
- Termination of Provider(s) (within an existing clinic/practice).
- Change in Provider or practice name, Tax ID, and/or National Provider Identifier (NPI).
- Opening or closing your practice to new patients (PCDs only).
- Change in specialty.
- Any other information that may impact Member access to care.
- For Provider terminations (within an existing clinic/practice), Providers must notify Molina in writing in accordance with the terms specified in your Provider Agreement with Molina.

Visit Molina's Provider Online Directory at molina.sapphirethreesixtyfive.com to validate your information. Providers can make updates through an online form on Molina's Provider website on the Frequently Used Forms page under Contracting & Provider Forms: Provider Information Update Form. Complete the form and send to MDVSProviderServices@MolinaHealthcare.com. Molina is required to audit and validate our Provider Network data and Provider Directories on a routine basis. As part of our validation efforts, we may reach out to our network of Providers

through various methods, such as letters, phone campaigns, face-to-face contact, fax, and fax-back verification, etc. Molina also may use a vendor to conduct routine outreach to validate data that impacts the Provider directory or otherwise impacts its membership or ability to coordinate Member care. Providers are required to supply timely responses to such communications.

All Molina Providers participating in a Medicaid network must be enrolled in the state Medicaid program to be eligible for reimbursement. If a Provider has not had a Medicaid number assigned, the Provider must apply for enrollment with the Department of Healthcare and Family Services (HFS) and meet the Medicaid Provider enrollment requirements set forth in Presentations and Materials | HFS for Fee-for-Service Providers of the appropriate provider type.

National Plan and Provider Enumeration System (NPPES) Data Verification

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

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

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

Molina Electronic Solutions Requirements

Molina 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.
- Electronic claims submission.
- Electronic Fund Transfers (EFT).
- Electronic Remittance Advice (ERA).
- Electronic claims appeal.
- Registration for and the use of the SKYGEN portal.

Electronic Claims include Claims submitted via a clearinghouse using the EDI process and Claims submitted through the SKYGEN 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 the SKYGEN portal within 30 days of entering the Molina network.

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

Electronic Solutions and Tools

Electronic solutions/tools available to Molina Providers include:

- Electronic Claim submission options,
- Electronic payment: EFT with ERA,
- SKYGEN portal.

Electronic Claim Submission Requirement

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

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

Molina offers the following electronic Claim submission options:

- Submit Claims directly to Molina via the SKYGEN portal
- Submit Claims to Molina through your EDI clearinghouse using Payer ID SKYGN without the "E".

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

SKYGEN portal Claim submission includes the ability to:

- Add attachments to claims.

- Submit corrected claims.
- Easily and quickly void claims.
- Check claim status.
- Receive timely notification of a change in status for a particular claim.
- Ability to save incomplete/un-submitted claims.
- Create/manage claim templates.

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

Electronic Payment Requirement

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

As a reminder, Molina's Payer ID is SKYGN WITHOUT THE E.

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

Additional instructions on how to register are available under the EDI/ERA/EFT tab on Molina's website at SKYGEN.

SKYGEN Hub

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

- Verify Member eligibility, covered services and view Healthcare Effectiveness Data and Information Set (HEDIS®) needed services (gaps)
- Claims:
  - Submit Professional ADA claims with attached files.
  - Correct/void claims.
  - Add attachments to previously submitted claims.
  - Check claim status.
  - View ERA and EOP.
  - Create and submit a Claim appeal with attached files.
  - Prior authorizations/service requests.
  - Create and submit prior authorization/service requests.
  - Check status of prior authorization/service requests.
  - Download forms and documents.

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

Balance Billing

Non-contracted Providers and Providers that are contracted with Molina cannot bill the Member for any Covered Services. The Provider is responsible for verifying eligibility and obtaining approval for those services that require Prior Authorization.

Providers agree that under no circumstance shall a Member be liable to the Provider for any sums that are the legal obligation of Molina to the Provider. Balance billing a Molina Member for covered services is prohibited, including copayment, coinsurance, and deductible amounts.

Member Rights and Responsibilities

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

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

Member Information and Marketing

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

Member Eligibility Verification

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

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

- SKYGEN portal.
- Molina's automated telephone system: (855) 994-1704.

Health Care Services (Utilization and Care Management)

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

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

Treatment Alternatives and Communication with Members

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

Participation in Quality Improvement Programs

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

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

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

Compliance

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

Confidentiality of Member Health Information and HIPAA Transactions

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

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

Participation in Grievance and Appeals Programs

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

For additional information please refer to the Appeals and Grievances section of this Provider Manual.

Uniform Credentialing and Recredentialing

In accordance with 42 CFR 438.214, Provider enrollment in the Illinois Medicaid Program Advanced Cloud Technology (IMPACT) system constitutes Illinois' Medicaid managed care uniform credentialing and recredentialing process. To participate in Molina's Provider Network, Molina must verify that practitioner is enrolled in IMPACT. Molina will submit monthly reports to the Illinois Department of Healthcare and Family Services (HFS) indicating which practitioners have completed the credentialing process and the results of the process.

Delegation

Delegated entities must comply with the terms and conditions outlined in Molina's Delegated Services Addendum. Please see the Delegation section of this Provider Manual for more information about Molina's delegation requirements and delegation oversight.

Primary Care Dental Provider Responsibilities

PCDs are responsible for:

- Serve as the ongoing source of primary and preventive care for Members.
- Assist with coordination of care as appropriate for the Member's health care needs.
- Recommend referrals to specialists participating with Molina.
- Triage appropriately.
- Notify Molina of Members who may benefit from care management.
- Participate in the development of care management treatment plans.

3. Cultural Competency and Linguistic Services

Background

Molina works to ensure all Members receive culturally and linguistically appropriate care across the service continuum to reduce health disparities and improve health outcomes. The Culturally and Linguistically Appropriate Services in Health Care (CLAS) standards published by the U.S. Department of Health and Human Services (HHS) seek to improve the appropriateness and accessibility of health care services by meeting the cultural, linguistic, and accessibility-related needs of individuals served.

Molina complies with Section 1557 of the Patient Protection and Affordable Care Act, prohibiting discrimination in health programs and activities receiving federal financial assistance on the basis of race, color, and national origin, sex, age, and disability per title VI of the Civil Rights Act of 1964, title IX of the Education Amendments of 1972, the Age Discrimination Act of 1975, and Section 504 of the Rehabilitation Act of 1975 (29 U.S.C. § 794). Molina complies with applicable portions of the Americans with Disabilities act of 1990. Molina also complies with all implementing regulations for the foregoing.

Compliance ensures the provision of linguistic access and disability-related access to all Members, including those with Limited English Proficiency (LEP) and Members who are deaf, hard of hearing, non-verbal, have a speech impairment, or have an intellectual disability.

Policies and procedures address how individuals and systems within the organization will effectively provide services to people of all cultures, races, ethnic backgrounds, sexes, ages, and religions, as well as those with disabilities in a manner that recognizes, values, affirms, and respects the worth of the individuals and protects and preserves the dignity of each.

Additional information on cultural competency and linguistic services is available at MolinaHealthcare.com, from local Molina Provider relations representatives or by calling the Molina Provider Contact Center at (855) 994-1817.

Non-discrimination in Health Care Service Delivery

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

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

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

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

Culturally and Linguistically Appropriate Practices

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

Provider and Community Training

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

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

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

Integrated Quality Improvement

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

Molina develops Member materials according to Plain Language Guidelines. Members or Providers may also request written Member materials in alternate languages and formats (i.e., Braille, audio, large print), leading to better communication, understanding and Member satisfaction. Online materials found on MolinaHealthcare.com and information delivered in digital form meet Section 508 accessibility requirements to support Members with visual impairments.

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

Access to Interpreter Services

Providers may request interpreters for Members whose primary language is other than English by calling the Molina Member Contact Center at **(855) 687-7861**. If Molina Member Contact

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

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

All eligible Members with LEP are entitled to receive interpreter services. Pursuant to Title VI of the Civil Rights Act of 1964, services provided for Members with LEP, limited reading proficiency (LRP) or limited hearing or sight are the financial responsibility of the Provider. Under no circumstances are Molina Members responsible for the cost of such services. 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.

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

Molina Members are entitled to:

- Be provided with effective communications with 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 individuals with cognitive impairments.
- Be notified by the Provider that interpreter services are available at no cost.
- Decide, with the 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 Member records.
    - Interpreters may, with Member written consent, share information from the Member's records only with appropriate dental professionals and agencies working on the Member's behalf.
    - Interpreters must ensure that this shared information is similarly safeguarded.
    - Have interpreters, if needed, during appointments with the Member's Providers and when talking to the health plan.

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

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

- Verify the Member's eligibility and dental benefits.

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

Documentation

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

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

Members Who are Deaf or Hard of Hearing

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

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

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

this request via the Molina Member Contact Center.

Program and Policy Review Guidelines

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

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

4. Member Rights and Responsibilities

Providers must comply with the rights and responsibilities of Molina Members as outlined in the Molina Member Handbook and on the Molina website. The Member Handbook that is provided to Members annually is hereby incorporated into this Provider Manual.

The Member Handbook that is provided to Members annually is hereby incorporated into this Provider Manual. The most current Member Handbook can be found on the Member pages of Molina's website at Members | Molina Healthcare Illinois.

The most current Member Rights and Responsibilities can be found on the Member pages of Molina's website at Members | Molina Healthcare Illinois.

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

For additional information, please contact the Molina Provider Contact Center at **(855) 994-1817**, 8 a.m. to 5 p.m., Central Time, Monday through Friday, excluding state and federal holidays. TTY users, please call **711**.

Second Opinions

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

5. Enrollment, Eligibility, and Disenrollment

Enrollment

Enrollment in Medicaid programs

The Illinois Medical Assistance Program implements Title XIX of the Social Security Act (Medicaid). HFS administers Medicaid under the Illinois Public Aid Code. Through an interagency agreement with HFS, the Illinois Department of Human Services (DHS) takes applications and determines the eligibility of individuals and families for HFS medical programs.

To apply for HFS medical benefits, an individual, a representative, or the responsible parent or guardian must complete and submit an application to DHS. This can be done by visiting the nearest DHS office, or where health reasons prohibit visiting an office, by contacting DHS to have an application mailed. Mailed applications are followed by a telephone interview. It is also possible to enroll for HFS medical benefits through the DHS website.

DHS can be contacted at:

Online: dhs.state.il.us/page.aspx
Phone: (800) 843-6154
TTY: (866) 324-5553

Effective Date of Enrollment

When initially applying for coverage, HFS applicants may request that their coverage is backdated to cover services they may have already received for up to three months prior to the month of their application. HFS will designate coverage to begin on the first day of a calendar month no later than three calendar months from the date HFS accepts the enrollment in its database.

Eligibility Verification

Medicaid Programs

The State of Illinois, through the Department for Medicaid Services, determines eligibility for the Medicaid programs. Payment for services rendered is based on eligibility and benefit entitlement. The contractual agreement between Providers and Molina places the responsibility for eligibility verification on the Provider of services.

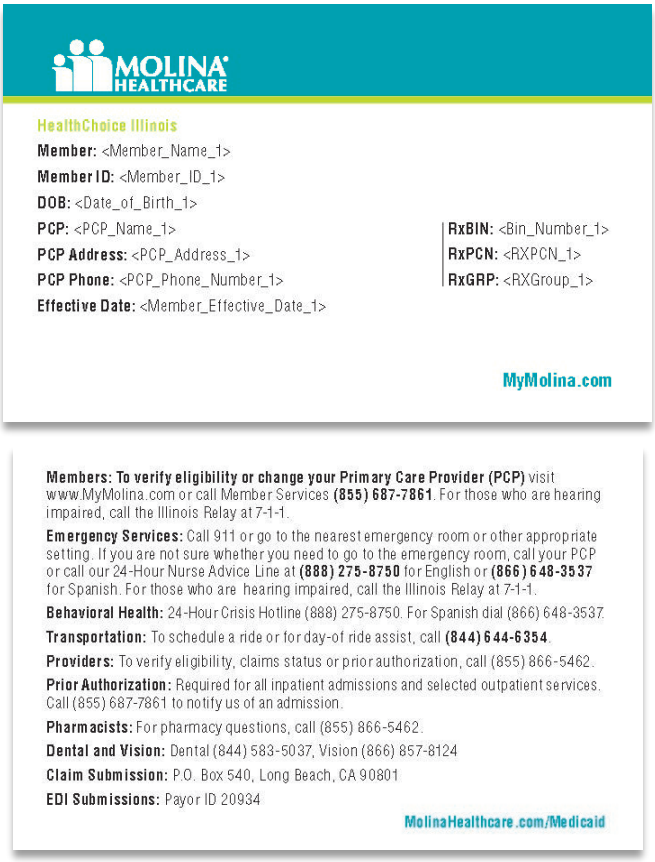
Eligibility Listing for Medicaid Programs

Providers can verify eligibility and health plan assignment for HFS recipients through the Medical Electronic Data Interchange (MEDI) system. MCO health plan effective dates are **always the first of the month.**

MEDI is a free, secure website. Providers can register for MEDI and create their login and password at hfs.illinois.gov/medicalproviders/edi/medi.html. Providers can also verify HFS eligibility and MCO health plan assignment on the phone by calling the HFS Automated Voice Response System at **(800) 842-1461**.

Possession of a Medicaid ID Card does not mean a recipient is eligible for Medicaid services. **Providers should verify a recipient's eligibility each time the recipient receives services**. The verification sources can be used to verify a recipient's enrollment in a managed care plan. The name and telephone number of the managed care plan are given along with other eligibility information.

Identification Cards



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

Disenrollment

Voluntary Disenrollment

When an Enrollee is subject to mandatory managed care enrollment under the Medicaid Managed Care Program, an Enrollee may request to disenroll for any of the following reasons at any time by notifying Molina, orally or in writing, of the Enrollee's request to disenroll. The request will be granted by the Department of Healthcare and Family Services when the reason matches any of the following (as determined by the department):

1. Molina, due to its exercise of right of conscience, does not provide the covered service that the Enrollee seeks.
2. The Enrollee needs related covered services to be performed at the same time, not all the related services are available through Molina, and the Enrollee's Provider determines that receiving the services separately would subject the Enrollee to unnecessary risk.
3. When a change in Enrollee's LTSS Provider (residential, institutional, or employment support) from a network Provider to a non-network Provider results in a disruption to residence or employment.
4. Other reasons, including poor quality of care, a sanction imposed by the department, lack of access to covered services, lack of access to Providers experienced in dealing with the Enrollee's health care needs, or if the Enrollee is automatically re-enrolled and such loss of coverage causes the Enrollee to miss the open enrollment period.

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

Involuntary Disenrollment

The department will terminate an Enrollee's coverage when the Enrollee becomes ineligible for HFS Medical Program or otherwise is not within the population described as being Enrollees under this contract or upon the occurrence of any of the following conditions:

Upon the Enrollee's death. Termination of coverage will take effect at 11:59 p.m. on the last day of the month in which the Enrollee dies. Termination may be retroactive to this date.

When an Enrollee elects to change MCOs during the change period or open-enrollment period. Termination of coverage with the previous MCO will take effect at 11:59 p.m. on the day immediately preceding the Enrollee's effective enrollment date with the new MCO. Molina Healthcare of Illinois, Inc. Medicaid Provider Manual 46 Any reference to Molina Members means Molina Medicaid Members.

When an Enrollee no longer resides in the contracting area. If an Enrollee is to be disenrolled at Molina's request, Molina must first provide documentation satisfactory to the department that the Enrollee no longer resides in the contracting area. Termination of coverage will take effect at 11:59 p.m. on the last day of the month prior to the month in which the department determines that the Enrollee no longer resides in the contracting area. Termination may be retroactive if the department is able to determine the month in which the Enrollee moved from the contracting area.

When the department determines that an Enrollee has other significant insurance coverage or is placed in spend-down status. The department will notify Molina of such disenrollment. This notification will include the effective disenrollment date.

When the department is made aware that an Enrollee is incarcerated in a county jail, Illinois Department of Corrections facility, or federal penal institution. Termination of coverage shall take effect at 11:59 p.m. on the last day of the month prior to the month in which the Enrollee was incarcerated.

When an Enrollee enters DCFS custody. Termination of coverage shall take effect at 11:59 p.m. on the day prior to the day on which the court grants DCFS custody of the Enrollee.

Primary Care Dentist (PCD) Dismissal

A PCD may dismiss a Member from their practice under following circumstances:

- Incompatibility of the PCD/patient relationship
- Member has not utilized a service within one year of enrollment in the PCD's practice
- PCD has documented unsuccessful contact attempts by mail and phone on at least six separate occasions during the year
- Inability to meet the dental needs of the Member

A PCD may not dismiss a Member from their practice under following circumstances:

- Change in Member's health status or need for treatment
- Member's utilization of dental services
- Member's diminished mental capacity
- Disruptive behavior that results from the Member's special health care needs unless the
- behavior impairs the ability of the PCD to furnish services to the Member or others
- Transfer requests shall not be based on race, color, national origin, handicap, age, or gender
- The initial PCD must serve until the new PCD begins serving the Enrollee, barring ethical or legal issues. The Enrollee has the right to a grievance regarding such a transfer. The PCD shall make the request for change to the Contractor in writing. The Enrollee may request a PCD change in writing, face to face or via telephone

This section does not apply if the Member's behavior is attributable to a physical or behavioral condition.

Missed Appointments

Participating Providers are responsible for establishing a process for documenting missed appointments. When a Member does not keep a scheduled appointment, it is to be noted in the Member's record, and the Provider is to assess if a visit is still medically indicated. All efforts to notify the Member must be documented in the dental record. Providers are strongly encouraged to report missed or cancelled appointments within the Missed or Cancelled Appointments Panel in Illinois.

6. Benefits and Covered Services

This section provides an overview of the dental benefits and covered services for Molina Members. Some benefits may have limitations. If there are questions as to whether a service is covered or requires prior authorization. please reference the prior authorization tools located on the Molina website and the SKYGEN portal. You may also please contact SKYGEN at **(855) 994-1817**, 8 a.m. to 5 p.m. Central Time, Monday through Friday, excluding state and federal holidays.

Services Covered by Molina

Molina covers the services described in the Summary of Benefits documentation. If there are questions as to whether a service is covered or requires prior authorization, please reference the prior authorization tools located at on the Molina website and the SKYGEN portal. You may also contact SKYGEN at **(855) 994-1817**, 8 a.m. to 5 p.m. Central Time, Monday through Friday, excluding state and federal holidays.

Links to Benefit Information

Covered services can be found on the state website at IL DENTAL BENEFITS.

The Member Handbook can be found on Molina's website at molinahealthcare.com/members/il/en-us/mem/medicaid/overvw/memguide.aspx.

Obtaining Access to Certain Covered Services

Benefits for Pregnant Women

In addition to the codes covered for Adults - Age 21 and older, the following codes are covered as a value-added benefit for Pregnant Women. These services are available during the term of pregnancy until the date of delivery.

Claims for pregnant women must be submitted with the word "Pregnant" in the Remarks field (Box 35) of the ADA claim form. If the word "Pregnant" is not included on the claim form, these additional covered services will deny.

Any reimbursement already made for an inadequate service may be recouped after the SKYGEN Dental Consultant reviews the circumstances.

Code	Description	Age Limitation	Teeth	PA Required	Benefit Limitations	Documentation Required
D0120	periodic oral evaluation	21 and older		No	One of (D0120) per 6 month(s) per patient.	
D1110	Prophylaxis - adult	21 and older		No	One of (D1110, D4355) per 6 month(s) per patient. Removal of plaque, calculus and	

					stains from tooth surfaces. Intended to control irrational factors.	
D4341	Periodontal scaling and root planing - four or more teeth per quadrant	21 and older	Per quadrant (10, 20, 30, 40, LL, LR, UL, UR)	Yes	One of (D4341, D4342) per 24 months per patient per quadrant. One full mouth service is covered every 24 months.	Pre-op x-ray(s), perio charting
D4342	Periodontal scaling and root planing - 1 - 3 teeth, per quadrant	21 and older	Per quadrant (10, 20, 30, 40, LL, LR, UL, UR)	Yes	One of (D4341, D4342) per 24 months per patient per quadrant. One full mouth service is covered every 24 months.	Pre-op x-ray(s), perio charting
D4355	Full mouth debridement to enable comprehensive periodontal evaluation	21 and older		No	One of (D1110, D4355) per 6 month(s) per patient.	

Emergency Mental Health or Substance Use Disorder Services

Members are directed to call 988, 911 or go to the nearest emergency room if they need emergency mental health or substance use services. Examples of emergency mental health or substance use problems are:

- Danger to self or others.
- Not being able to carry out daily activities.
- Things that will likely cause death or serious bodily harm.

Out-of-area Emergencies

Members who have a health emergency who cannot get to a Molina approved Provider are directed to do the following:

- Go to the nearest emergency room.
- Call the number on the Molina Member ID card.
- Call Member's PCD and follow-up within 24 to 48 hours.

For out-of-area emergency services, out-of-network Providers are directed to call the Molina contact number on the back of the Molina Member ID card for additional benefit information and may be asked to transfer Members to an in-network facility when the Member is stable.

Emergency Transportation

When a Member's condition is life-threatening and requires the use of special equipment, life support systems and close monitoring by trained attendants while en route to the nearest

appropriate facility, emergency transportation is thus required. Emergency transportation includes but is not limited to ambulance, air, or boat transport.

Non-emergency Dental Transportation

For Molina Members who have non-emergency dental transportation as a covered service, Molina covers transportation to dental facilities when the Member's dental and physical condition does not allow them to take regular means of public or private transportation (car, bus, etc.). Molina Dental Services provides up to 15 round trips or 30 one-way Provider trips, less than 30 miles from the member's home.

Members can use this benefit to visit any Molina Dental Services Network Provider.

Prior Authorization is required by the Health Plan for over 30 miles. Members should call at least 3 business days before their appointment to schedule transportation.

For assistance with transportation services please call:

- **HealthChoice Illinois(Medicaid):** (844) 644-6354
- **D-SNP:** (844) 644-6353
- **Schedule rides for members:** (855) 740-3105
- **TTY/TDD:** 711

Health Management Programs

Molina offers programs to help our Members and their families manage various health conditions.

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

7. Health Care Services (HCS)

Introduction

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

Utilization Management (UM)

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

- Managing available benefits effectively and efficiently while ensuring quality care
- Evaluating the medical necessity and efficiency of health care services across the continuum of care
- Defining the review criteria, information sources and processes that are used to review and approve the provision of items and services, including prescription drugs
- Coordinating, directing, and monitoring the quality and cost effectiveness of health care resource utilization
- Implementing comprehensive processes to monitor and control the utilization of health care resources
- Ensuring services are available in a timely manner, in appropriate settings and are planned, individualized, and measured for effectiveness
- Reviewing processes to ensure care is safe and accessible
- Ensuring qualified health care professionals perform all components of the UM processes
- Ensuring that UM decision making tools are appropriately applied in determining medical necessity decision

Key Functions of the UM Program

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

- **Eligibility and Oversight**
  - Eligibility verification
  - Benefit administration and interpretation
  - Verification that authorized care correlates to Member's dental necessity needs(s) and benefit plan
  - Verifying of current Provider/hospital contract status

- **Resource Management**
  - Prior authorization and referral management
  - Admission and inpatient review
  - Referrals for discharge planning and care transitions
  - Staff education on consistent application of UM functions

- **Quality Management**
  - Evaluate satisfaction of the UM program using Member and Provider input
  - Utilization data analysis
  - Monitor for possible over- or under-utilization of clinical resources
  - Quality oversight
  - Monitor for adherence to CMS, NCQA, state and health plan UM standards

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

Providers and delegated entities who assume responsibility for UM must adhere to Molina's UM Policies. Their programs, policies and supporting documentation are reviewed by Molina at least annually.

UM Decisions

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

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

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

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

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

Providers can contact Molina's Healthcare Services department at (855) 866-5462 to obtain Molina's UM Criteria.

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

Medical Necessity

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

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

For these purposes, "generally accepted standards of dental practice" means standards that are based on credible scientific evidence published in peer-reviewed dental literature. This literature is generally recognized by the relevant dental community, Provider specialty society recommendations, the views of Providers practicing in relevant clinical areas and any other relevant factors.

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

Medical Necessity Review

Molina only reimburses for services that are medically necessary. Medical necessity review may take place prospectively, as part of the inpatient admission notification/concurrent review or retrospectively. To determine medical necessity, in conjunction with independent professional

medical judgment, Molina uses nationally recognized evidence-based guidelines, third party guidelines, CMS guidelines, state guidelines, Molina clinical policies, guidelines from recognized professional societies and advice from authoritative review articles and textbooks.

Levels of Administrative and Clinical Review

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

All UM requests that may lead to a medical necessity adverse determination are reviewed by a health care professional at Molina (Dental director, Pharmacy director or appropriately licensed health care professional).

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

Clinical Information

Molina requires copies of clinical information to be submitted for documentation. Clinical information includes but is not limited to Provider emergency department notes, inpatient history/physical exams, discharge summaries, Provider progress notes, Provider office notes, Provider orders, nursing notes, results of laboratory or imaging studies, therapy evaluations and therapist notes. Molina does not accept clinical summaries, telephone summaries or inpatient case manager criteria reviews as meeting the clinical information requirements unless state or federal regulations allows such documentation to be acceptable.

Prior Authorization (PA)

Molina requires prior authorization for specified services if the requirement complies with federal or state regulations and the Provider Agreement with Molina. The list of services that require prior authorization is available in narrative form, along with a more detailed list by Current Procedural Terminology (CDT®) and Healthcare Common Procedural Coding System (HCPCS) codes.

CDT® is a registered trademark of the American Dental Association.

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

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

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

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

Providers who request prior authorization for services and/or procedures may request to review the criteria used to make the final decision. A Molina Dental director is available to discuss medical necessity decisions with the requesting Provider at (855) 806-5190, 8 a.m.- 5 p.m., Monday through Friday (except for state and federal holidays).

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

Peer-to-peer Review

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

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

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

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

If a Dental director is not immediately available, the call will be returned within two (2) business days. Every effort will be made to return calls as expeditiously as possible.

Requesting Prior Authorization

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

The most current prior authorization guidelines and the Prior Authorization Request Form can be found on SKYGEN.

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

- Create and submit prior authorization requests.
- Check status of prior authorization requests.
- Receive notification of change in status of prior authorization requests.
- Attach documentation required for timely review and decision-making.

Open Communication about Treatment

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

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

Delegated UM Functions

Molina may delegate UM functions to qualifying Providers and delegated entities. These entities must be able to perform the delegated activities and maintain specific delegation criteria in compliance with all current Molina policies and regulatory and certification requirements. For more information about delegated UM functions and the oversight of such delegation, please refer to the Delegation section of this Provider Manual.

Emergency Services

A medical screening exam performed by licensed medical personnel in the emergency department and subsequent emergency services rendered to the Member do not require prior authorization from Molina.

Emergency services are covered on a 24-hour basis without the need for prior authorization for all Members experiencing an emergency dental condition.

Post-stabilization care services are covered services that are:

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

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

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

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

Care managers will also contact the PCD to ensure that Members are not accessing the emergency department because of an inability to be seen by the PCD.

Post-service Review

Failure to obtain prior authorization when required may result in denial of payment for those services. The only possible exception for payment because of post-service review is if information is received indicating the Provider did not know, nor could have known, that the patient was a Molina Member or there was a Molina error. In those cases, a medical necessity review will be performed. Decisions, in this circumstance, will be based on medical necessity.

Specific federal or state requirements or Provider contracts that prohibit administrative denials supersede this policy.

Affirmative Statement about Incentives

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

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

Out-of-network Providers and Services

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

Avoiding Conflict of Interest

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

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

Coordination of Care and Services

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

Molina staff provide an integrated approach to care needs by assisting Members with identification of resources available to the Member, such as community programs, national support groups, appropriate specialists, and facilities, identifying best practice or new and innovative approaches to care. Care coordination by Molina staff is done in partnership with

Providers, Members, and/or their authorized representative(s) to ensure efforts are efficient and non-duplicative.

Continuity and Coordination of Provider Communication

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

Reporting of Suspected Abuse and/or Neglect

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

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

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

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

Child Abuse

Suspected child abuse should be reported to the Child Protection Branch of the STATE Cabinet for Health and Family Services (CHFS). To report suspected child abuse and neglect, call toll-free: (800) 252-2873 or TTY (800) 358-5117. (800) 752-6200. If the child's life is in danger, call 911.

Adult Abuse

Suspected abuse or neglect of an adult should be reported to the Adult Protection branch of CHFS. Non-emergency reports should be made online using the STATE Child/Adult Protective Services Reporting System at (866) 800-1409 or TTY (800) 206-1327. If the situation is a life-threatening emergency, call 911.

Member Newsletters

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

Member Health Education Materials

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

Program Eligibility Criteria and Referral Source

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

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

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

Provider Participation

Provider resources and services may include:

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

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

Primary Care Dental (PCD) Providers

Molina provides a panel of PCDs to care for its Members.

Specialty Providers

Molina maintains a network of specialty Providers to care for its Members.

Molina will help to arrange specialty care outside the network when Providers are unavailable, or the network is inadequate to meet a Member's Dental needs. To obtain such assistance contact the Molina UM department. Referrals to specialty care outside the network require prior authorization from Molina.

Care Management (CM)

Molina provides a comprehensive ICM program to all Members who meet the criteria for services. The ICM program focuses on coordinating the care, services and resources needed by Members throughout the continuum of care. Molina adheres to Case Management Society of America Standards of Practice Guidelines in its execution of the program.

The Molina care managers may be licensed professionals and are educated, trained, and experienced in Molina's ICM program. The ICM program is based on a Member advocacy philosophy, designed and administered to assure the Member value-added coordination of health care and services, to increase continuity and efficiency and to produce optimal outcomes. The ICM program is individualized to accommodate a Member's needs with collaboration and input from the Member's PCD. The Molina care manager will complete an assessment with the Member upon engagement after identification for ICM enrollment, assist with arrangement of individual services for Members whose needs include ongoing dental care, home health care, rehabilitation services and preventive services. The Molina care manager is responsible for assessing the Member's appropriateness for the ICM program and for notifying the PCD of ICM program enrollment, as well as facilitating and assisting with the development of the Member's ICP.

8. Quality

Maintaining Quality Improvement Processes and Programs

Molina works with Members and Providers to maintain a comprehensive Quality Improvement (QI) program. You can contact the Molina Quality department at (855) 866-5462 or fax (855) 556-2074.

The address for mail requests is:

Molina Healthcare of Illinois, Inc.
Quality Department
2001 Butterfield Rd., Suite 750
Downers Grove, IL 60515

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

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

Molina does not delegate quality improvement activities to dental providers. However, Molina requires contracted Providers to comply with the following core elements and standards of care. Molina Providers must:

- Have a quality improvement program in place.
- Comply with and participate in Molina's QI program including reporting of access and availability survey and activity results and provision of dental records as part of the HEDIS® review process and during potential quality of care and/or critical incident investigations.
- Cooperate with Molina's quality improvement activities that are designed to improve quality of care and services and Member experience.
- Allow Molina to collect, use and evaluate data related to Provider performance for quality improvement activities, including but not limited to focus areas, such as clinical care, care coordination and management, service, access, and availability.
- Allow access to Molina quality personnel for site and dental record review processes.

Patient Safety Program

Molina's Patient Safety Program identifies appropriate safety projects and error avoidance for Molina Members in collaboration with their PCDs. Molina continues to support safe health practices for our Members through our safety program, pharmaceutical management and care

management/health management programs and education. Molina monitors nationally recognized quality index ratings for facilities including adverse events and hospital-acquired conditions as part of a national strategy to improve health care quality mandated by the Patient Protection and Affordable Care Act (ACA) and the Department of Health and Human Services (HHS) to identify areas that have the potential for improving health care quality to reduce the incidence of events.

Quality of Care

Molina has established a systematic process to identify, investigate, review, and report any quality of care, adverse event/never event, critical incident (as applicable) and/or service issues affecting Member care. Molina will research, resolve, track, and trend issues. Confirmed adverse events/never events are reportable when related to an error in dental care that is clearly identifiable, preventable and/or found to have caused serious injury or death to a patient. Molina is not required to pay for inpatient care related to "never events."

Dental Records

Molina requires that dental records be maintained in a manner that is current, detailed, and organized to ensure that care rendered to Members is consistently documented (hard copy or electronic) and that necessary information is readily available in the dental record in accordance with Molina Healthcare of Nebraska's policies and procedures. All entries will be indelibly added to the Member's record. A Member's dental record is the property of the provider who generates the record. PCDs should maintain the following dental record components that include but are not limited to:

- Dental record confidentiality and release of dental records within dental and behavioral health care records.
- Each Member is entitled to a copy of their dental record at no cost.
- Upon notification of transferring Members, Molina will ensure their dental records or copies of dental records are forwarded to the new PCD within ten (10) business days from receipt of the request for transfer of the dental records.
- Dental record content and documentation standards include legibility, accuracy, and plan of care that comply with applicable law and Molina written standards.
- Storage maintenance and disposal processes.
- Process for archiving dental records and implementing improvement activities.
- If care has not been established, information may be kept temporarily in an appropriately labeled file, in lieu of a permanent dental record.
- The temporary file must be associated with the Member's dental record as soon as one is established.

Information related to fraud and abuse may be released. However, HIV-related information may not be disclosed except as provided in state statute, and substance use disorder

information shall only be disclosed consistent with Federal and State law including, but not limited to 42 CFR § 2.1 et seq.

Dental Record Keeping Practices

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

- Each patient has a separate record.
- All records are to be in a locked secure environment.
- Records are available at each visit and archived records are available within 24 hours.
- If its hard copy, pages are securely attached in the dental record and records are organized by dividers or color-coded when thickness of the record dictates.
- If electronic, all those with access have individual passwords.
- Record keeping is monitored for Quality and HIPAA compliance.
- Storage maintenance for the determined timeline and disposal per record management processes.
- Process for archiving dental records and implementing improvement activities.
- Records are kept confidential and there is a process for release of dental records.

Dental Record Content

Providers must remain consistent in their practices with Molina's dental record documentation guidelines. Dental records are maintained and should include the following information:
Each page in the record contains the patient's name or ID number. Member name, date of birth, gender, legal guardianship (if applicable), marital status, address, employer, home and work telephone numbers, and emergency contact. Primary language spoken by the Member and any translation needs. Legible signatures and credentials of Provider and other staff members within a paper chart. All Providers who participate in the Member's care.

The primary care dentist is responsible for documenting all services provided directly by the PCD. This includes all ancillary and diagnostic services ordered by the PCD, and all diagnostic and therapeutic services for which the member was referred by the PCD. At a minimum, each dental record must contain the following:

- Member demographics: Member name, member ID number, date of birth, gender, marital status, address, employer, home and work telephone numbers, emergency contact information, primary language, and translation needs.
- Legible signature and credentials of provider and other staff members if a paper dental record; after each entry into progress notes. Process notes should include:
    - Review of medical and dental history.
    - Exam findings and diagnosis.
    - Verbal or written informed consent.
    - Date of Service.

- Services performed including:
    - Tooth number.
    - Arch.
    - Surfaces.
    - Quadrant.
    - Summary of the appointment and discussions with the member.
    - Review treatment for the next visit as applicable.
    - Presenting complaints, diagnoses, and treatment plans, including follow-up visits and referrals to other providers.
- Prescribed medications, including dosages and dates of initial or refill prescriptions.
- Allergies and adverse reactions (or notation that none are known).
- Treatment plans are consistent with diagnosis.
- A working diagnosis is recorded with the clinical findings.
- Progress notes clearly and thoroughly state the intent on all ordered services and treatments.
- There are notations regarding follow-up care, calls, or visits, including the next preventative care visit when appropriate.
- Notes from consultants are in the record if applicable.
- All staff and provider notes are signed physically or electronically with either name or initials.
- All entries are dated.
- All ancillary services reports.

Dental Record Organization

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

Dental Record Retrieval

- The dental record is available to the Provider at each encounter.
- The dental record is available to Molina for purposes of Quality Improvement.
- The dental record is available to the applicable State and/or Federal agency and the External Quality Review Organization upon request.
- The dental record is available to the Member at their request at no cost.
- A storage system for inactive Member dental records which allows retrieval within 24 hours, is consistent with State and Federal requirements, and the record is maintained for not less than 10 years from the last date of treatment or for a minor, one year past their 20th birthday but, never less than 10 years.

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

Confidentiality

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

- Ensure that dental information is released only in accordance with applicable Federal or State Law in pursuant to court orders or subpoenas.
- Maintain records and information in an accurate and timely manner.
- Ensure timely access by Members to the records and information that pertain to them.
- Abide by all Federal and State Laws regarding confidentiality and disclosure of dental records or other health and enrollment information.
- Dental Records are protected from unauthorized access.
- Access to computerized confidential information is restricted.
- Precautions are taken to prevent inadvertent or unnecessary disclosure of protected health information.

Education and training for all staff on handling and maintaining protected health care information.

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

Access to Care

Molina maintains access to care standards and processes for ongoing monitoring of access to health care provided by contracted PCDs and participating specialists. Providers surveyed include PCDs (family/general practice, internal medicine and pediatric), OB/GYN (high-volume specialists), Oncologist (high-impact specialists) and behavioral health Providers. Providers are required to conform to the access to care appointment standards listed below to ensure that health care services are provided in a timely manner. The PCD or their designee must be available 24 hours a day, 7 days a week to Members.

Network Adequacy

Time and Distance Standards	Urban	Rural
Dental Access for Children	Access to at least one (1) dentist, who serves Children, within a thirty (30)–mile radius of or thirty (30)–minute drive from the Enrollee's residence.	Access to at least one (1) dentist, who serves Children, within a sixty (60)–mile radius of or sixty (60)–minute drive from the Enrollee's residence.

Appointment Access

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

Dental Appointment

APPOINTMENT TYPE	TIME FRAME
EMERGENT	24 HOURS
URGENT	72 HOURS
INITIAL AND RECALL ROUTINE	30 DAYS
TREATMENT FOLLOW UP	45 DAYS

Emergency Dental Condition – a dental or oral condition that requires immediate service for relief of symptoms and stabilization of the condition; such conditions include severe pain, hemorrhage, acute infection, traumatic injury to the teeth and surrounding tissue, or unusual swelling of the face or gums.

Emergency Dental Services – those services necessary for the treatment of any condition requiring immediate attention for the relief of pain, hemorrhage, acute infection, or traumatic injury to the teeth, supporting structure (periodontal membrane, Gingival, alveolar bone), jaws, and tissues of the oral cavity.

Urgent Care – those problems, which, though not life threatening, could result in serious injury or disability unless attention is received or do substantially restrict a member's activity.

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

Office Wait Time

Providers should see a Member within 30 minutes of arriving at the office for a scheduled appointment. All PCDs are required to monitor waiting times and adhere to this standard.

After Hours

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

Appointment Scheduling

Each Provider must implement an appointment scheduling system. The following are the minimum standards:

1. The Provider must have an adequate telephone system to handle patient volume. Appointment intervals between patients should be based on the type of service provided and a policy defining required intervals for services. Flexibility in scheduling is needed to allow for urgent walk-in appointments.
2. A process for documenting missed appointments must be established. When a Member does not keep a scheduled appointment, it is to be noted in the Member's record, and the Provider is to assess if a visit is still medically indicated. All efforts to notify the Member must be documented in the dental record.
3. When the Provider must cancel a scheduled appointment, the Member is given the option of seeing an associate or having the next available appointment time.
4. Special needs of Members must be met when scheduling appointments. This includes but is not limited to wheelchair-using Members and Members requiring language interpretation.
5. A process for Member notification of preventive care appointments must be established. This includes but is not limited to immunizations and mammograms.
6. A process must be established for Member recall in the case of missed appointments for a condition which requires treatment, abnormal diagnostic test results or the scheduling of procedures which must be performed prior to the next visit.

In applying the standards listed above, participating Providers have agreed that they will not discriminate against any Member on the basis of age, race, creed, color, religion, sex, national origin, sexual orientation, marital status, physical, mental or sensory handicap, gender identity, pregnancy, sex stereotyping, place of residence, socioeconomic status or status as a recipient of Medicaid benefits. Additionally, a participating Provider may not limit their practice because of a Member's dental (physical or mental) condition or the expectation for the need of frequent or high-cost care. If a PCD chooses to close their panel to new Members, Molina must receive 30 calendar day advance written notice from the Provider.

Monitoring Access for Compliance with Standards

Access to care standards are reviewed, revised as necessary and approved by the Quality Improvement and Health Equity Transformation Committee on an annual basis.

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

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

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

Quality of Provider Office Locations

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

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

Physical Accessibility

Molina evaluates office sites as applicable to ensure that Members have safe and appropriate access to the office site. This includes, but is not limited to, ease of entry into the building, accessibility of space within the office site and ease of access for patients with physical disabilities.

Physical Appearance

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

Adequacy of Waiting and Exam Room Space

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

Administration and Confidentiality of Facilities

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

- Office appearance demonstrates that housekeeping and maintenance are performed appropriately on a regular basis, the waiting room is well-lit, office hours are posted, and the parking area and walkways demonstrate appropriate maintenance.
- Accessible parking is available; the building and exam rooms are accessible with an incline ramp or flat entryway, and the restroom is accessible with a bathroom grab bar.
- Adequate seating includes space for an average number of patients in an hour and there is a minimum of two (2) office exam rooms per Provider.
- Basic emergency equipment is in an easily accessible area. This includes a pocket mask and Epinephrine, plus any other medications appropriate to the practice.
- At least one (1) CPR-certified employee is available.
- Yearly Occupational Safety and Health Administration (OSHA) training (fire, safety, blood-borne pathogens, etc.) is documented for offices with 10 or more employees.
- A container for sharps is in each room where injections are given.
- Labeled containers, policies, contracts, and evidence of a hazardous waste management system in place.
- Patient check-in systems are confidential. Signatures on fee slips, separate forms, stickers, or labels are possible alternative methods.
- Confidential information is discussed away from patients. When reception areas are unprotected by sound barriers, scheduling and triage phones are best placed at another location.
- Dental records are stored away from patient areas. Record rooms and/or file cabinets are preferably locked.
- A Clinical Laboratory Improvement Amendment (CLIA) waiver is displayed when the appropriate lab work is run in the office.
- Prescription pads are not kept in exam rooms.
- Narcotics are locked, preferably double-locked. Medication and sample access is restricted.

- System in place to ensure expired sample medications are not dispensed and injectables and emergency medication are checked monthly for outdates.
- Drug refrigerator temperatures are documented daily.

Early and Periodic Screening, Diagnostic and Treatment (EPSDT) Services to Enrollees Under 21 Years of Age

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

Monitoring for Compliance Standards

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

Quality Improvement Activities and Programs

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

Health and Care Management

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

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

Clinical Practice Guidelines

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

Cultural and Linguistic Appropriate Services

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

Measurement of Clinical and Service Quality

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

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

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

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

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

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

HEDIS®

Molina utilizes NCQA HEDIS® as a measurement tool to provide a fair and accurate assessment of specific aspects of managed care organization performance. HEDIS® is an annual activity conducted in the spring. The data comes from on-site dental record review and available administrative data. All reported measures must follow rigorous specifications and are

externally audited to ensure continuity and comparability of results. The HEDIS® measurement set currently includes a variety of health care aspects including immunizations, women's health screening, diabetes care, well check-ups, medication use and cardiovascular disease.

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

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

CAHPS®

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

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

Provider Satisfaction Survey

Recognizing that HEDIS® and CAHPS® both focus on Member experience with health care Providers and health plans, Molina conducts a Provider Satisfaction Survey annually. The results from this survey are especially important to Molina, as this is one of the primary methods used to identify improvement areas pertaining to the Molina Provider network. The survey results have helped establish improvement activities relating to Molina's specialty network, inter-Provider communications and pharmacy authorizations. This survey is fielded to a random sample of Providers each year. If your office is selected to participate, please take a few minutes to complete and return the survey.

Effectiveness of Quality Improvement Initiatives

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

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

What can Providers do?

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

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

9. Risk Adjustment Management Program

What is Risk Adjustment?

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

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

Why is Risk Adjustment Important?

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

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

Interoperability

The Provider agrees to deliver relevant clinical documents (Clinical Document Architecture (CDA) or Continuity of Care Document (CCD) format) at encounter close for Molina Members by using one of the automated methods available and supported by the Provider's electronic medical records (EMR), including but not limited to Epic Payer Platform, Direct Protocol, Secure File Transfer Protocol (sFTP), query or Web service interfaces such as Simple Object Access Protocol (External Data Representation) or Representational State Transfer (Fast Healthcare Interoperability Resource).

The CDA or CCD document should include signed clinical note or conform with the United States Core Data for Interoperability (USCDI) common data set and Health Level 7 (HL7) Consolidated Clinical Data Architecture (CCDA) standard.

The Provider will also enable HL7 v2 Admission/Discharge/Transfer (ADT) feed for all patient events for Molina Members to the interoperability vendor designated by Molina.

The Provider will participate in Molina's program to communicate Clinical Information using the Direct Protocol. Direct Protocol is the HIPAA-compliant mechanism for exchanging health care information that is approved by the Office of the National Coordinator for Health Information Technology (ONC).

- If the Provider does not have a Direct Address, the Provider will work with its EMR vendor to set up a Direct Messaging Account, which also supports the CMS requirement of having the Provider's Digital Contact Information added in NPPES.
- If the Provider's EMR does not support the Direct Protocol, the Provider will work with Molina's established interoperability partner to get an account established.

Your Role as a Provider

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

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

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

Contact Information

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

10. Compliance

Fraud, Waste, and Abuse

Introduction

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

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

Mission Statement

Our mission is to pay claims correctly the first time and that mission begins with the understanding that we need to proactively detect fraud, waste, and abuse, correct it and prevent it from reoccurring. Since not all fraud, waste or abuse can be prevented, Molina employs processes that retrospectively address fraud, waste or abuse that may have already occurred. Molina strives to detect, prevent, investigate and report suspected health care fraud, waste, and abuse to reduce health care costs 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, submitting bills for services never performed or items never furnished or otherwise causing a false claim to be submitted.

Deficit Reduction Act

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

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

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

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

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

- Employment reinstatement at the same level of seniority.
- Two times the amount of back pay plus interest.
- Compensation for special damages incurred by the employee because of the employer's inappropriate actions.

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

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

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

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

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

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

Marketing Guidelines and Requirements

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

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

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

Stark Statute

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

Sarbanes-Oxley Act of 2002

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

Definitions

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

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

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

Examples of Fraud, Waste, and Abuse by a Provider

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

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

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

Examples of Fraud, Waste, and Abuse by a Member

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

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

Review of Provider Claims and Claims System

Molina Claims examiners are trained to recognize unusual billing practices, which are key in trying to identify fraud, waste, and abuse. If the Claims examiner suspects fraudulent, abusive, or wasteful billing practices, the billing practice is documented and reported to the SIU through our Compliance Alertline/reporting repository.

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

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

Prepayment of Fraud, Waste, and Abuse Detection Activities

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

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

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

Post-payment Recovery Activities

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

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

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

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

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

Claim Auditing

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

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

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

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

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

Provider Education

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

Molina will notify the Provider of the deficiency and will take steps to educate the Provider, which may include the Provider submitting a CAP to Molina addressing the issues identified and how it will cure these issues moving forward.

Reporting Fraud, Waste, and Abuse

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

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

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

Molina Healthcare of Illinois, Inc.
Attn: Compliance
2001 Butterfield Rd., Suite 750
Downers Grove, IL 60515

Phone: (888) 858-2156

The following information should be included when reporting:

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

Suspected fraud and abuse may also be reported directly to CMS:

Phone: (800) 633-4227 [(800) MEDICARE]
or
Office of Inspector General
Attn: OIG Hotline Operations
PO Box 23489
Washington, DC 20026

Phone: (800) 447-8477
TTY/TDD: (800) 377-4950
Fax (10 page max): (800) 223-8164

Health and Human Services Office of the Inspector General
Online: oig.hhs.gov/fraud/report-fraud/index.asp

Suspected fraud and abuse may also be reported to the state at:
Illinois State Police
Medicaid Fraud Control Unit
8151 W. 183rd Street, Suite F
Tinley Park, Illinois 60477

Phone: (844) 453-7283/(844) ILFRAUD

Illinois Attorney General
Online: hfs.illinois.gov/oig/reportfraud.html
Failure to report instances of suspected fraud, waste, and abuse is a violation of the law and subject to the penalties provided by law.

HIPAA Requirements and Information

Molina's Commitment to Patient Privacy

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

Provider Responsibilities

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

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

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

Applicable Laws

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

1. **Federal Laws and Regulations**

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

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

Artificial Intelligence

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

Notwithstanding the foregoing, the Provider shall give advance written notice to your Molina Contract Manager (for any AI used by the Provider that may impact the provision of covered services to Molina Members) that describes (i) Providers' use of the AI tool(s) and (ii) how the Provider oversees, monitors and evaluates the performance and legal compliance of such AI

tool(s). If the use of AI is approved by Molina, the Provider further agrees to (i) allow Molina to audit Providers' AI use, as requested by Molina from time to time, and (ii) to cooperate with Molina with regard to any regulatory inquiries and investigations related to Providers' AI use related to the provision of covered services to Molina Members.

Uses and Disclosures of PHI

Member and patient PHI should only be used or disclosed as permitted or required by applicable law. Under HIPAA, a Provider may use and disclose PHI for their own treatment, payment, and health care operations activities (TPO) without the consent or authorization of the patient who is the subject of the PHI. Uses and disclosures for TPO apply not only to the Provider's own TPO activities, but also for the TPO of another covered entity[1]. Disclosure of PHI by one covered entity to another covered entity or health care Provider, for the recipient's TPO is specifically permitted under HIPAA in the following situations:

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

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

Confidentiality of Substance Abuse Disorder Patient Records

Federal confidentiality of substance abuse disorder patient records regulations apply to any entity or individual providing federally assisted alcohol or drug abuse prevention treatment. Records of the identity, diagnosis, prognosis, or treatment of any patient which are maintained in connection with substance use disorder treatment or programs are confidential and may be disclosed only as permitted by 42 CFR Part 2. Although HIPAA protects substance use disorder information, the federal confidentiality of substance abuse disorder patient records regulations

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

are more restrictive than HIPAA and they do not allow disclosure without the Member's written consent except as set forth in 42 CFR Part 2.

Inadvertent Disclosures of PHI

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

Written Authorizations

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

Patient Rights

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

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

6. **Request Accounting of PHI Disclosures**
   Patients may request an accounting of disclosures of PHI made by the Provider during the preceding six (6) year period. The list of disclosures does not need to include disclosures made for treatment, payment, or health care operations.

HIPAA Security

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

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

HIPAA Transactions and Code Sets

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

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

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

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

Code Sets

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

National Provider Identifier (NPI)

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

Additional Requirements for Delegated Providers

Providers that are delegated for Claims and utilization management activities are the "business associates" of Molina. Under HIPAA, Molina must obtain contractual assurances from all business associates that they will safeguard Member PHI. Delegated Providers must agree to various contractual provisions required under HIPAA's privacy and security rules.

Reimbursement for Copies of PHI

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

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

Information Security and Cybersecurity

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

1. Definitions:

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

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

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

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

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

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

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

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

(h) "Nonpublic Information" includes:

i. Molina's proprietary and/or confidential information.

ii. Personally Identifiable Information as defined under applicable state data security laws, including, without, limitation, "nonpublic personal information," "personal data," "personally identifiable information," "personal information" or any other similar term as defined pursuant to any applicable law; and

iii. Protected Health Information as defined under HIPAA and HITECH.

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

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

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

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

iii. Security. Safeguarding the security of the Information Systems and Molina Information accessible to or held by Provider, which shall include hardware and software protections such as network firewall provisioning, intrusion and threat detection controls designed to protect against malicious code and/or activity, regular (three or more annually) third

party vulnerability assessments, physical security controls and personnel training programs that include phishing recognition and proper data management hygiene.

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

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

i. Network Security. Network security shall conform to generally recognized industry standards and best practices. Generally recognized industry standards include, but are not limited to, the applicable Industry Standards.

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

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

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

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

vi. Data Re-Use. Provider agrees that all Molina Information exchanged shall be used expressly and solely for the purposes enumerated in the Provider Agreement with Molina and this section. Data shall not be distributed, repurposed, or shared across other applications, environments, or

business units of Provider. Provider further agrees that no Molina Information or data of any kind shall be transmitted, exchanged, or otherwise passed to other affiliates, contractors or interested parties, except on a case-by-case basis as specifically agreed to in advance and in writing by Molina.

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

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

   (b) BC/DR Plan.

      i. Provider's procedures addressing continuity of business operations, including disaster recovery, shall be collected and/or summarized in a documented BC and DR plan or plans in written format ("BC/DR Plan"). The BC/DR Plan shall identify the service level agreement(s) established between Provider and Molina. The BC/DR Plan shall include the following:
         a) Notification, escalation, and declaration procedures.
         b) Roles, responsibilities and contact lists.
         c) All Information Systems that support services provided to Molina.
         d) Detailed recovery procedures in the event of the loss of people, processes, technology and/or third parties or any combination thereof providing services to Molina.
         e) Recovery procedures in connection with a Cybersecurity Event, including ransomware.
         f) Detailed list of resources to recover services to Molina including but not limited to applications, systems, vital records, locations, personnel, vendors, and other dependencies.
         g) Detailed procedures to restore services from a Cybersecurity Event including ransomware.
         h) Documented risk assessment which shall address and evaluate the probability and impact of risks to the organization and services provided to Molina. Such risk assessment shall evaluate natural, man-made, political and cybersecurity incidents.
      ii. To the extent that Molina Information is held by Provider, Provider shall maintain backups of such Molina Information that are adequately protected from unauthorized alterations or destruction consistent with applicable Industry Standards.
      iii. Provider shall develop information technology disaster recovery or systems contingency plans consistent with applicable Industry Standards and in accordance with all applicable laws.

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

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

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

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

4. Cybersecurity Events.

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

(b) In the event of a Cybersecurity Event that threatens or affects Molina's Information Systems (in connection with Provider having access to such Information Systems); Provider's Information Systems; or Molina Information accessible to or held by Provider, Provider shall notify Molina's Chief Information Security Officer of such event by telephone and email as provided below (with follow-up notice by mail) as promptly as possible, but in no event later than 24 hours from Provider's discovery of the Cybersecurity Event.

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

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

including those of the Office of Foreign Assets Control. Notification to Molina's Chief Information Security Officer shall be provided to:

- Molina Chief Information Security Officer
  Molina Healthcare, Inc.
  200 Oceangate Blvd., Suite 100
  Long Beach, CA 90802
  Telephone: (844) 821-1942
  Email: CyberIncidentReporting@Molinahealthcare.com

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

(d) Following notification of a Cybersecurity Event, Provider must promptly provide Molina any documentation requested by Molina to complete an investigation, or, upon request by Molina, complete an investigation pursuant to the following requirements:

i. make a determination as to whether a Cybersecurity Event occurred.
ii. assess the nature and scope of the Cybersecurity Event.
iii. identify Molina's Information that may have been involved in the Cybersecurity Event; and
iv. perform or oversee reasonable measures to restore the security of the Information Systems compromised in the Cybersecurity Event to prevent further unauthorized acquisition, release, or use of Molina Information.

(e) Provider must provide Molina the following required information regarding a Cybersecurity Event in electronic form. Provider shall have a continuing obligation to update and supplement the initial and subsequent notifications to Molina concerning the Cybersecurity Event. The information provided to Molina must include at least the following, to the extent known:

i. the date of the Cybersecurity Event.
ii. a description of how the information was exposed, lost, stolen, or breached.
iii. how the Cybersecurity Event was discovered.
iv. whether any lost, stolen, or breached information has been recovered and if so, how this was done.
v. the identity of the source of the Cybersecurity Event.

vi. whether Provider has filed a police report or has notified any regulatory, governmental or law enforcement agencies and, if so, when such notification was provided.

vii. a description of the specific types of information accessed or acquired without authorization, which means data elements including, for example, types of dental information, types of financial information or types of information allowing identification of the consumer.

viii. the period during which the Information System was compromised by the Cybersecurity Event.

ix. the number of total consumers in each state affected by the Cybersecurity Event.

x. the results of any internal review identifying a lapse in either automated controls or internal procedures or confirming that all automated controls or internal procedures were followed.

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

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

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

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

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

6. Other Provisions. Provider acknowledges that there may be other information security and data protection requirements applicable to Provider in the performance of services

which may be addressed in an agreement between Molina and Provider but are not contained in this section.

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

11. Claims and Compensation

Payer ID	**SKYGN WITHOUT THE E**
SKYGEN Portal	SKYGEN
Clean Claim Timely Filing	Medicaid 180 Calendar Days | D-SNP 365 Days

Electronic Claim Submission

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

- Reducing operations costs associated with paper claims (printing, postage, etc.).
- Increases accuracy of data and efficient information delivery.
- Reduces claim delays since errors can be corrected and resubmitted electronically.
- Eliminates mailing time and claims reach Molina faster.

Molina offers the following electronic Claim submission options:

- Submit claims directly to Molina via the SKYGEN portal.
- Submit claims to Molina via your regular EDI clearinghouse.

SKYGEN Hub

The SKYGEN portal is a no-cost online platform that offers a number of claims processing features:

- Submit Professional (ADA Claim Form) claims with attached files.
- Correct/void claims.
- Add attachments to previously submitted claims.
- Check claim status.
- View ERA and EOP.
- Create and manage claim templates.
- Create and submit a claim appeal with attached files.

Clearinghouse

Providers can submit Claims to SKYGEN via a clearinghouse.

SKYGEN accepts EDI transactions for claims via the 837D for Dental. It is important to track your electronic transmissions using your acknowledgement reports. The reports assure claims are received for processing in a timely manner.

When Your Claims are Filed via a Clearinghouse:

- You should receive a 999 acknowledgment from your clearinghouse.

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

EDI Claim Submission Issues

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

Timely Claim Filing

Providers shall promptly submit to Molina claims for covered services rendered to Members. All claims shall be submitted in a form acceptable to and approved by Molina and shall include all dental records pertaining to the claim if requested by Molina or otherwise required by Molina's policies and procedures. claims must be submitted by the Provider to Molina within 180 calendar days after the discharge for inpatient services or the date of service for outpatient services.

If Molina is not the primary payer under the coordination of benefits or third-party liability, the Provider must submit claims to Molina within 90 calendar days after final determination by the primary payer. Except as otherwise provided by law or provided by government program requirements, any Claims that are not submitted to Molina within these timelines shall not be eligible for payment and the Provider hereby waives any right to payment.

Claim Submission

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

National Provider Identifier (NPI)

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

Required Elements

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

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

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

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

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

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

EDI (Clearinghouse) Submission

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

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

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

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

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

Paper Claim Submission

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

Molina Healthcare of Illinois
PO Box 2136
Milwaukee, WI 53201

When submitting paper Claims:

- Paper Claim submissions are not considered to be "accepted" until received at the appropriate Claims PO Box; Claims received outside of the designated PO Box will be returned for appropriate submission.
- Paper Claims are required to be submitted on original ADA claim forms.
- Paper Claims not submitted on the required forms will be rejected. This includes black and white forms, copied forms and any altering to include Claims with handwriting.
- Claims must be typed with either 10 or 12-point Times New Roman font, using black ink.
- Link to paper Claims submission guidance from CMS: cms.gov/Medicare/Billing/ElectronicBillingEDITrans/1500.

Corrected Claim Process

Providers may correct any necessary field of the ADA Claim form.

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

All corrected Claims:

- Must be free of handwritten or stamped verbiage (paper claims).
- Paper claims are required to be submitted on original ADA claim forms.
- Original claim number must be inserted in box 35 of the ADA claim form.

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

Corrected Claim Submission Options:

- Submit Corrected Claims directly to Molina via the SKYGEN portal.
- Submit corrected Claims to Molina via your regular EDI clearinghouse.

Coordination of Benefits (COB) and Third-party Liability (TPL)

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

Medicaid is always the payer of last resort and Providers shall make reasonable efforts to determine the legal liability of third parties to pay for services furnished to Molina Members. If third-party liability can be established, Providers must bill the primary payer, enter the primary payment on each billing line and submit the primary explanation of benefits (EOB) to Molina for secondary Claim processing. If coordination of benefits occurs, the Provider shall be reimbursed based on the state regulatory COB methodology. Primary carrier payment information is required with the Claim submission. Providers can submit Claims with attachments, including EOB and other required documents. Molina will pay Claims for prenatal care and EPSDT and

then seek reimbursement from third parties. If services and payment have been rendered prior to establishing third-party liability, an overpayment notification letter will be sent to the Provider requesting a refund including third-party policy information required for billing.

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

Molina Coding and Payment Policies

Frequently requested information on Molina's coding policies and payment policies is available on the MolinaHealthcare.com website under the **Policies** tab. Questions can be directed to your Molina Provider Relations Representative.

Reimbursement and Payment Guidelines

Providers are responsible for the submission of accurate Claims. Molina requires coding of both diagnoses and procedures for all Claims as follows:

- For diagnosis (if required), the required coding schemes are the International Classification of Diseases, 10th Revision, Clinical Modification (ICD-10-CM).
- For procedures: Professional and outpatient Claims require the Current Dental Terminology.

Furthermore, Molina requires that all Claims be coded in accordance with the HIPAA transaction code set guidelines and follow the guidelines within each code set.

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

- Manuals and files published by CMS, including:
  - NCCI edits, including procedure to procedure (PTP) bundling edits and Medically Unlikely Edits (MUE). In the event a state benefit limit is more stringent/restrictive than a federal MUE, Molina will apply the state benefit limit. Furthermore, if a professional organization has a more stringent/restrictive standard than a federal MUE or state benefit limit the professional organization standard may be used.
  - In the absence of state guidance, Medicare National Coverage Determinations (NCD).
  - In the absence of state guidance, Medicare Local Coverage Determinations (LCD).
  - Dental Fee Schedule.
- CDT guidance published by the ADA.
- ICD-10 guidance published by the National Center for Health Statistics.
- State-specific Claim reimbursement guidance.
- Other coding guidelines published by industry-recognized resources.

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

National Correct Coding Initiative (NCCI)

CMS has directed all federal agencies to implement NCCI as policy in support of Section 6507 of the ACA. Molina uses NCCI standard payment methodologies.

NCCI procedure to procedure edits prevent inappropriate payment of services that should not be bundled or billed together and to promote correct coding practices. Based on the NCCI coding manual and CDT guidelines, some services/procedures performed will bundle into the procedure when performed by the same Provider and separate reimbursement will not be allowed if the sole purpose for the visit is to perform the procedures. NCCI editing also includes MUE which prevent payment for an inappropriate number/quantity of the same service on a single day. An MUE for a HCPCS/CDT code is the maximum number of units of service under most circumstances reportable by the same Provider for the same patient on the same date of service. Providers must correctly report the most comprehensive CDT code that describes the service performed, including the most appropriate modifier when required.

General Coding Requirements

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

CDT and HCPCS Codes

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

ICD-10-CM

Molina utilizes ICD-10-CM and ICD-10-PCS billing rules and will deny claims that do not meet Molina's ICD-10 Claim submission guidelines. To ensure proper and timely reimbursement, codes must be effective on the date of service for which the procedure or service was rendered and not the date of submission. Refer to the ICD-10 CM Official Guidelines for Coding and Reporting on the proper assignment of principal and additional diagnosis codes.

Place of Service (POS) Codes

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

Coding Sources

Definitions

CDT – Current Dental Terminology; the American Dental Association (ADA) maintained uniform coding system consisting of descriptive terms and codes that are used primarily to identify Dental services and procedures furnished by Providers and other health care professionals.

HCPCS – HealthCare Common Procedural Coding System; a CMS maintained uniform coding system consisting of descriptive terms and codes that are used primarily to identify procedure, supply and durable medical equipment codes furnished by Providers and other health care professionals.

ICD-10-CM – International Classification of Diseases, 10th revision, Clinical Modification ICD-10-CM diagnosis codes are maintained by the National Center for Health Statistics, Centers for Disease Control (CDC) within the Department of Health and Human Services (HHS).

Claim Auditing

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

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

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

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

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

Timely Claim Processing

Claim processing will be completed for contracted Providers in accordance with the timeliness provisions set forth in the Provider Agreement with Molina. Unless the Provider and Molina have agreed in writing to an alternate schedule, Molina will process the claim for service within 180 days after receipt of Clean Claims.

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

Electronic Claim Payment

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

Overpayments and Incorrect Payments Refund Requests

Molina requires network Providers to report to Molina when they have received an overpayment and to return the overpayment to Molina within 60 calendar days after the date on which the overpayment was identified and notify Molina in writing of the reason for the overpayment.

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

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

A copy of the overpayment request letter and details are available in the SKYGEN portal. In the Overpayment Application section, Providers can make an inquiry, contest an overpayment with supporting documentation, resolve an overpayment, or check status. This is Molina's preferred method of communication.

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

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

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

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

Claim Disputes, Reconsiderations and Appeals

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

Encounter Data

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

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

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

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

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

When Encounters are filed electronically Providers should receive two (2) types of responses:

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

12. Complaints, Grievances, and Appeals

Definitions

Grievance: A complaint is any oral or written expression of dissatisfaction by an enrollee submitted to the health plan or to a state agency and resolved by close of business the following day. Possible subjects for complaints include, but are not limited to, the quality of care, the quality of services provided, aspects of interpersonal relationships such as rudeness of a provider or health plan employee, failure to respect the enrollee's rights, health plan administration, claims practices, or provision of services that relates to the quality of care rendered by a provider pursuant to the health plan's contract. Possible subjects for grievances include but are not limited to the quality of care, the quality of services provided and aspects of interpersonal relationships such as rudeness of a provider or health plan employee or failure to respect the enrollee's rights.

Appeal: A formal request from an enrollee to seek a review of an action taken by the Plan pursuant to 42 CFR 438.400(b). An appeal is a request for review of an action.

Expedited Appeal: An expedited request for review of an action. An Expedited appeal should be processed when it is determined that allowing the time for a standard resolution could seriously jeopardize the member's life, health, or ability to attain, maintain, or regain maximum function. Such determination is based on:

- A request from the Member.
- A provider's support of a member's request.
- A provider's request on behalf of the member or.
- The plans' determination.

Member Grievances and Timelines

A patient has the right to express grievances regarding any violation of his or her rights, as stated in Illinois law, through the grievance process of the dental care provider or dental care facility which served him or her and to the appropriate state licensing agency.

SKYGEN assists Molina with the grievance process. Members are directed to send their grievances to Molina. Providers acting on behalf of the member would also submit their grievance to Molina. Molina will contact SKYGEN for assistance if needed to resolve the grievance.

For grievances received from the member or the Provider acting on the member's behalf, SKYGEN communicates the recommendation to Molina. Molina will communicate the resolution to the member. SKYGEN will communicate the resolution directly to the provider when the provider is acting on their own behalf. The grievance will be closed and maintained on file for tracking and trending purposes.

A Grievance specialist will conduct the review and will mail a resolution letter to the Member within 60 calendar days from the date the Grievance is received. The resolution letter may not take the place of the acknowledgement letter, unless a decision is reached before the acknowledgement letter is sent, then one letter shall be sent which includes the acknowledgement and the decision letter.

Member Standard Appeals and Timeline

The Appeal must be received verbally or in writing within 60 calendar days of the date of the Adverse Action. For verbal filings, the time frames for resolution begin on the date the verbal filing was received by Molina Healthcare. Unless written confirmation of a standard verbal Appeal request is received, the case is closed as an upheld Appeal, and Appeal rights are exhausted. The written follow-up requirement does not apply to qualifying Expedited Appeal requests. An acknowledgement letter will be sent to the Member no later than three (3) business days after the Appeal is received, confirming receipt and providing the expected date of resolution. An Appeal Specialist will ensure the appeal is reviewed as expeditiously as the Member's health condition requires. A resolution letter to the Member will be mailed no later than fifteen (15) days from the receipt of the Appeal. If the Provider files an Appeal on the Member’s behalf, Molina will respond to the Provider. The Provider shall give a copy of the notice to the Member or inform the Member of the provisions of the notice.

Expedited Appeal Process and Timeline

An Appeal will be expedited in response to the clinical urgency of the situation, i.e., when a delay would jeopardize a Member’s life or materially jeopardize a Member’s health. A request to expedite may come from the Member, Member’s representative, or a Provider with the Member’s written consent. If an appeal request qualifies for expedited, written member consent will not be required.

An expedited Appeal will be acted on quickly and a decision will be made within 72 hours from the date the Appeal request is received either verbally or in writing. If we determine the request does not meet the Commonwealth’s definition of an expedited Appeal we will immediately transfer the Appeal to the process and timeframes for a Standard Appeal resolution, in which a 30-day period will begin on the date we receive the original Appeal request, and we’ll also notify the Member within two calendar days.

External Independent Review

Providers are required to follow the Illinois Department of Healthcare and Family Services (HFS) process for filing a grievance about an MCO. The HFS complaint tracking process took effect in 2020. Under this process, any Provider filing a complaint to HFS requires a unique Managed Care Organization (MCO) Tracking Number issued by the MCO for every complaint submitted through the HFS Provider Portal.

Important: Per the HFS process, before filing a complaint with HFS, a Provider must first follow Molina's internal dispute process:

- Submit a Claims Dispute Request form to the MCO. The Claims Dispute Request form is found on the Frequently Used Forms page of Molina's website under Contracting & Provider Forms. Molina will review the Dispute.
- Refer to the outcome letter. After the Provider has submitted the Claim Dispute Request form, it's crucial to refer to the outcome letter that Molina sent in response. The unique MCO Tracking Number is found in the header of the outcome letter. The Provider must have this number to file a complaint with the HFS. Please note that this letter is mailed to the remit address on file with Molina or faxed to the HIPAA-compliant fax number provided.
- Submit a complaint to the state via the HFS Provider Portal. If the Provider disagrees with the outcome, they may use the HFS Provider Portal to file a complaint on the HFS website. Note: Complaints cannot be submitted through the HFS Provider Portal sooner than 30 calendar days after submitting the complaint to Molina, nor can they be submitted any later than:
  - 30 calendar days after unsatisfactory resolution.
  - 60 calendar days after the Provider submits the dispute to Molina for internal resolution.

All HFS Provider complaint portal submissions must include the Molina-provided MCO Tracking Number and the date the complaint was filed with Molina's internal dispute resolution process. If applicable, include the date the Provider received the MCO resolution.

The HFS Provider Portal will present the dispute to Molina within ten (10) business days of receiving a complaint. Molina will have 30 calendar days from the complaint receipt date to issue a written proposal to resolve the dispute unless HFS grants Molina an extension.

Provider Claim Dispute

The processing, payment, or nonpayment of a Claim by Molina shall be classified as a Provider dispute and must be filed within 90 calendar cays from the date of the original remittance advice. Molina must respond within 30 calendar days. Disputes can be sent to the following address:

Molina Healthcare of Illinois, Inc.
Attention: Provider Appeals & Grievances
PO Box 649
Milwaukee, WI 53201

Reporting

Grievance and appeal trends are reported to the Quality Improvement and Health Equity Transformation Committee quarterly. This trend report includes a quantitative review of

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

13. Credentialing and Recredentialing

Uniform Credentialing and Recredentialing

If the practitioner is not enrolled in the Illinois Medicaid Program Advanced Cloud Technology (IMPACT) system, the practitioner must follow Molina's credentialing and recredentialing process.

In accordance with 42 CFR 438.214, Provider enrollment in IMPACT constitutes Illinois' Medicaid managed care uniform credentialing and recredentialing process. To participate in Molina's Provider Network, Molina must verify that the practitioner is enrolled in IMPACT.

Molina will submit monthly reports to the Illinois Department of Healthcare and Family Services (HFS) indicating which practitioners have completed the credentialing process and the results of the process.

14. Delegation

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

- Utilization management.
- Credentialing and recredentialing.
- Claims.
- Complex case management.
- CMS Preclusion List monitoring.
- Other clinical and administrative functions.

When Molina delegates any clinical or administrative functions, Molina remains responsible to external regulatory agencies and other entities for the performance of the delegated activities, including functions that may be sub-delegated. To become a delegate, the Provider/accountable care organization (ACO)/vendor must be in compliance with Molina's established delegation criteria and standards. Molina's Delegation Oversight Committee (DOC) or other designated committee must approve all delegation and sub-delegation arrangements. To remain a delegate, the Provider/ACO/vendor must maintain compliance with Molina's standards and best practices.

Delegation Reporting Requirements

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

Corrective Action Plans and Revocation of Delegated Activities

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

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