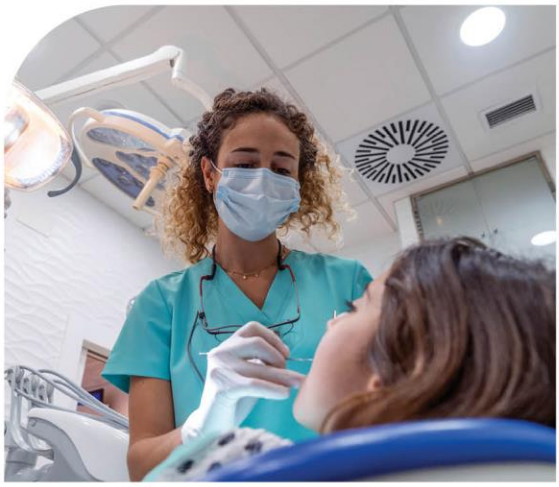
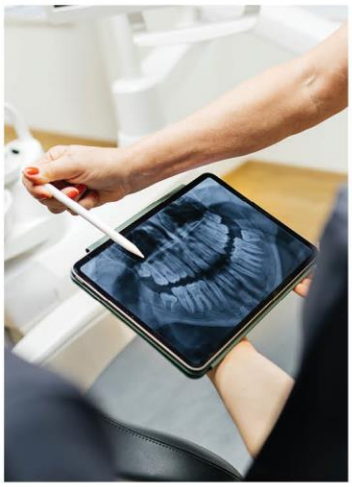
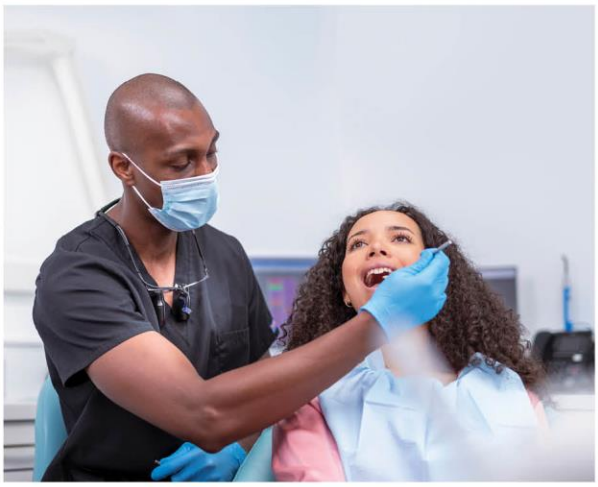




DENTAL PROVIDER MANUAL

Molina Healthcare of Nebraska, Inc.

Heritage Health 2025

EFFECTIVE DATE: 01/01/2025

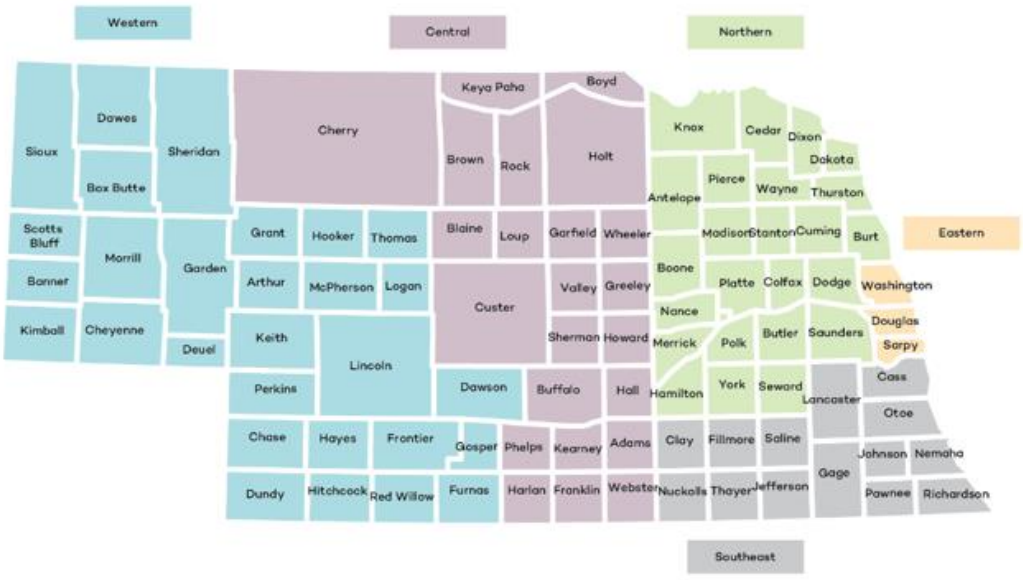
MOLINA® HEALTHCARE | HERITAGE HEALTH

Table of Contents

INTRODUCTION

Molina Dental Services (MDS) is dedicated to the administration of the statewide Nebraska Medicaid Dental Program. In partnership with Molina Healthcare of Nebraska, Inc., and SKYGEN USA LLC our mission is to deliver effective, reliable, and affordable dental care to those who need it most. . The training schedule for the HUB is available on the SKYGEN Dental HUB via this link: https://www.dentalHUB.com/

MOLINA HEALTHCARE OF NEBRASKA, INC. SERVICE AREA



CONTACT INFORMATION

Business Areas and Contact Information

Business Areas	Contact Information	Hours of Operation
Molina Dental Services Provider Relations	Bethany Stech and Theresa Ellenwood are the local dedicated Senior Provider Relations Representative and can be reached via: MDVSProviderServices@MolinaHealthcare.com Phone: (844) 862-4564 Hearing Impaired: 711 Fax: (855) 297-3304	Available Monday through Friday from 8:00 a.m. to 5:00 p.m. CT, Calls returned within 24 hours
Molina Dental Services Practice Changes/Updates/Credentialing	MDVSPIM@MolinaHealthcare.com Fax: (844) 891-2865	Available Monday through Friday from 8:00 a.m. to 5:00 p.m. CT
Molina Dental Services Contracting Questions	Denta.Visiondevelopment@MolinaHealthcare.com Fax: (844) 584-3686	Available Monday through Friday from 8:00 a.m. to 5:00 p.m. CT
Main Phone: SKYGEN Dental Provider HUB Support	Phone: (855) 609-5156	Available Monday through Friday from 8 :00a.m. to 4:30 p.m. CT, Calls returned within 24 hours
SKYGEN Dental HUB	https://app.dentalHUB.com/app/login	
Molina Member Call Center through SKYGEN	Phone: (844) 782-2018 TTY: 711 Nurse Advice Line (24/7/365): (844) 782-2721 (TTY: 711)	Available Monday through Friday from 8:00 a.m. to 6 p.m. CT Member telephone and written inquiries regarding Member Dental Claims, benefits, eligibility/identification, selecting or changing primary care dentist

		and Member grievances and appeals
Holidays	Molina and SKYGEN are closed.	• New Year's Day • Martin Luther King Jr. • Memorial Day Holiday • Independence Day • Labor Day • Thanksgiving Day • Day after Thanksgiving • Christmas Day
Molina automated Member Eligibility Verification through SKYGEN	Phone: (855) 806-5192 TTY: 711 https://app.dentalHUB.com/app/login	Phone hours: 7:00 a.m. to 8:00 p.m. CT, Monday through Friday 24 hours a day/7 days a week/365 days electronically on SKYGEN
SKYGEN Provider Services	Phone: (855) 806-5192 TTY: 711	Phone hours: 7:00 a.m. to 8:00 p.m. CT, Monday through Friday
Molina Credentialing and Recredentialing is through Verisys	For Questions regarding credentialing, please contact Verisys at https://verisys.com/contact-us/	
CAQH	https://proview.caqh.org/PR/Registration	To obtain a CAQH ProView ID visit the CAQH website
Provider Training for the SKYGEN Dental HUB	https://app.dentalHUB.com/app/login	24 hours a day, 7 days a week
Molina Utilization Management (Pre-Authorizations) through SKYGEN	Phone: (855) 806-5192(TTY: 711 https://app.dentalHUB.com/app/login	7:00 a.m. to 8:00 p.m. CT, Monday through Friday

Molina Electronic Claims Submittals and Adjustments through SKYGEN	https://app.dentalHUB.com/app/login The mailing address to submit paper 2012 or newer ADA Dental Claim Forms is: Molina Dental Services Claims PO Box 2136 Milwaukee, WI 53201 Provider Overpayment Disputes/Refund checks	24 hours a day, 7 days a week
Molina Member Grievance & Appeals	Phone: 844-782-2018 TTY: 711	8:00 a.m. to 6:00 p.m. CT, Monday through Friday,

Eligibility Verification

Providers who contract with Molina may verify a Member's eligibility utilizing one of the following options:

- **Nebraska Medicaid Eligibility System (NMES) line**

  Lincoln Phone: (402) 471-9580 or (800) 642-6092
  Hours of Operation: 24 hours a day/seven days a week/365 days
- SKYGEN Dental HUB https://app.dentalHUB.com/app/login
  24 hours a day/seven days a week/365 days electronically on SKYGEN
- SKYGEN Provider Services at: (855) 806-5192 from 7:00 a.m. to 8:00 p.m. CT, Monday through Friday.

Molina Healthcare of Nebraska, Omaha Office

Website: MolinaHealthcare.com
Address: Molina Healthcare of Nebraska, Inc.
14748 W Center Rd, Suite 104
Omaha NE 68144

REVISION HISTORY

Version	Date	Revision Information
1.0		Initial version.
1.1	12/08/2023	Second submission, updates completed by Janine Fitzpatrick based on state feedback
1.2	12/13/2023	Final submission, updates completed by Janine Fitzpatrick based on state feedback
1.3	01/11/2024	Updated PO Box from 2136 to 306 on pg. 148, added “not” to first sentence under NON-COVERED SERVICES Medicaid does not reimburse any non-covered service on pg. 156.
1.4	02/14/2024	Replaced Guidelines for Non-Intravenous and IV Sedation Requirements Dentists providing sedation or anesthesia services must have the appropriate certification from the Nebraska State Board of Dentistry for the level of sedation or anesthesia provided. All practice locations of a dentist applying for a permit to administer general anesthesia or deep sedation, moderate sedation, or minimal sedation may be inspected at the discretion of the board. The board may contract to have such inspections performed. Molina Dental Services must have on file a copy of the certification prior to rendering sedation services as follows: • A Nebraska-licensed dentist to administer general, moderate, minimal anesthesia or deep sedation • A dentist licensed in this state may administer inhalation analgesia in the practice of dentistry without a permit pursuant to the act • General anesthesia, deep sedation, moderate sedation, and minimal sedation shall not be administered by a dentist without the presence and assistance of a licensed dental hygienist or a dental assistant

- a licensed dental hygienist may administer and titrate nitrous oxide analgesia under the indirect supervision of a licensed dentist

Dental Providers who are providing sedation services for codes D9223, D9243, and D9248 must have the appropriate permits for the level of sedation provided.

D9248	Level 1 and Level 2
D9223 & D9243	Level 3
D9222 & D9239	Level 4
D9230	Nebraska Dental license

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

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

Dentists providing sedation or anesthesia services must have the appropriate permit from the Board of Dentistry in in the state which the provider practices for the level of sedation or anesthesia provided.

All practice locations where a dentist administers minimal sedation, moderate sedation, or deep sedation/general anesthesia, must have the required permit, and comply with the State Board of Dentistry guidelines with:

Molina Dental Services must have on file a copy of the permit prior to rendering sedation services as follows:

- A licensed dentist may administer inhalation analgesia in the practice of dentistry without a permit pursuant to the act, unless specified by the state in which the provider practices.
- Minimal sedation, moderate sedation, or deep sedation/general anesthesia shall not be administered by a dentist without the presence and assistance of a licensed dental hygienist or a dental assistant.
- A licensed dental hygienist may administer and titrate nitrous oxide analgesia under the indirect supervision of a licensed dentist, unless otherwise specified by the state in which the provider practices.

Dental Providers who are providing sedation services for codes D9223, D9243, and D9248 must have the appropriate permits for the level of sedation provided.

Sedation Type	License/Permit	Codes	Code Des
Nitrous/Analgesia Gas	State Dental License	D9230	Inhalatior
Non-IV Conscious Sedation (Level 1 and Level 2)	Minimal Sedation Permit	D9248	Non-Intra
IV Moderate Sedation (Level 3)	Moderate Sedation Permit	D9239	Intraveno Sedation/
		D9243	Intraveno Sedation/ Minute In
Deep Sedation/General Anesthesia (Level 4)	General/Deep Sedation Permit	D9222	Deep Sed Minutes
		D9223	Deep Sed Subseque

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

		• There is documented local anesthesia toxicity. • Patient displays severe cognitive impairment or developmental disability. • Patient displays severe physical disability. • Patient displays uncontrolled behavior management problem. • Treatment plan requires extensive or complicated surgical procedures. • Local anesthesia fails. • There are documented medical complications. • Patient presents with acute infection(s) on page 144. A copy of the certification of BLS, PALS, ACLS is also required. • For minimal sedation, the dentist must be certified in basic life support and for persons under 12 years of age to be certified in pediatric advanced life support. • If providing moderate sedation, deep sedation or general anesthesia, the dentist must be certified in basic life support and either advanced cardiac life support or other appropriate emergency management course for anesthesia and dental sedation and is a fellow of the American Dental Society of Anesthesiology
1.5	02/14/2024	Added include rationale for the use of D9420, including factors such as age, extent of caries, mental/physical handicap, description of accident, behavior/phobia, and documentation of any failed sedation on page 112
1.6	02/14/2024	Replaced Guidelines for Dental Services Rendered in an Outpatient or Ambulatory Service Center (ASC) Molina requires the following information to be submitted with prior authorization requests for dental therapeutic services and other procedures to be performed at a hospital outpatient or ambulatory surgical center: A completed Molina ASC Scorecard Molina ASC Scorecard fillable.pdf. In addition, all forms can be found on SKYGEN's Dental HUB and Molina's Healthcare Website. A complete written treatment plan (electronic ADA form, 2012 ADA, or newer, claim form). Narrative of medical necessity for the need to have the requested services performed at a hospital outpatient or

		ambulatory surgical center. The location where the procedures will be performed (hospital or ambulatory surgical center) with Guidelines for Dental Services Rendered in an Outpatient or Ambulatory Service Center (ASC) Please ensure the following information is included with all claims: 1. CDT Codes: Submit all CDT codes for treatment completed, along with the D9420 (electronic ADA form, 2012 ADA, or newer, claim form). 2. Rationale for D9420: Include rationale for the use of D9420, including factors such as age, extent of caries, mental/physical handicap, description of accident, behavior/phobia, and documentation of any failed sedation. 3. Location of Procedures: Specify the location where the procedures were performed (hospital or ambulatory surgical center). 4. Coding Guidelines: • When treating a member in a hospital or ASC, code D9420 should be used for each member along with all completed treatment. Do not code D9222 for these cases, as the member's medical insurance will cover anesthesia costs. • D9420 will only be paid once per day per facility per state regulations. If multiple members are seen in one day, D9420 will be paid for only one member and denied for the others. However, please use this code for every member undergoing general anesthesia, even if denied. • Include rationale for member needing general anesthesia when using code D9420 (e.g., age, extent of caries, behavior/phobia with any failed sedation attempts, description of accident, etc.). • Providers using D9222/9223 with a deep sedation/general anesthesia permit will not need to use code D9420. Prior Authorization: Prior authorization is not required for D9420 or D9222/9223. Claims are subject to pre-payment review on page 146
1.6	02/14/2024	D9223 Changed prepayment review from NO to YES for D9223

1.7	02/14/2024	Added Guidelines for Prosthodontic Services Prosthetic Appliances • Coverage of prosthetic appliances includes all materials, fitting, and placement of the prosthesis. • The plan covers the following prosthetic appliances, subject to service specific coverage criteria: o Dentures that are immediate, replacement or complete, or interim or complete; o Resin base partial dentures, including metal clasps; o Flipper partials that are considered a permanent replacement of one to three anterior teeth only; and o Cast metal framework with resin denture base partials, covered for clients age 20 and under. • Replacement: Plan covers a one-time replacement within the five-year coverage limit for broken, lost, or stolen appliances. This one-time replacement is available once within each Patient's lifetime, and a prior authorization request must be submitted and marked as a one-time replacement request. Replacement of any prosthetic appliance is covered once every five years when: o The client's dental history does not show that previous prosthetic appliances have been unsatisfactory to the client; o The client does not have a history of lost prosthetic appliances; o A repair will not make the existing denture or partial functional; o A reline will not make the existing denture or partial functional; or o A rebase will not make the existing denture or partial functional. Complete Dentures Maxillary and Mandibular • Complete dentures, maxillary and mandibular. o DOCUMENTATION REQUIREMENTS. Providers must submit the following documentation with prior authorization request:

		▪ Date of previous denture placement; ▪ Information on condition of existing denture; and ▪ For initial placements, submit panorex or full mouth series radiographs. Immediate Denture, Maxillary and Mandibular • An immediate denture, maxillary and mandibular, is considered a permanent denture. o DOCUMENTATION REQUIREMENTS. Providers must submit the following documentation with prior authorization request: ▪ Date and list of teeth to be extracted; ▪ Narrative documenting medical necessity; and ▪ Submit panorex or full mouth series radiographs. Partial Resin Base, Maxillary or Mandibular; Adequate occlusion for partial dentures is first molar to first molar, or a similar combination of anterior and posterior teeth on the upper or lower arch in occlusion. • Partial resin base, maxillary or mandibular, is covered if the client does not have adequate occlusion. Cast metal clasps are included on partial dentures. One to three missing anterior teeth should be replaced with a flipper partial which is considered a permanent replacement. o DOCUMENTATION REQUIREMENTS. Providers must submit the following documentation with prior authorization request: ▪ Chart or list of missing teeth and teeth to be extracted; ▪ Age and condition of any existing partial, or a statement identifying the prosthesis as an initial placement; ▪ Narrative documenting how there is not adequate occlusion; and ▪ For initial placements, radiographs of remaining teeth are required

		Partial cast metal base, Maxillary or Mandibular
		• Partial cast metal base, maxillary or mandibular is covered for clients age 20 and younger only.
		  o More than one posterior tooth must be missing for partial placement.
		  o One to three missing anterior teeth should be replaced with a flipper partial which is considered a permanent replacement.
		
		Repair to Denture and Partials
		• Plan covers two repairs per prosthesis every 365 days.
		
		Rebase of Dentures and Partials
		• Rebase of dentures and partials are covered
		  o Once per prosthesis every 365 days.
		  o Chair side and lab rebases are covered, but only one can be provided within the 365-day period.
		
		Reline of Dentures and Partials
		• Reline of dentures and partials are covered
		  o Covered once per prostheses every 365 days.
		  o Chair side and lab relines are covered, but only one can be provided within the 365-day period.
		
		Interim Complete Dentures Maxillary and Mandibular
		• Interim dentures can be replaced with a complete denture 180 days after placement of the interim denture. Complete dentures require prior authorization in accordance with this chapter.
		  o DOCUMENTATION REQUIREMENTS. Providers must submit the following documentation with prior authorization request:
		  ▪ Date and list of teeth to be extracted;
		  ▪ Narrative documenting medical necessity; and
		  ▪ Submit panorex or full mouth series
		
		Flipper Partial Dentures, Maxillary and Mandibular

		• Flipper partial dentures, maxillary and mandibular are considered a permanent replacement for one to three anterior teeth.
		  ○ It is not covered for temporary replacement of missing teeth.
		  ○ DOCUMENTATION REQUIREMENTS. Providers must submit the following documentation with prior authorization request:
		  ▪ Chart or list missing teeth and teeth to be extracted;
		  ▪ Age and condition of existing partials, or a statement identifying the prosthesis as an initial placement; and
		  ▪ Radiographs
		
		Tissue Conditioning
		• Covered one time during the first 180 days following placement of a prosthetic appliance.
		• Necessary tissue conditioning may be covered two times per prosthesis every 365 days, with documentation in the dental record.
		
		Dentures and Extensive Treatment Circumstances
		• Plan will review, and consider coverage of:
		  ○ Services that cause the client to exceed the annual coverage limit,
		  ○ Where the client is in need of dentures and extensive treatment in a hospital setting due to a disease or medical condition, or
		  ○ Client is disabled and it is in the best interest of the client's overall health to complete the treatment in a single setting.
		• A prior authorization request must be submitted with medical necessity documentation starting on page 137
		
		Guidelines for Interrupted Denture Delivery starting on page 139
		
		MDS may reimburse providers in the event denture treatment is interrupted and the provider is unable to deliver the final dentures

		to the client. Providers may be reimbursed according to how many stages of the covered denture service they were able to complete prior to interruption. Providers must keep diagnostic models and undelivered dentures for one year before they discard them. Providers may submit claims for each of the following stages in denture treatment: 1) After final impression but BEFORE initial jaw relations- 25% only 2) Final jaw relation to processing (this step is being updated to reflect in the regs)- 50% only 3) If not interrupted, this process doesn't trigger, and provider will submit claim when denture is seated Providers are required to maintain documentation of their attempts to reach the client to complete the denture service. They must make at least three attempts to contact the client within 30 days following the initial appointment-setting attempt. If contact is not made within this period, the provider must send a letter to the client. If there is no response from the client for 30 days after the letter is postmarked, the denture service may be classified as interrupted. If a client returns within 180 days of an interrupted denture service and is still Medicaid eligible, the provider should complete the service and report the delivery at the remaining allowable rate. The total reimbursement will not exceed 100% of the provider's allowable rate for the denture service. After 180 days of interruption, the client must restart the denture process. A client may only be considered interrupted once every 5 years and should not routinely abandon care while in active treatment. If the provider decides to deliver the completed dentures to a member who is no longer Medicaid eligible, the provider may bill the remaining contract rate amount under these circumstances. It is the provider's responsibility to verify member eligibility with MLTC before delivering the dentures. **Procedure:**

		Providers must submit an authorization for D5899, indicating interrupted care and including documentation that supports: • The level of service completion; • The patient's death or failure to return within three months; • Three attempts to contact the patient to schedule an appointment within 30 days of the initial attempt, followed by another 30-day waiting period after mailing a letter. MDS will review the authorization and decide if sufficient documentation is provided. If approved, MDS will define a prorated amount for D5899 based on the allowable rate(s) and stage of completion. Upon approval, the provider may submit a claim for D5899 to receive payment at the authorized amount for the interrupted denture service. If the client returns within 180 days after being considered interrupted, the provider should complete the denture service and submit a claim for the remaining allowable amount. Total reimbursement will not exceed 100% of the allowable rate. After 181 days, the client must restart the denture process. Further interruptions will not be covered by MLTC for five years, and clients may be liable for services beyond this date.
1.8	02/14/2024	Added covered benefits D0190 and D0191 to page 64.
1.9	02/14/2024	Updated date range to ALL for D0330 on page 76
1.10	02/28/2024	Removed and confirm Primary Care Dentist and Dental Home assignment.
1.11	2/29/2024	Updated documentation section of D0120 to determined appropriate by the treating dental provider on page 74.
1.12	2/29/2024	Added A-T in teeth column for D2920 on page 96.

1.13	2/29/2024	Updated documentation required to requires rationale on page 117.
1.14	2/29/2024	Removed narrative documenting medical necessity and on page 137.
1.15	2/29/2024	Removed partial resin base, maxillary or mandibular; adequate occlusion for partial dentures is first molar to first molar, or similar combination of anterior and posterior teeth on the upper or lower arch in occlusion on page 137.
1.16	2/29/24	Removed for initial placement, radiographs for remaining teeth are required on page 138.
1.17	2/29/2024	Removed narrative documenting medical necessity; and on page 139.
1.18	2/29/2024	Removed dentures and extensive treatment circumstances Plan will review and consider coverage of: services that cause the client to exceed the annual coverage limit, where the client is in need of dentures and extensive treatment in a hospital setting due to disease or medical condition, or client is disabled and it is in the best interest of the client's overall health to complete the treatment in a single setting. A prior authorization request must be submitted with medical necessity documentation on page 139
1.19	2/29/2024	Updated Guidelines for Sedation Permits section to be Nebraska specific on page 144.
1.20	2/29/2024	Added bullet point deep sedation/general anesthesia administration requires the presence of the operating dentist and a separate anesthesia provider on page 144.
1.21	3/12/2024	Updated Guidelines for Guidelines for Dental Services Rendered in a Hospital or Ambulatory Surgical Center (ASC) on pages 145-146

1.22	4/9/2024	Updated measure column for D0190 and D0191 on page 78
1.23	4/9/2024	Removed age restriction for D5213 and D5214 on page 103
1.24	4/9/2024	Updated Guidelines for Prosthodontic Services to remove age restriction for D5213 and D5214 on page 137 and 139.
1.25	05/08/2024	Removed statement "Maximum payment per date of service for any combination of codes D0210 – D0330 is the FFS rate for D0330" on page 72.
1.26	10/14/2024	D9219 Evaluation for deep sedation or general anesthesia(ga) all ages, No PA or Post service review 1 per year per patient per provider, provider must have a deep sedation/ga permit on file to provide this service on page 101.
1.27	10/14/2024	D7210 Surgical removal of erupted tooth requiring elevation of mucoperiosteal flap and removal of bone and/or section of tooth all ages, updated to include all teeth 01-32, A-T, 51-82, AS-TS, No AR required, post service review requires x-rays and rationale on page 95
1.28	10/14/2024	Added link to page 59 Molina offers educational opportunities in cultural competency concepts for Providers, their staff, and Community Based Organizations. Molina conducts Provider training during Provider orientation with annual reinforcement training offered through Provider Services and/or online/web-based training modules such as Oral Health Providers - Think Cultural Health (hhs.gov)
1.29	11/19/2024	Added language to page 26 regarding Prior Authorization Extensions. In the event that Molina Healthcare of Nebraska receives a prior authorization service request that requires additional information, outreach to the provider will be completed to obtain the required clinical information (e.g., x-rays, perio chart, rationale). To allow us time to make our decision, we will extend our review by

		fourteen (14) calendar days and a decision will be made no more than 25 days from the request date. If, after the extension, the outstanding clinical information has not been received, the authorization will be denied, and the provider will be instructed to submit a new authorization. If you do not agree, you may file grievance. If you have any questions or need assistance, please call the SKYGEN Provider Contact Center at 855-806-5192, Monday-Friday 7am to 8pm CT.
1.30	12/02/2024	Added language starting on page 123: 599 CHIP Services What is 599 CHIP? The 599 CHIP program is designed for unborn children of pregnant women who are otherwise ineligible for coverage under Medicaid or CHIP. This program is not full Medicaid coverage and only applies to prenatal care and pregnancy-related services. These services are connected to the health of the unborn child (emergency benefits for unborn), including labor and delivery.
1.31	12/02/2024	Updated language and pre-pay review to D9999.
1.32	12/09/2024	Updated Benefit grid to add D5899 for Interrupted Denture Treatment on page 118
2.01	02/122025	Updated Quality Improvement Section pages 54-62
2.02	02/17/2025	Added Artificial Intelligence 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 or not 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. If you have additional questions, please contact your Molina Contract Manager to page 188
2.03	02/17/2025	Replaced "include rationale" with "attach medical necessity" throughout the manual
2.04	02/17/2025	Removed prepayment review from D7111 to page 118.
2.05	02/17/2025	Removed Business Continuity Plan and Replaced Cybersecurity language starting on page 177
2.06	03/17/2025	Updates to benefit grid: D0270- add 1 per day; Max 4 Bitewings per DOS ADDED D0272- add 1 per day; Max 4 Bitewings per DOS ADDED

		D0273- add 1 per day; Max 4 Bitewings per DOS ADDED D0274- add 1 per day; Max 4 Bitewings per DOS ADDED D1354, D1355- edit 3 PER CODE PER TOOTH EVERY YEAR of D1354 or D1355 ALREADY IN MANUAL D1510- add only 1 D1510 or D1575 per year ADDED D1575-add 1 per code per quadrant every year; only 1 D1510 or D1575 per year ADDED D2929- UPDATE C-H, M-R for teeth covered UPDATED D2940- add limit 1 per tooth per lifetime ADDED D2950- add limit 1 per 60 months per tooth; ADDED update Teeth covered 2-5,18-31 UPDATED D2951- add limit 3 per tooth every 12 months ADDED D2954- add 1 per tooth every 60 months ADDED D2980- add 1 per day per tooth ADDED D3220, 3230, 3240, 3310, 3320, 3330, 3346,3347, 3348, 3351, 3410- add 1 per tooth per lifetime ADDED D3230- change teeth covered to C-H, M-R UPDATED D4210, 4211- add 1 per year per quadrant ADDED D5130/5140- add 1 per lifetime ADDED D5511, D5512, D5520, D5611, 5612, 5621, 5622, 5630, 5640, 5650, 5660- add not payable within 180 days of initial placement ADDED D5730/5731/5741/5750/5751/5760/5761- add 1 per year ADDED D5810/5811/5820/5821- add relines and adjustments not covered with 180 days of placement ADDED D6930- add 1 per year, not payable within first 6 months of placement ADDED D7111-D7250 (all extractions)- add 1 per tooth per lifetime ADDED D7471- remove requires path report REMOVED and add requires x-rays and narrative ADDED D7961- add 2 per arch per lifetime ADDED D7962- add 1 per lifetime ADDED D8210/8220- add pre-pay review, add 1 per lifetime, requires photo and narrative ADDED D8696/8697/8698/8699- add 5 per lifetime ADDED D8703/8704- add pre-pay review and add 1 per lifetime, requires narrative ADDED D8999- add requires medical necessity attachment ADDED D9219- edit spelling for 1 per year ADDED

		D9239, D9248- add pre-pay review, add must have appropriate permit; requires narrative, monitored vital signs, anesthesia time log, including start and stop times, medication administered, and dose required ADDED New code to start 7/1/25- D9310 (Consultation- diagnostic service provided by dentist or physician other than requesting dentist or physician) 1 per year ADDED PA AND PPR ARE NO, CORRECT? 9944,9945,9946- add 1 per 3 years ADDED

Delegation

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

- Provider and Member Call Center
- Utilization Management
- Claims
- CMS Preclusion List Monitoring
- Peer to Peer Reviews
- Provider Complaints, Grievances, and Appeals (post-service only)

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 Molina Dental Services at (844) 862-4564 from 8:00 a.m. to 5:00 p.m. CT, Monday through Friday.

SKYGEN Dental Provider Services Department

The SKYGEN Provider Services department conducts Provider trainings on the SKYGEN HUB, inquiries from Providers, including policy and procedure questions, claims issues, and contracting questions.

The SKYGEN Provider Services department handles telephone and written inquiries from Providers regarding address and Tax-ID changes, contracting and training. The department has SKYGEN Provider Services representatives who serve all of Molina's Provider network. Eligibility verifications can be conducted at your convenience via the SKYGEN Dental HUB.

SKYGEN Dental HUB: https://app.dentalHUB.com/app/login
Phone: (855) 806-5192 from 7:00 a.m. to 8:00 p.m. CT, Monday through Friday, TTY: 711

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

Contracting

A signed Dental Provider Service Agreement (DPSA) under the practicing TIN is required. Once your Tax ID has contracted, each provider will be required to complete credentialing. Effective 01/01/2025, Nebraska Medicaid implemented centralized credentialing. Nebraska Medicaid has approved the selection of the Centralized Verification Organization (CVO) by the three Nebraska managed care organizations (MCO) —Nebraska Total Care, Molina Healthcare, and United Healthcare Community Plan—and chose Verisys as the shared CVO vendor.

Credentialing

All Medicaid providers must be enrolled in the Nebraska Medicaid Program to provide Medicaid services in Nebraska. Maximus, the enrollment contractor for the Nebraska Department of Health and Human Services (DHHS), gathers and screens the information entered into their system. For more information please visit https://dhhs.ne.gov/Pages/Medicaid-Provider-Screening-and-Enrollment

Providers can enroll for the first time or update their existing agreement by visiting Maximus's website at www.nebraskamedicaidproviderenrollment.com. Questions about the process should be addressed to Maximus Customer Service. Maximus can be reached by phone and email:

Phone:(844)374-5022 Monday-Friday 8:00am-5:30pm CT

Email: nebraskamedicaidPSE@maximus.com

Mailing Address: MAXIMUS NE Provider Screening and Enrollment
P.O. Box 81890
Lincoln, Nebraska 68501

Verisys will perform a streamlined verification process for all three Nebraska MCOs. This centralized credentialing system aims to eliminate the need for separate credentialing processes with each MCO and aligns with the State of Nebraska's objective to reduce the duration and administrative burdens associated with MCO-specific credentialing processes.

Recredentialing will commence later in 2025. The CVO will conduct recredentialing for providers every three years unless the provider is credentialed by a Nebraska-approved vendor or a delegated credentialing entity. Providers selected for recredentialing will receive notification from Verisys via USPS, sent to the "mail to" address listed on their provider record. The letter will be generated six months before the recredentialing due date to alert providers about recredentialing.

This process adheres to NCQA and CMS federal guidelines for both the procedures and the types of providers subject to credentialing. The following items are required to begin the credentialing process:

- A completed CAQH application, including the Attestation Statement
- Current medical license, when applicable
- Current DEA certificate, when applicable or DEA waiver

- Current professional liability insurance

The CVO will verify licensure, education and training, board certification, and malpractice claims history using primary sources.

Please note that centralized credentialing does not replace the required Medicaid provider enrollment screening process. All Medicaid providers must enroll with the program through Maximus. More information on enrolling in the Nebraska Medicaid Program can be found here: Nebraska Provider Enrollment

For questions regarding credentialing, please contact Verisys customer service at (855) 743-6161.Practice Changes/Updates

Molina Dental Services encourages providers to report changes to your Practice within 30 days to ensure accurate updates to our Provider Online Directory. Changes are required to be submitted in writing by completing a Provider Information Form (PIF) NE PIF.pdf. In addition, all forms can be found on SKYGEN's Dental HUB and Molina's Healthcare Website.

The changes required to be reported include:

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

Forms may be submitted via USPS at:

Molina Healthcare of Nebraska, Inc.
14748 W Center Rd. Suite 104
Omaha, NE 86144
or email to Provider Information Management (PIM) at mdvspim@MolinaHealthcare.com

QUALITY AND PERFORMANCE

Dental Health Quality Assessment and Process Improvement Program

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

Molina's Dental Health QAPI Program objectively and systematically monitors and evaluates the quality and appropriateness of care and services and promotes patient outcomes through monitoring and evaluation activities. Improvement strategies will include performance improvement projects, dental record reviews, performance measures and surveys. Molina will assess the quality and appropriateness of dental care provided to enrollees with special healthcare needs. The program will also detect over and underutilization of dental services.

This program will address components of effective healthcare management and define processes for ongoing monitoring and evaluation that will promote quality of care. High-risk and high-volume areas of patient care will receive priority in the selection of QAPI activities. In addition, the program will define and implement improvements in processes that enhance clinical efficiency, provide effective utilization, and focus on improved outcome management achieving the highest level of success.

Molina's governing body oversees and evaluates the impact and effectiveness of the Dental Health QAPI Program, as well as ensuring the Dental Health QAPI Program is incorporated into the overarching QAPI Program and operations throughout Molina.

Maintaining Quality Improvement Processes and Programs

Molina works with Members and Providers to maintain a comprehensive Dental Health Quality Assessment and Process Improvement Program. You can contact the Molina Quality department at (844) 782-2678, Monday – Friday 7:00 a.m. – 6:00 p.m. CT.

The address for mail requests is:

Molina Healthcare of Nebraska, Inc.
Attn: Quality Department
14748 W. Center Rd. Suite 140
Omaha, NE 68144

The goal of the Molina Dental Health QAPI Program is to continuously ensure that each member has appropriate, timely, accessible, available, and medically necessary delivery of dental services while maintaining established guidelines and standards reflective of the current physical state and behavioral health knowledge. Molina has a Dental QAPI Committee that includes the Molina Nebraska Dental Director as the chairperson, other Molina staff representing various departments, and network providers. The network providers include general dentists and dental specialists that are knowledgeable about the treatment of children, adolescents, and adults and have experience caring for the Medicaid population, including a variety of ages and races/ethnicities, and rural and urban population. This committee will also include member advocate representatives, family members/guardians of children or youth who are Medicaid members and/or Adult Medicaid members.

The Dental Health Quality Assessment and Process Improvement Committee must:

a) Meet on a quarterly basis;
b) Direct and review quality improvement (QI) activities;
c) Ensure that the QI activities are implemented throughout Molina;
d) Review and suggest new and/or improved QI activities;
e) Direct task forces and committees to review areas of concern in the provision of dental services to members;
f) Designate evaluation and study design procedures;
g) Conduct individual dental home and dental home practice quality performance measure profiling;
h) Report findings to appropriate executive authority, staff, and department within Molina;
i) Direct and analyze periodic reviews of members; service utilization patterns;
j) Maintain minutes of all committee and sub-committee meetings and submit a summary of the meeting minutes to the state;
k) Report an evaluation of the impact and effectiveness of the Dental Health QAPI Program annually. This report will include all dental care management activities;
l) Review and approve Molina's Dental Health QAPI Program Description, Work Plan and Annual Program evaluation prior to state submission;
m) Review and approve Dental Utilization Management (UM) clinical practice guidelines annually;
n) Review the Cultural Competency Plan;
o) Study and evaluate issues that may be identified;
p) Establish annual performance targets;
q) Review and approve all member and provider surveys prior to state submission;
r) Define the role, goals, and guidelines for the Dental Health QAPI Committee, set agendas, and produce meeting summaries;
s) Provide training; participation stipends; and reimbursement for travel, child-care, or other reasonable participation costs for members or their family members;

t) Molina will incorporate all recommendations from staff and committees, the results of Performance Improvement Projects, other studies, improvement goals, and other interventions into the Dental Health QAPI Program, Dental Health QAPI Program Description, work plan and annual evaluation;
u) The Dental Health QAPI Committee will perform all the above duties in coordination with the overarching Molina Quality Assessment and Process Improvement Committee.

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

- Healthcare Effectiveness Data and Information Set (HEDIS®)
- Consumer Assessment of Healthcare Providers and Systems (CAHPS ®)
- Provider Satisfaction Survey
- Effectiveness of Quality Improvement Initiatives

Molina evaluates continuous performance according to, or in comparison with objectives, measurable performance standards and benchmarks at the national, regional and/or at the local/health plan level. Contracted Providers and Facilities must allow Molina to use its performance data collected in accordance with the Provider's or facility's contract. The use of performance data may include, but is not limited to, the following: (1) development of Quality Improvement activities; (2) public reporting to consumers; (3) preferred status designation in the network; (4) and/or reduced Member cost sharing. Molina's most recent results can be obtained from your local Molina Quality department or by visiting our website at MolinaHealthcare.com.

A copy of the Dental Health Quality Assessment and Process Improvement (QAPI)Program is available to all participating providers upon request. Please contact the Molina Quality department at (844) 782-2678, Monday – Friday 7:00 a.m. – 6:00 p.m. CT

Your Role in Quality

Every Molina network provider is a participant in the Dental Health Quality Assessment and Process Improvement (QAPI) Program through his or her contractual agreement with Molina. You may be asked to serve on any of the committees that are part of the QAPI Program or contribute to the development of audits, Clinical Practice Guidelines, member education programs, or projects. Participation on a committee is voluntary and encouraged. You can help us identify any issues that may directly or indirectly impact member care by reporting them on an Incident Report Form, which is available to download in the Forms section on the Molina Healthcare Inc. website or SKYGEN Dental HUB. This can be submitted to Molina via fax, email, or regular mail. The Molina Dental Director might contact your office about an incident report.

Please keep a copy of any incident report you file with Molina in the appropriate member's dental record.

Quality Enhancement Programs (Focus Studies)

Molina monitors and evaluates the quality and appropriateness of care and service delivery (or the failure to provide care or deliver services) to members and providers through performance improvement projects (PIPs), dental record reviews, performance measures, surveys, and related activities. As a provider for Medicaid, Molina will perform one (1) or more state-approved PIPs per year. The PIPs will focus on both clinical and non-clinical areas.

Quality Review of Key Clinical and Service Indicators

One of Molina Dental Health Quality Assessment and Process Improvement (QAPI) Program objectives is to perform a quality review of key clinical and service indicators through analysis of member and provider data to assess and improve member and provider satisfaction rates. These clinical and service indicators include reviews of:

- Member and provider complaints about care or service
- Sentinel events (defined as any event involving member care that warrants further investigation for quality-of-care concerns)
- National Committee for Quality Assurance's (NCQA's) Healthcare Effectiveness Data and Information Set (HEDIS®)
- Application of Clinical Practice Guidelines
- Application of appropriate dental record documentation, and continuity and coordination of care standards
- Health outcome intervention studies or activities
- Member claims and encounters
- Member pre-authorizations requests and referrals

In order to support the quality review activities of our QAPI Program, your office is required to make available, upon a request from a Molina representative, the dental records of any Molina member in your care.

Corrective Action

When the Dental Health Quality Assessment and Process Improvement (QAPI) Program identifies specific cases of substandard quality of care during its review process, a letter requesting corrective action will be mailed to the treating provider. There are many forms of corrective action that may be recommended. Some examples of corrective action include:

- A Quality Correction Letter indicating the deficiency or deficiencies and requiring changes to be implemented within a maximum of 60 days (the severity of the deficiency or deficiencies noted will dictate the number of days that the provider has to implement the required changes)
- Special pre-authorization/claims review
- Post-treatment reviews of members by a licensed dentist who serves as a Molina Dental Clinical Reviewer
- Requirement for the provider to attend training sessions or participate in continuing education programs
- Restriction on the acceptance of new members until the provider becomes compliant with all standards of care for a specified amount of time
- Recoupment of sums paid where billing discrepancies are found during reviews
- Restriction on a provider's authorized scope of services.
- Referral of a case to the state Board of Dental Examiners and/or the Department of Justice, Attorney General's Office, and/or Office of Inspector General of the State
- Termination of the Provider Agreement

Where corrective action is recommended, our priority is to work with the provider to improve performance and compliance with all Molina policies and procedures defined in the Dental Provider Service Agreement (DPSA) and this Provider Manual.

Molina is willing to provide support for a provider who shows sincere intent to correct deficiencies.

Member Records - Chart Reviews

Molina establishes and maintains a review process that demonstrates Molina provides care and services that meet or exceed community and professional standards, state contractual requirements and National Committee for Quality Assurance (NCQA) standards and that dental care delivery is continuously and measurably improved in both the inpatient and outpatient/ambulatory care setting. Dental Record Review will be completed on all providers who have treated more than 100 distinct members in a calendar year, whether individual offices or a group practice. Each site will have a random selection of charts selected using a roster of treated patients and a random number generator to select at least 10 records or up to 10% of the patients seen. A minimum of 10 records will be reviewed at each audit. If a passing score is achieved on 10 records, the office is passed. If a passing score is not achieved the full 10% of dental records will be reviewed. The Dental Coordinator will be responsible for conducting dental record reviews and scoring the audit. Results of the audits will be reviewed by the Dental Director and Dental Utilization Management Committee.

The Primary Care Dentist (PCD)/practice will be notified of the audit results by the Dental Coordinator via email within ten (10) business days.

Healthcare Effectiveness Data and Information Set (HEDIS®)

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

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

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

Member Satisfaction Survey - Consumer Assessment of Healthcare Providers and Systems (CAHPS®)

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

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

Provider Satisfaction Survey - The Healthcare Effectiveness Data and Information Set (HEDIS®)

Recognizing that HEDIS® and CAHPS®/Qualified Health Plan Enrollee Experience Survey both focus on Member experience with health care Providers and health plans, Molina conducts a Provider Satisfaction Survey annually. The survey includes but is not limited to:

- Molina response time to provider inquiries and complaints
- Molina communications
- Claims payment process
- Authorization process
- Molina availability and effectiveness

The results from this survey are very 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.

ACCESS REQUIREMENTS

Molina maintains access to care standards and processes for ongoing monitoring of access to health care provided by contracted providers and participating specialists. Providers are required to conform to the Access to Care appointment standards listed below to ensure that health care services are provided in a timely manner. The PCD or their designee must be available 24 hours a day, seven days a week to Members.

Appointment Access

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

Dental Appointment Types	Standard
Emergent	Immediate of Member contact 24 hours a day, 7 days per week
Urgent	Within 24 hours of Member contact
Routine, asymptomatic/symptomatic	Within 6 weeks of Member contact

Office Wait Time

For scheduled appointments, the wait time in offices should not exceed forty-five (45) minutes, including time spent in the waiting room and the examining room, unless the provider is unavailable or delayed because of an emergency. All Primary Care Dentists and Dental Providers are required to monitor waiting times and adhere to this standard. If a provider is delayed, the member should be notified immediately. If a wait of more than ninety (90) minutes is anticipated, the member should be offered a new appointment.

After Hours

All Providers must have back-up (on call) coverage after hours or during the Provider's absence or unavailability. Molina requires Providers to maintain a 24-hour telephone service, seven days a week. This access may be through an answering service or a recorded message after office hours. The service or recorded message should instruct Members with an Emergency to hang-up and call 911 or go immediately to the nearest emergency room. Voicemail alone after hours **is not acceptable.** If not a life-threatening emergency, patient should be instructed to contact PCD the next business day.

Geographic Access Standards

Geographic Access Type	Standard
Dental—General Dentist	• Urban: 2 general dentists within 45 miles of Members • Rural: 1 general dentist within 60 miles of Members • Frontier: 1 general dentist within 100 miles of Members
Dental—Dental Specialists One (1) oral surgeon, one (1) orthodontist, one (1) periodontist, one (1) endodontist, one (1) prosthodontist, and One (1) pedodontist	• Urban: 1 of each specialty within 45 miles of 85% of Members • Rural: 1 of each specialty within 60 miles of 75% of Members • Frontier: 1 of each specialty within 100 miles of 75% of Members

Monitoring Access for Compliance with Standards

Access to care standards are reviewed, revised as necessary, and approved by the Dental Health Quality Assessment and Process Improvement (QAPI) Committee on an annual basis.

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

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

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

Monitoring for Compliance with Standards

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

PROVIDER ROLES AND RESPONSIBILITIES

Provider Rights

Providers have the right to:

- Be treated by their patients and other health care workers with dignity and respect.
- Receive accurate and complete information and medical histories for Members' care.
- Have their patients act in a way that supports the care given to other patients and that helps keep the doctor's office, hospital, or other offices running smoothly.
- Expect other network Providers to act as partners in Members' treatment plans.
- Expect Members to follow their directions.
- File a complaint/grievance or file a Claim appeal against Molina.
- File a grievance with Molina on behalf of a member, with the Member's consent.
- File an appeal with Molina on the behalf of the Member, with the Member's consent.

- Have access to information about Molina quality improvement programs, including program goals, processes, and outcomes that relate to Member care and services.
- Contact the Molina Provider Services department with any questions, comments, or problems.
- Collaborate with other health care professionals who are involved in the care of Members.

Quality of Provider Office Sites

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

- Physical Accessibility.
- Physical Appearance.
- Adequacy of Waiting and Examining Room Space.

Physical Accessibility

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

Physical Appearance

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

Adequacy of Waiting and Examining Room Space

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

Administration & Confidentiality of Facilities

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

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

EPSDT Services to Enrollees Under 21 Years of Age

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

Dental Home/Primary Care Dentist Role and Responsibility

Molina Healthcare Inc. defines a Primary Care Dentist as the Provider of Dental Home services. Establishment of a Member's Primary Care Dentist begins no later than six months of age. Nebraska defines the Dental Home in accordance with the American Academy of Pediatric Dentistry (AAPD) as an ongoing relationship between the dentist and the patient, inclusive of all aspects of oral health care delivered in a comprehensive, continuously accessible, coordinated, and family-centered way. Principles for Dental Homes include:

- Care that is comprehensive and includes acute, corrective, and preventative services.
- Care that is individualized to each Member based upon a dental exam for tooth decay and gum problems.
- Care that is preventative and includes information about proper care for the Member's teeth and gums, and correct diet.
- For children, care prepares parents and guardians with guidance about what to expect for their child's age for the growth of teeth and the jaw.
- For children, care is educational and helps parents and guardians learn about their child's dental health now and as their child grows.
- Care that is provided in a culturally competent manner.

Within a Dental Home, dental care experts work together as a team with the Member and/or the Member's family to ensure that the Member receives the care they need. Primary Care Dentists (PCDs) include general or pediatric dentists that practice in solo or group practices, and the following facilities:

- Federally Qualified Health Centers, Rural Health Clinics, or Indian Health Service facilities. PCDs provide preventive care and therapeutic care to Members.
- Members are encouraged to select their own primary care dentist (PCD) to serve as their Dental Home. They may change their PCD any time by contacting Molina Healthcare Inc.'s toll-free Member Hotline. When a member does not select a Primary Care Dentist, Molina Healthcare Inc. will auto-assign to a Primary Care Dentist.
- Providers who are not in good standing are not considered during the auto-assignment methodology.

Molina Healthcare Inc. strives to keep families together.

If a member of a family is assigned to a PCD, other Members of the same family will be assigned to the same PCD. However, if the PCD has age restrictions that would prevent a family Member from being assigned, we will assign that family Member to another PCD in the same office that meets the age restrictions if possible.

If there is historical Claims data available that identifies a dentist that performed dental services on the Member, we will assign the Member to such dentist, as long as the dentist is a participating PCD that meets the age restrictions and travel distance requirement for the Member.

For each Member that needs to be auto assigned to a PCD, we will generate a pool of Participating PCDs that meet the age restrictions of the Member who are located near the Member's residence address. The search radius will be increased until a PCD is located for assignment within the time and distance requirements of the plan.

Once a pool of Providers is generated, Members living within that radius needing auto-assignment will be assigned to PCDs from this pool in a random sequence to equalize the patient load amongst Providers within such radius. Participating Providers must offer the same services to a Medicaid Member as those offered to a non-Medicaid patient provided these services are reimbursable by the Medicaid program. In addition, Participating Providers have the responsibility to develop a Provider-Member relationship based on trust and cooperation. Coordination of care strengthens the positive relationship between the Member and Provider and is a critical tool for achieving positive oral health outcomes. Dental Home Providers are required to educate Members about the importance of good oral hygiene and timely preventive care such as sealants, cleanings, and fluoride applications.

For Members ages 6-35 months of age, the education efforts are focused around providing anticipatory guidance to the parents or guardians to establish a lifetime of healthy dental habits. All PCDs are required to educate Members about what to do in a dental emergency. The PCD is responsible for coordination with other involved health care Providers in the case of acute dental trauma or in situations involving Members with cleft or craniofacial anomalies. Within the Dental Home, dental care experts work together as a team with a member's family to ensure that the child receives the services they need. Dental Home Providers must assess the dental needs of Members for referral to specialty care Providers and provide referrals as needed. The PCD must ensure that an appropriate referral is made as expediently as the patient's clinical condition requires. The PCD/Dental Home must coordinate the Member's care with specialty care Providers after a referral takes place and ensure that all appropriate treatment was received.

PCDs are responsible to:

- 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

PCD Assignment

Molina Members are allowed to select an in-network PCD at the time of enrollment. If no PCD is selected, one will be assigned by Molina. Molina must provide members in urban counties with two (2) general dentists within 45 miles of their personal residences. Molina must provide members in rural counties with one (1) general dentist within 60 miles of their personal residences. Molina must provide members in frontier counties one (1) general dentist within 100 miles of their personal residence. Molina must provide 85% of members in urban counties with one (1) pediatric dentist within 45 miles of their personal residence. Molina must provide 75% of members in rural counties one (1) pediatric dentist within 60 miles of their personal residence. Molina must provide 75% of members in frontier counties with one (1) pediatric dentist within 100 miles of their personal residence.

PCD Changes

Members may change their PCD at any time. Members who wish to change their PCD may call Molina Member Services at (844) 782-2018 Monday through Friday from 8:00 a.m. to 6 p.m. CT.

PCD Responsibilities in Case Management Referrals

The Member's PCD is the primary leader of the oral health team involved in the coordination and direction of services for the Member. The PCD is responsible for the provision of preventive services and for the primary oral care of Members.

What is Medical Case Management?

Case management (CM) is a collaborative process that assesses, plans, implements, coordinates, monitors, and evaluates the options and services required to meet the beneficiaries' health and human service needs. It is characterized by advocacy, communication, and resource management and promotes quality and cost-effective interventions and outcomes.

When should a PCD refer to CM? Catastrophic dental conditions (treatment on ten or more teeth at the same time), Dental Care during Pregnancy, Cleft Palate.

What other information can Molina's Dental Care Coordination help with?

- Complete medication list
- Recent lab results (HbA1c, INR)
- History of bisphosphonate use
- Clearance for chemotherapy/radiation, transplant
- History of recent stroke/MI or heart surgery (stint, valve replacement)

- Joint replacement pre-medication
- Use and adjustment of blood thinners

To refer a member to case management:

- E-mail to MHN_DentalCareCoordination@MolinaHealthcare.com (please indicate "urgent" if applicable), this link is included in the SKYGEN Dental HUB

Please include:

- Name of PCD
- Patient name
- Medicaid ID number
- Reason for referral

Participation in Quality Programs

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

- Access to Care Standards
- Site and Medical Record-Keeping Practice Reviews as applicable
- Delivery of Patient Care Information

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

Public Health Dental Hygienist Role and Responsibilities

Nebraska defines a public health dental hygienist as an individual who has a public health permit that allows for specific services to be completed without direct supervision of a dentist. These services can be completed in a health care or related facility defined as a hospital, a nursing facility, an assisted living facility, a correctional facility, a tribal clinic, or a school based preventive health program. A public health setting means a federal, state, or local public health department or clinic, community health center, or similar program or agency that primarily serves public health care program recipients.

The following procedure codes are covered under a public health dental hygienist:

- Dental prophylaxis (Adult) Oral prophylaxis, periodontal scaling, and root planing which includes supragingival and subgingival debridement; Polish all exposed tooth surfaces, including restorations; Conduct and assess preliminary charting, probing, screening

examinations, and indexing of dental and periodontal disease, with referral, when appropriate, for a dental diagnosis by a licensed dentist

- Dental prophylaxis (Child) Oral prophylaxis, periodontal scaling, and root planing which includes supragingival and subgingival debridement; Polish all exposed tooth surfaces, including restorations; Conduct and assess preliminary charting, probing, screening examinations, and indexing of dental and periodontal disease, with referral, when appropriate, for a dental diagnosis by a licensed dentist
- Topical fluoride varnish
- Topical application of fluoride
- Dental Sealant
- Interim Caries Arresting Medicament Application - Per Tooth

Specialist Role and Responsibilities

The role of the specialist (Endodontist, Orthodontist, Oral Surgeon, Pediatric Dentist, Periodontist, and Prosthodontist) is to provide covered services to members for medically necessary treatment. Once treatment is complete, the specialist discharges the member back to their Primary Care Dentist for follow-up. Molina allows Pediatric Dentists to serve as PCDs for our pediatric members.

Medically Necessary Services

The following guidelines are found in the Nebraska Administrative code, 471 NAC 1.002.02A: Medical Necessity. Not all state Medicaid Programs have the same definition.

The Nebraska Medical Assistance Program (NMAP) uses the following definition of medical necessity:

1. Health care services and supplies which are medically appropriate and:
2. Necessary to meet the basic health needs of the client;
3. Rendered in the most cost-efficient manner and type of setting appropriate for the delivery of the covered service; Consistent in type, frequency, duration of treatment with scientifically based guidelines of national medical, research, or healthcare coverage organizations or governmental agencies;
4. Consistent with the diagnosis of the condition;
5. Required for means other than convenience of the client or his or her provider;
6. No more intrusive or restrictive than necessary to provide a proper balance of safety, effectiveness, and efficiency; and
7. Relative to the goal of improved patient health outcomes.

Preventive Treatment

The American Academy of Pediatric Dentistry (AAPD) recognizes that caries risk assessment and management can assist with oral health education and lead to the prevention of dental caries. PCDs must perform the completion of a caries risk assessment as part of comprehensive oral examination. Documentation and the completion of the caries risk assessment tool should be used and maintained in the member's dental record. These are essential elements of preventive oral health care services for members under the age of 21. The guidelines on caries risk assessment and management can be found on the ADA website at www.ada.org.

Members under age 21 should be encouraged to return for a recall visit as frequently as indicated by their individual oral health status and within plan time parameters in accordance with EPSDT guidelines. It is important that each dental office has a recall procedure in place. The following should be accomplished at each recall visit:

- Update medical history
- Review of oral hygiene practices and necessary instruction provided
- Complete prophylaxis and periodontal maintenance procedures
- Topical application of fluoride, if indicated
- Sealant application, if indicated

Please refer to the American Academy of Pediatric Dentistry's recommendations for treatment of pediatric patients by age below for further guidance.

Nondiscrimination in Health Care Service Delivery

Providers must comply with the nondiscrimination in health care service delivery requirements as outlined in the Cultural Competency and Linguistic Services section of this Dental Provider Manual.

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

Section 1557 Investigations

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

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

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

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

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

Facilities, Equipment and Personnel

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

Provider Data Accuracy and Validation

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

Maintaining an accurate and current Provider Directory is a State and Federal regulatory requirement, as well as an NCQA required element. Invalid information can negatively impact Member access to care, Member/PCD assignments and referrals. Additionally, current information is critical for timely and accurate Claims processing.

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

- Change in office location(s)/address, office hours, phone, fax, or email.
- Addition or closure of office location(s).
- Addition of a Provider (within an existing clinic/practice).
- Change in Provider or practice name, Tax ID, and/or National Provider Identifier (NPI).

- Opening or closing your practice to new patients
- Change in specialty.
- Any other information that may impact Member access to care.

For Provider terminations (within an existing clinic/practice), Providers must notify Molina in writing in accordance with the terms specified in your Provider Agreement.

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

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

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

National Plan and Provider Enumeration System (NPPES) Data Verification

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

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

Molina supports the CMS recommendations around NPPES data verification and encourages our Provider network to verify Provider data via nppes.cms.hhs.gov. Additional information regarding the use of NPPES is available in the Frequently Asked Questions (FAQ) document published at the following link: cms.gov/Medicare/Health-Plans/ManagedCareMarketing/index.

Molina Electronic Solutions Requirements

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

Electronic Claims include Claims submitted via a clearinghouse using the EDI process and Claims submitted through the SKYGEN Dental HUB. Molina is committed to complying with all HIPAA Transactions, Code Sets, and Identifiers (TCI) standards. Providers must comply with all HIPAA requirements when using electronic solutions with Molina. Providers must obtain a National Provider Identifier (NPI) and use their NPI in HIPAA Transactions, including Claims submitted to Molina. Providers may obtain additional information by visiting Molina's HIPAA Resource Center located on our website at MolinaHealthcare.com.

Electronic Solutions/Tools Available to Providers

Electronic Tools/Solutions available to Molina Providers include:

- Electronic Claims Submission Options
- Electronic Payment: EFT with ERA
- SKYGEN Dental HUB

Electronic Claims Submission Requirement

Molina strongly encourages Participating Providers to submit Claims electronically whenever possible.

Molina offers the following electronic Claims submission options:

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

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

SKYGEN Dental HUB

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

- Verify Member eligibility and Covered Services
- Claims:
  - Submit Claims with attached files
  - Correct/Void Claims
  - Add attachments to previously submitted Claims
  - Check Claims status
  - View Electronic Remittance Advice (ERA) and Explanation of Payment (EOP)
  - Create and submit a Claim Appeal with attached files
- Prior Authorizations/Service Requests
  - Create and submit Prior Authorization/Service Requests
  - Check status of Authorization/Service Requests
- Download forms and documents

Balance Billing

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

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

Treatment Alternatives and Communication with Members

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

Compliance

Providers must comply with all State and Federal Laws and regulations related to the care and management of Molina Members.

Confidentiality of Member Health Information and HIPAA Transactions

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

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

Patient Safety Program

Molina's Patient Safety Program identifies appropriate safety projects and error avoidance for Molina Members in collaboration with their PCPs. Molina continues to support safe personal health practices for our Members through our safety program, pharmaceutical management, care management/disease management programs and education. Molina monitors nationally recognized quality index ratings for facilities, including adverse events and hospital-acquired conditions. This is part of a national strategy to improve health care quality mandated by the Patient Protection and Affordable Care Act (ACA) and Health and Human Services (HHS). This aids in identifying areas that have the potential for improving health care quality to reduce the incidence of events.

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:

- All medical and dental healthcare professionals.
- Public or private school employees or childcare givers.
- Psychologists, social workers, family protection workers, or family protection specialists.
- Attorneys, ministers, or law enforcement officers.

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

Child Abuse

Report suspected abuse or neglect to the Child Abuse and Neglect Hotline at (800) 652-1999.

For additional information, reach out to DHHS at DHHS.ChildrenandFamilyServices@nebraska.gov.

Adult Abuse

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

Report suspected abuse or neglect of a vulnerable adult to Adult Protective Services at (800) 652-1999.

Molina's Health Care Services (HCS) teams will work with PCPs and Medical Groups/Independent Physician Group (IPA) and other delegated entities who are obligated to communicate with each other when there is a concern that a member is being abused. Final actions are taken by the PCP/Medical Group/IPA, other delegated entities, or other clinical personnel. Under State and Federal Law, a person participating in good faith in making a report or testifying about alleged abuse, neglect, abandonment, financial exploitation, or self-neglect of a vulnerable adult in a judicial or administrative proceeding may be immune from liability resulting from the report or testimony.

Molina will follow up with Members that are reported to have been abused, exploited, or neglected to ensure appropriate measures were taken, and follow up on safety issues. Molina will track, analyze, and report aggregate information regarding abuse reporting to the Health Care Services Committee and the proper State agency.

Participation in Grievance and Appeals Programs

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

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

Participation in Credentialing

Providers are required to participate in Molina's credentialing and re-credentialing process and will satisfy, throughout the term of their contract, all credentialing and re-credentialing criteria established by Molina and applicable accreditation, State and Federal requirements. This includes providing prompt responses to Molina's requests for information related to the credentialing or re-credentialing process.

Providers must notify Molina no less than 30 days in advance when they relocate or open an additional office.

More information about Molina's Credentialing program, including Policies and Procedures, is available in the Credentialing and Recredentialing section of this Dental Provider Manual.

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.

CULTURAL COMPETENCY AND LINGUISTIC SERVICES

Molina works to ensure all Members receive culturally competent care across the service continuum to reduce health disparities and improve health outcomes. The Culturally and Linguistically Appropriate Services in Health Care (CLAS) standards published by the U.S. Department of Health and Human Services (HHS), Office of Minority Health (OMH) guide the activities to deliver culturally competent services. Molina complies with Section 1557 of the Patient Protection and Affordable Care Act, prohibiting discrimination in health programs and activities receiving federal financial assistance on the basis of race, color, national origin, sex, age, and disability per title VI of the Civil Rights Act of 1964, title IX of the Education Amendments of 1972, the Age Discrimination Act of 1975, and Section 504 of the Rehabilitation Act of 1975 (29 U.S.C. § 794). Molina complies with applicable portions of the Americans with Disabilities act of 1990. Molina also complies with all implementing regulations for the

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

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

- Additional information on cultural competency and linguistic services is available at MolinaHealthcare.com, from your local MDS Provider Services representative and by calling SKYGEN Provider Services at: (855) 806-5192 from 7 a.m. to 8:00 p.m. CT, Monday through Friday.

Nondiscrimination in Health Care Service Delivery

Providers must comply with the nondiscrimination in health care service delivery requirements as outlined in the Cultural Competency and Linguistic Services section of this Provider Manual. Additionally, Molina requires Providers to deliver services to Molina Members without regard to source of payment. Specifically, Providers may not refuse to serve Molina Members because they receive assistance with cost sharing from a government-funded program Section 1557 Investigations

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

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

Cultural Competency

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 Services and/or online/web-based training modules such as Oral Health Providers - Think Cultural Health (hhs.gov)

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

1. Provider written communications and resource materials.
2. On-site cultural competency training.
3. Online cultural competency provider training modules.
4. Integration of cultural competency concepts and nondiscrimination of service delivery into Provider communications.

Integrated Quality Improvement – Ensuring Access

Molina ensures Member access to language services such as oral interpretation, American Sign Language (ASL), and written translation. Molina ensures access to programs, aids, and services which uphold culturally congruent care, which is provided. Molina supports Members with disabilities and assists Members with limited English proficiency (LEP).

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

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

Access to Interpreter Services

Providers must provide their own translation services and bill Molina for the service. Please see PB 24-22 at:
https://dhhs.ne.gov/Medicaid%20Provider%20Bulletins/Provider%20Bulletin%2024-22.pdf

. Molina Members are not charged for interpretation services.

Molina Providers 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.

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

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

Members Who Are Deaf or Hard of Hearing

Molina provides a TTY/TDD connection accessible by dialing 711. This connection provides access to Member Services, Quality, Health Care Services, and all other health plan functions.

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

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

Nurse Advice Line

Molina provides Nurse Advice Services for Members 24 hours per day, seven days per week. The Nurse Advice Line provides access to 24-hour interpretive services. Members may call Molina's Nurse Advice Line directly: (844) 782-2721 or TTY/TDD 711. The Nurse Advice Line telephone numbers are also printed on membership cards.

Program and Policy Review Guidelines

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

- Annual collection and analysis of race, ethnicity, and language data from:
  - Eligible individuals to identify significant 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 CAHPS®/Qualified Health Plan Enrollee Experience survey results for potential cultural and linguistic disparities that prevent Members from obtaining the recommended key chronic and preventive services.

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:

- Medical record confidentiality and release of dental records within medical and behavioral health care records.
    - Each Member is entitled to a copy of their dental record at no cost.
    - Upon notification of 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.
    - MLTC is not required to obtain written approval from a member before requesting the Member's dental record from the PCD or any other organization or agency.
- Molina Healthcare of Nebraska must afford **Medicaid and Long-Term Care** MLTC access to all Members' dental records, whether electronic or paper, in the form, manner, and deadline directed by MLTC.
- Medical 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. Medical records are maintained and should include the following information:

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

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

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

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 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.
- Medical Records are protected from unauthorized access.
- Access to computerized confidential information is restricted.
- Precautions are taken to prevent inadvertent or unnecessary disclosure of protected health information.
- Education and training for all staff on handling and maintaining protected health care information.

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

MEMBER ELIGIBILITY, ENROLLMENT & DISENROLLMENT

Nebraska Medicaid Dental Program

Nebraska DHHS determines eligibility for the Medicaid Program. Payment for services rendered is based on eligibility and benefit entitlement. The effective date of enrollment will be 12:01 a.m. on the first calendar day of the month of Medicaid eligibility. The Contractual Agreement between Providers and Molina places the responsibility for eligibility verification on the Provider of services.

Eligibility

The goals of the Nebraska Medicaid Dental Program are to provide medically necessary dental services for children, pregnant women, and adults.

To be eligible for the Nebraska Medicaid Dental Program, Nebraskans need to be identified as being in one (1) of the following categories:

- Children through the age of 18
- Adults aged 19 or older
- Pregnant women aged 19 or older
- An individual who is blind or disabled according to Social Security Administration criteria

The following eligibility criteria must also be met:

- Being a resident of the State of Nebraska

- Be a citizen or legal immigrant
- Have resources that do not exceed the program resource limits
- Maintain a household income that is less than the program income limits for their household size

Due to possible eligibility status changes, the information provided does not guarantee payment. Nebraska Medicaid eligibility information is available at: https://iserve.nebraska.gov/

Molina Member ID Cards

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

Possession of a Molina ID Card does not mean a recipient is eligible for Medicaid services. A Provider should verify a recipient's eligibility each time the recipient receives services. The

verification sources can be used to verify a recipient's enrollment in a managed care plan. The name and telephone number of the managed care plan are given along with other eligibility information.

Disenrollment

A disenrollment is a change in a member's enrollment from one Heritage Health plan to another. A Molina member may request a change from Molina to another Heritage Health Plan. The effective date will be the first day of the month following the month of the approval determination. MLTC will allow for a disenrollment as follows:

- With cause, at any time.
- During the 90 days following the date of the member's initial enrollment with the Heritage Health plan, or the date MLTC sends the member's notice of enrollment, whichever is later.
- During the designated open enrollment period.
- Upon automatic reenrollment if the temporary loss of Medicaid eligibility has caused the member to miss the annual disenrollment opportunity; or
- If MLTC imposes the established intermediate sanctions on the Heritage Health plan.

With Cause Disenrollment

A Molina member may request a change from Molina to another Heritage Health plan for one of the following reasons:

- Molina does not, because of moral or religious objections, cover the service the member seeks
- The member needs related services (for example a cesarean section and a tubal ligation) to be performed at the same time; not all related services are available within the network; and the member's primary care provider or another provider determines that receiving the services separately would subject the member to unnecessary risk
- Other reasons, including but not limited to, poor quality of care, lack of access to providers experienced in dealing with the member's health care needs or lack of access to services covered under the contract; or
- MLTC and Molina contract termination.

If a member would like to request a With Cause Disenrollment they can contact Heritage Health Monday – Friday 7am – 7pm CT at 1-888-255-2605.With Cause disenrollment does not preclude Members from filing a grievance with Molina for incidents occurring during the time they were covered.

Molina Disenrollment Requests

Molina may request that a member be disenrolled from our plan and re-enrolled in another plan. Molina may not request disenrollment because of a Member's health diagnosis; adverse change in health status; utilization of dental services; diminished medical capacity; pre-existing dental condition; refusal of dental care or diagnostic testing; uncooperative or disruptive behavior resulting from their special needs, unless it seriously impairs Molina's ability to furnish services to the Member or other Molina Members; or the Member attempts to exercise their rights under Molina's grievance system, or attempts to exercise their right to change, for cause, the PCD that they chose or was assigned (42 CFR § 438.56(b)(2)).

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

- The member's condition or illness would be better treated by another Heritage Health plan
- Molina has established fraud, forgery, or has evidence of unauthorized use or abuse of services by the member

BENEFITS AND COVERED SERVICES

This section provides an overview of the dental benefits and Covered Services for Molina Heritage Health Members. Some benefits may have limitations which may not all be outlined in the summary table below. If there are questions as to whether a service is covered or requires prior authorization, please reference the prior authorization tools located on the Molina website and the SKYGEN Dental HUB. You may also contact SKYGEN Provider Services at (855) 806-5192 from 7:00 a.m. to 8:00 p.m. CT, Monday through Friday.

Services Covered by Molina

Molina covers, at a minimum, core benefits and services specified in our Agreement with Nebraska Medicaid, DHHS and defined in the Nebraska Administrative Code, Division of Medicaid policies and procedure handbook. Please refer to the Nebraska Medicaid website for additional information at https://dhhs.ne.gov/Pages/medicaid-and-long-term-care.aspx.

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 Dental HUB. You may also contact SKYGEN Provider Services at (855) 806-5192, 7:00 a.m. to 8:00 p.m. CT Monday through Friday.

Dental Benefits (Services are covered at minimum in accordance with 471 NAC 6)

CODE	DESCRIPTION	AGE	TEETH/ COMMENT	PA	PREPAY REVIEW REQUIRED	BENEFIT LIMIT	MEASURE	DOCUMENTATION REQUIRED
D0120	PERIODIC ORAL EXAMINATION	ALL		NO	NO *FREQUENCY EXCEPTIONS ONLY	AGE 20 AND YOUNGER: COVERED ONCE EVERY 175 DAYS. AGE 21 AND OLDER: COVERED ONCE EVERY 180 DAYS. NOT REIMBURSABLE IF PROCEDURE CODE D0145 OR D0150 HAS BEEN REIMBURSED TO THE SAME BILLING PROVIDER, FACILITY, OR GROUP WITHIN THE PRIOR SIX-MONTH PERIOD FOR THE SAME MEMBER. SPECIAL NEEDS AND DISABLED: COVERED AT THE FREQUENCY DETERMINED APPROPRIATE BY THE TREATING DENTAL PROVIDER. A CLIENT WITH SPECIAL NEEDS IS A CLIENT WHO IS UNABLE TO CARE FOR THEIR MOUTH PROPERLY ON THEIR OWN BECAUSE OF A DISABLING CONDITION. SUBMIT CODE D9997 WITH A NARRATIVE TO IDENTIFY A MEMBER WITH SPECIAL HEALTH CARE NEEDS. EXCEPTION FREQUENCY NOT TO EXCEED ONE EVERY 90 DAYS.	PER PATIENT PER (PROVIDER OR LOCATION)	SUBMIT CODE D9997 WITH A NARRATIVE TO IDENTIFY A MEMBER WITH SPECIAL HEALTH CARE NEEDS. EXCEPTION FREQUENCY DETERMINED APPROPRIATE BY THE TREATING DENTAL PROVIDER.
D0140	LIMITED ORAL EVALUATION - PROBLEM FOCUSED	ALL		NO	YES	LIMITED TO TWO IN A TWELVE-MONTH PERIOD FOR EACH CLIENT. AS A VAB, TWO ADDITIONAL D0140S ARE COVERED WITHIN A TWELVE-MONTH PERIOD. COVERED FOR TREATMENT OF A SPECIFIC PROBLEM AND/OR DENTAL EMERGENCIES, TRAUMA, ACUTE INFECTIONS, ETC. NOT PAYABLE FOR FOLLOW-UP CARE.	PER PATIENT	DOCUMENTATION THAT SPECIFIES MEDICAL NECESSITY IS REQUIRED.

CODE	DESCRIPTION	AGE	TEETH/ COMMENT	PA	PREPAY REVIEW REQUIRED	BENEFIT LIMIT	MEASURE	DOCUMENTATION REQUIRED
D0145	ORAL EVALUATION FOR A PATIENT UNDER THREE YEARS OF AGE AND COUNSELING WITH PRIMARY CAREGIVER	0-3		NO	NO *FREQUENCY EXCEPTIONS ONLY	1 PER EVERY 175 DAYS. COVERED MORE FREQUENTLY IF NEEDED FOR TREATMENT. ATTACH MEDICAL NECESSITY FOR THE NEED FOR MORE FREQUENT EVALUATION WITH CLAIM SUBMISSION. NOT REIMBURSABLE IF PROCEDURE CODE D0120 OR D0150 HAS BEEN REIMBURSED TO THE SAME BILLING PROVIDER, FACILITY, OR GROUP WITHIN THE PRIOR SIX-MONTH PERIOD FOR THE SAME MEMBER. IN ADDITION, PROCEDURE CODES D0120 AND D0140 ARE NOT REIMBURSABLE IF PROCEDURE CODE D0145 HAS BEEN REIMBURSED TO THE SAME BILLING PROVIDER, FACILITY, OR GROUP WITHIN THE PRIOR SIX-MONTH PERIOD FOR THE SAME MEMBER.	PER PATIENT PER (PROVIDER OR LOCATION)	ATTACH MEDICAL NECESSITY FOR THE NEED FOR MORE FREQUENT EVALUATION WITH CLAIM SUBMISSION.
D0150	COMPREHENSIVE ORAL EVALUATION - NEW OR ESTABLISHED PATIENT	ALL		NO	NO	1 PER CODE EVERY 3 YEARS. NOT REIMBURSABLE IF PROCEDURE CODE D0120 OR D0145 HAS BEEN REIMBURSED TO THE SAME BILLING PROVIDER, FACILITY, OR GROUP WITHIN THE PRIOR SIX-MONTH PERIOD FOR THE SAME MEMBER. NOT PAYABLE IN CONJUNCTION WITH EMERGENCY TREATMENT VISITS, DENTURE REPAIRS, OR SIMILAR APPOINTMENTS	PER PATIENT PER (PROVIDER OR LOCATION)	
D0160	DETAILED AND EXTENSIVE ORAL EVALUATION - PROBLEM FOCUSED, BY REPORT	ALL		NO	NO	1 PER CODE EVERY 3 YEARS. NOT PAYABLE IN CONJUNCTION WITH EMERGENCY TREATMENT VISITS, DENTURE REPAIRS, OR SIMILAR APPOINTMENTS	PER PATIENT PER (PROVIDER OR LOCATION)	
D0170	RE-EVALUATION-LIMITED, PROBLEM FOCUSED	ALL		NO	NO	1 PER CODE EVERY YEAR NOT PAYABLE FOR ROUTINE POST OPERATIVE FOLLOW-UP	PER PATIENT	
D0171	RE-EVALUATION-POST OPERATIVE OFFICE VISIT	ALL		NO	NO	1 PER CODE EVERY YEAR.	PER PATIENT	
D0180	COMPREHENSIVE PERIODONTAL EVALUATION - NEW OR	ALL		NO	NO	1 PER CODE EVERY 3 YEARS. NOT PAYABLE ON SAME DATE OF SERVICE AS D0120, D0140, D0150, D0160 OR D0170. NOT PAYABLE IN CONJUNCTION WITH	PER PATIENT PER (PROVIDER OR LOCATION)	

CODE	DESCRIPTION	AGE	TEETH/ COMMENT	PA	PREPAY REVIEW REQUIRED	BENEFIT LIMIT	MEASURE	DOCUMENTATION REQUIRED
	ESTABLISHED PATIENT					EMERGENCY TREATMENT VISITS, DENTURE REPAIRS, OR SIMILAR APPOINTMENTS		
D0190	Screening of a patient. A screening, including state or federally mandated screenings, to determine an individual's need to be seen by a dentist for a diagnosis.	ALL		NO	NO	2 SERVICES IN A 12-MONTH PERIOD. A LICENSED PUBLIC HEALTH DENTAL HYGIENIST IS ABLE TO SUBMIT A CLAIM FOR THIS CODE WHEN PERFORMING THIS SERVICE IN A PUBLIC HEALTH SETTING	PER PATIENT PER (PROVIDER OR LOCATION)	
D0191	Assessment of a patient. A limited clinical inspection that is performed to identify possible signs of oral or systemic disease, malformation, or injury, and the potential need for referral for diagnosis and treatment.	ALL		NO	NO	2 SERVICES IN A 12-MONTH PERIOD. A LICENSED PUBLIC HEALTH DENTAL HYGIENIST IS ABLE TO SUBMIT A CLAIM FOR THIS CODE WHEN PERFORMING THIS SERVICE IN A PUBLIC HEALTH SETTING	PER PATIENT PER (PROVIDER OR LOCATION)	
D0210	INTRAORAL-COMPLETE SERIES (INCLUDING BITEWINGS)	ALL		NO	NO	1 D0210 EVERY 3 YEARS. NOT ALLOWED FOR AN EMERGENCY SERVICE.	PER PATIENT PER (PROVIDER OR LOCATION)	TOTAL COST OF PERIAPICALS AND OTHER RADIOGRAPHS CANNOT EXCEED THE PAYMENT FOR A COMPLETE SERIES D0210. INTRAORAL - COMPLETE SERIES - COVERED EVERY THREE YEARS D0240 OCCLUSAL FILM IS 2 ¼ X 3 ¼ SIZE BITEWING MAXIMUM OF 4 PER DATE OF SERVICE. FREQUENCY EXCEPTION- MUST INCLUDE RATIONAL FOR THE NEED FOR MORE FREQUENT PANOREX WITH CLAIM SUBMISSION.
D0220	INTRAORAL - PERIAPICAL-FIRST FILM	ALL		NO	NO	LIMITED TO 1 SERVICE PER DAY	PER PATIENT PER (PROVIDER OR LOCATION)	

CODE	DESCRIPTION	AGE	TEETH/ COMMENT	PA	PREPAY REVIEW REQUIRED	BENEFIT LIMIT	MEASURE	DOCUMENTATION REQUIRED
D0230	INTRAORAL - PERIAPICAL EACH ADDITIONAL FILM	ALL		NO	NO	MAX REIMBURSEMENT LIMITED TO D0210	PER PATIENT PER (PROVIDER OR LOCATION)	
D0240	INTRAORAL-OCCLUSAL FILM	ALL		NO	NO	LIMITED TO 2 SERVICES IN A SIX-MONTH PERIOD.	PER PATIENT PER (PROVIDER OR LOCATION)	
D0270	BITEWING-EACH FILM	ALL		NO	NO	LIMITED TO 1 SERVICE PER DAY, MAX 4 BITEWINGS PER DOS	PER PATIENT PER (PROVIDER OR LOCATION)	
D0272	BITEWING-TWO FILMS	ALL		NO	NO	LIMITED TO 1 SERVICE PER DAY, MAX 4 BITEWINGS PER DOS	PER PATIENT PER (PROVIDER OR LOCATION)	
D0273	BITEWINGS - THREE FILMS	ALL		NO	NO	LIMITED TO 1 SERVICE PER DAY, MAX 4 BITEWINGS PER DOS	PER PATIENT PER (PROVIDER OR LOCATION)	
D0274	BITEWING-FOUR FILMS	ALL		NO	NO	LIMITED TO 1 SERVICE PER DAY, MAX 4 BITEWINGS PER DOS	PER PATIENT PER (PROVIDER OR LOCATION)	
D0330	PANORAMIC FILM	ALL		NO	NO *FREQUENCY EXCEPTIONS ONLY	1 PER CODE EVERY 3 YEARS ON A ROUTINE BASIS. COVERED MORE FREQUENTLY IF NECESSARY FOR TREATMENT.	PER PATIENT PER PAYEE	FREQUENCY EXCEPTION- MUST INCLUDE MEDICAL NECESSITY FOR THE NEED FOR MORE FREQUENT PANOREX WITH CLAIM SUBMISSION.
D0340	CEPHALOMETRIC FILM	0-20	COVERED FOR CLIENTS AGE 20 AND YOUNGER IF THE CASE MEETS THE CRITERIA FOR AN APPROVED ORTHO CASE.	NO	NO			NOT INCLUDED IN THE MAXIMUM DOLLAR AMOUNT

CODE	DESCRIPTION	AGE	TEETH/ COMMENT	PA	PREPAY REVIEW REQUIRED	BENEFIT LIMIT	MEASURE	DOCUMENTATION REQUIRED
D0470	DIAGNOSTIC CASTS	0-20	COVERED FOR CLIENTS AGE 20 AND YOUNGER IF THE CASE MEETS THE CRITERIA FOR AN APPROVED ORTHO CASE.	NO	NO			
D1110	PROPHYLAXIS-ADULT (AGE 14 AND OLDER)	14-999		NO	NO *FREQUENCY EXCEPTIONS ONLY	1 EVERY 180 DAYS. 1 D1110 OR D1120 PER PATIENT. SPECIAL NEEDS AND DISABLED: COVERED AT THE FREQUENCY DETERMINED APPROPRIATE BY THE TREATING DENTAL PROVIDER. A CLIENT WITH SPECIAL NEEDS IS A CLIENT WHO IS UNABLE TO CARE FOR THEIR MOUTH PROPERLY ON THEIR OWN BECAUSE OF A DISABLING CONDITION. SUBMIT CODE D9997 WITH A NARRATIVE TO IDENTIFY A MEMBER WITH SPECIAL HEALTH CARE NEEDS. EXCEPTION FREQUENCY NOT TO EXCEED 1 EVERY 90 DAYS.	PER PATIENT	SUBMIT CODE D9997 WITH A NARRATIVE TO IDENTIFY A MEMBER WITH SPECIAL HEALTH CARE NEEDS.
D1110	PROPHYLAXIS-ADULT	14-999	PREGNANT WOMAN	NO	YES	3 PER CODE EVERY 365 DAYS	PER PATIENT	SUBMIT DIAGNOSIS CODE PREGNANT Z3A.00 OR POSTPARTUM Z39.2 ON CLAIM SUBMISSION.
D1120	PROPHYLAXIS-CHILD	0-13		NO	NO *FREQUENCY EXCEPTIONS ONLY	1 EVERY 175 DAYS. ONE D1110 OR D1120 PER PATIENT. SPECIAL NEEDS AND DISABLED: COVERED AT THE FREQUENCY DETERMINED APPROPRIATE BY THE TREATING DENTAL PROVIDER. A CLIENT WITH SPECIAL NEEDS IS A CLIENT WHO IS UNABLE TO CARE FOR THEIR MOUTH PROPERLY ON THEIR OWN BECAUSE OF A DISABLING CONDITION. SUBMIT CODE D9997 WITH A NARRATIVE TO IDENTIFY A MEMBER WITH SPECIAL HEALTH CARE NEEDS. EXCEPTION FREQUENCY NOT TO EXCEED 1 EVERY 90 DAYS.	PER PATIENT	SUBMIT CODE D9997 WITH A NARRATIVE TO IDENTIFY A MEMBER WITH SPECIAL HEALTH CARE NEEDS.
D1120	PROPHYLAXIS-CHILD	0-13	PREGNANT WOMAN	NO	YES	3 PER CODE EVERY 365 DAYS	PER PATIENT	SUBMIT DIAGNOSIS CODE PREGNANT Z3A.00 OR POSTPARTUM Z39.2 ON CLAIM SUBMISSION.

CODE	DESCRIPTION	AGE	TEETH/ COMMENT	PA	PREPAY REVIEW REQUIRED	BENEFIT LIMIT	MEASURE	DOCUMENTATION REQUIRED
D1206	TOPICAL FLUORIDE VARNISH; THERAPEUTIC APPLICATION FOR MODERATE TO HIGH CARIES RISK PATIENTS	ALL		NO	NO* *FREQUENCY EXCEPTIONS ONLY	4 PER CODE EVERY YEAR. COVERED MORE FREQUENTLY IF NEEDED FOR TREATMENT. ATTACH MEDICAL NECESSITY FOR THE NEED TO EXCEED FREQUENCY WITH CLAIM SUBMISSION.	PER PATIENT	ATTACH MEDICAL NECESSITY FOR THE NEED TO EXCEED FREQUENCY WITH CLAIM SUBMISSION.
D1208	TOPICAL APPLICATION OF FLUORIDE-EXCLUDING VARNISH	ALL		NO	NO* *FREQUENCY EXCEPTIONS ONLY	4 PER CODE EVERY YEAR COVERED MORE FREQUENTLY IF NEEDED FOR TREATMENT. INCLUDE RATIONALE FOR THE NEED TO EXCEED FREQUENCY WITH CLAIM SUBMISSION.	PER PATIENT	ATTACH MEDICAL NECESSITY FOR THE NEED TO EXCEED FREQUENCY WITH CLAIM SUBMISSION.
D1351	SEALANT - PER TOOTH	0-20	02-03, 14-15, 18-19, 30-31, A-B, I-L, S-T	NO	NO	1 PER CODE PER TOOTH EVERY 730 DAYS	PER PATIENT	
D1354	INTERIM CARIES ARRESTING MEDICAMENT APPLICATION PER TOOTH	ALL	01-32, A-T	NO -FIRST THREE APPLICATION YES -4TH APPLICATION	NO	3 PER CODE PER TOOTH EVERY YEAR FREQUENCY MAY BE EXCEEDED FOR UP TO 4 TIMES PER TOOTH PER 12 MONTH PERIOD, FOR MEMBERS WITH A HIGH CARIES RISK. PRIOR AUTHORIZATION REQUIRED FOR 4TH APPLICATION.	PER PATIENT	PROVIDERS ARE REQUIRED TO RETAIN DOCUMENTATION DEMONSTRATING MEDICAL NECESSITY. A PRIOR AUTHORIZATION IS REQUIRED FOR THE FOURTH APPLICATION. A PERMANENT RESTORATION IS NOT PAYABLE ON THE SAME TOOTH FOR THREE (3) MONTHS FROM THE DATE OF SERVICE OF COMPLETED D1354 PER PATIENT BY THE SAME PROVIDER, FACILITY, OR GROUP.
D1355	CARIES PREVENTATIVE MEDICAMENT APPLICATION PER TOOTH	ALL	01-32, A-T	NO -FIRST THREE APPLICATION YES -4TH APPLICATION	NO	3 PER CODE PER TOOTH EVERY YEAR FREQUENCY MAY BE EXCEEDED FOR UP TO 4 TIMES PER TOOTH PER 12 MONTH PERIOD, FOR MEMBERS WITH A HIGH CARIES RISK. PRIOR AUTHORIZATION REQUIRED FOR 4TH APPLICATION.	PER PATIENT	PROVIDERS ARE REQUIRED TO RETAIN DOCUMENTATION DEMONSTRATING MEDICAL NECESSITY. A PRIOR AUTHORIZATION IS REQUIRED FOR THE FOURTH APPLICATION. A PERMANENT RESTORATION IS NOT PAYABLE ON THE SAME TOOTH FOR THREE (3) MONTHS FROM THE DATE OF SERVICE OF COMPLETED D1354 PER PATIENT BY THE SAME PROVIDER, FACILITY, OR GROUP.
D1510	SPACE MAINTAINER - FIXED UNILATERAL	0-20	LL, LR, UL, UR	NO	NO	1 D1510 OR D1575 PER YEAR	PER PATIENT	REQUIRES INDICATION OF QUADRANT OR ORAL CAVITY

CODE	DESCRIPTION	AGE	TEETH/ COMMENT	PA	PREPAY REVIEW REQUIRED	BENEFIT LIMIT	MEASURE	DOCUMENTATION REQUIRED
D1516	SPACE MAINTAINER FIXED BILATERAL MAXILLARY	0-20		NO	NO	1 PER CODE EVERY YEAR	PER PATIENT	
D1517	SPACE MAINTAINER FIXED BILATERAL MANDIBULAR	0-20		NO	NO	1 PER CODE EVERY YEAR	PER PATIENT	
D1551	RE-CEMENT OR RE-BOND BILATERAL SPACE MAINTAINER-MAXILLARY	0-20		NO	NO	1 PER CODE EVERY YEAR THE BILLING PROVIDER IS RESPONSIBLE FOR REPLACEMENT AND RECEMENTATION WITHIN THE FIRST SIX (6) MONTHS AFTER PLACEMENT OF THE SPACE MAINTAINER.	PER PATIENT	
D1552	RE-CEMENT OR RE-BOND BILATERAL SPACE MAINTAINER-MANDIBULAR	0-20		NO	NO	1 PER CODE EVERY YEAR THE BILLING PROVIDER IS RESPONSIBLE FOR REPLACEMENT AND RECEMENTATION WITHIN THE FIRST SIX (6) MONTHS AFTER PLACEMENT OF THE SPACE MAINTAINER.	PER PATIENT	
D1553	RE-CEMENT OR R-BOND UNILATERAL SPACE MAINTAINER-PER QUADRANT	0-20	LL, LR, UL, UR	NO	NO	1 PER CODE PER QUADRANT EVERY YEAR THE BILLING PROVIDER IS RESPONSIBLE FOR REPLACEMENT AND RECEMENTATION WITHIN THE FIRST SIX (6) MONTHS AFTER PLACEMENT OF THE SPACE MAINTAINER.	PER PATIENT	
D1556	REMOVAL OF FIXED UNILATERAL SPACE MAINTAINER-PER QUADRANT	0-20	LL, LR, UL, UR	NO	NO	1 PER CODE PER QUADRANT EVERY YEAR REMOVAL OF A FIXED SPACE MAINTAINER IS NOT PAYABLE TO THE PROVIDER OR DENTAL GROUP PRACTICE THAT ORIGINALLY PLACED THE DEVICE	PER PATIENT	
D1557	REMOVAL OF FIXED BILATERAL SPACE MAINTAINER-MAXILLARY	0-20		NO	NO	1 PER CODE EVERY YEAR	PER PATIENT	
D1558	REMOVAL OF FIXED BILATERAL SPACE	0-20		NO	NO	1 PER CODE EVERY YEAR	PER PATIENT	

CODE	DESCRIPTION	AGE	TEETH/ COMMENT	PA	PREPAY REVIEW REQUIRED	BENEFIT LIMIT	MEASURE	DOCUMENTATION REQUIRED
	MAINTAINER-MANDIBULAR							
D1575	DISTAL SHOE SPACE MAINTAINER - FIXED - UNILATERAL	0-20	LL, LR, UL, UR COVERED FOR PEDIATRIC PATIENTS ONLY	NO	NO	1 D1510 OR D1575 PER YEAR PER QUADRANT		
D1999	UNSPECIFIED PREVENTIVE PROCEDURE CODE	ALL	PPE REIMBURSEMENT IS A VALUE-ADDED SERVICE.	NO	NO	1 PER DAY	PER PATIENT MUST BE BILLED WITH A COVERED PROCEDURE.	FQHCS AND IHSS WHO ARE REIMBURSED USING AN ENCOUNTER RATE OR PPS METHODOLOGY WILL RECEIVE ONLY THE AMOUNT LISTED FOR D1999, WHICH IF BILLED ALONE DOES NOT QUALIFY FOR AN ENCOUNTER RATE OR PPS RATE. MUST BILL D1999 ALONG WITH A PAYABLE SERVICE TO RECEIVE THE ENCOUNTER RATE PLUS THE D1999 PAYMENT.
A MAXIMUM FEE IS COVERED PER TOOTH FOR ANY COMBINATION OF AMALGAM OR RESIN RESTORATION PROCEDURE CODES. THE MAXIMUM FEE IS EQUAL TO THE MEDICAID FEE FOR A FOUR OR MORE SURFACE RESTORATION.								
D2140	AMALGAM - ONE SURFACE, PRIMARY OR PERMANENT	ALL	01-32, A-T	NO	NO	1 D2140-D2161, D2330-D2235, D2391-D2394 PER TOOTH EVERY 12 MONTHS	PER SURFACE PER PATIENT PER (PROVIDER OR LOCATION)	
D2150	AMALGAM - TWO SURFACES, PRIMARY OR PERMANENT (1-3-03)	ALL	01-32, A-T	NO	NO	1 D2140-D2161, D2330-D2235, D2391-D2394 PER TOOTH EVERY 12 MONTHS	PER SURFACE PER PATIENT PER (PROVIDER OR LOCATION)	
D2160	AMALGAM - THREE SURFACES, PRIMARY OR PERMANENT	ALL	01-32, A-T	NO	NO	1 D2140-D2161, D2330-D2235, D2391-D2394 PER TOOTH EVERY 12 MONTHS	PER SURFACE PER PATIENT PER (PROVIDER OR LOCATION)	
D2161	AMALGAM - FOUR OR MORE SURFACES, PRIMARY OR PERMANENT	ALL	01-32, A-T	NO	NO	1 D2140-D2161, D2330-D2235, D2391-D2394 PER TOOTH EVERY 12 MONTHS	PER SURFACE PER PATIENT PER (PROVIDER OR LOCATION)	
D2330	RESIN-BASED COMPOSITE - ONE SURFACE, ANTERIOR	ALL	06-11, 22-27, C-H, M-R	NO	NO	1 D2140-D2161, D2330-D2235, D2391-D2394 PER TOOTH EVERY 12 MONTHS	PER SURFACE PER PATIENT PER (PROVIDER OR LOCATION)	

CODE	DESCRIPTION	AGE	TEETH/ COMMENT	PA	PREPAY REVIEW REQUIRED	BENEFIT LIMIT	MEASURE	DOCUMENTATION REQUIRED
D2331	RESIN-BASED COMPOSITE - TWO SURFACES, ANTERIOR	ALL	06-11, 22-27, C-H, M-R	NO	NO	1 D2140-D2161, D2330-D2235, D2391-D2394 PER TOOTH EVERY 12 MONTHS	PER SURFACE PER PATIENT PER (PROVIDER OR LOCATION)	
D2332	RESIN-BASED COMPOSITE - THREE SURFACES, ANTERIOR	ALL	06-11, 22-27, C-H, M-R	NO	NO	1 D2140-D2161, D2330-D2235, D2391-D2394 PER TOOTH EVERY 12 MONTHS	PER SURFACE PER PATIENT PER (PROVIDER OR LOCATION)	
D2335	RESIN-BASED COMPOSITE - FOUR OR MORE SURFACES OR INVOLVING INCISAL ANGLE (ANTERIOR)	ALL	06-11, 22-27, C-H, M-R	NO	NO	1 D2140-D2161, D2330-D2235, D2391-D2394 PER TOOTH EVERY 12 MONTHS	PER SURFACE PER PATIENT PER (PROVIDER OR LOCATION)	
D2390	RESIN-BASED COMPOSITE CROWN, ANTERIOR	ALL	C-H, M-R	NO	NO			
D2391	RESIN-BASED COMPOSITE - ONE SURFACE, POSTERIOR	ALL	01-05, 12-21, 28-32, A-B, I-L, S-T	NO	NO	1 D2140-D2161, D2330-D2235, D2391-D2394 PER TOOTH EVERY 12 MONTHS	PER SURFACE PER PATIENT PER (PROVIDER OR LOCATION)	
D2392	RESIN-BASED COMPOSITE - TWO SURFACES, POSTERIOR	ALL	01-05, 12-21, 28-32, A-B, I-L, S-T	NO	NO	1 D2140-D2161, D2330-D2235, D2391-D2394 PER TOOTH EVERY 12 MONTHS	PER SURFACE PER PATIENT PER (PROVIDER OR LOCATION)	
D2393	RESIN-BASED COMPOSITE - THREE SURFACES, POSTERIOR	ALL	01-05, 12-21, 28-32, A-B, I-L, S-T	NO	NO	1 D2140-D2161, D2330-D2235, D2391-D2394 PER TOOTH EVERY 12 MONTHS	PER SURFACE PER PATIENT PER (PROVIDER OR LOCATION)	
D2394	RESIN-BASED COMPOSITE - FOUR OR MORE SURFACES, POSTERIOR	ALL	01-05, 12-21, 28-32, A-B, I-L, S-T	NO	NO	1 D2140-D2161, D2330-D2235, D2391-D2394 PER TOOTH EVERY 12 MONTHS	PER SURFACE PER PATIENT PER (PROVIDER OR LOCATION)	

CODE	DESCRIPTION	AGE	TEETH/ COMMENT	PA	PREPAY REVIEW REQUIRED	BENEFIT LIMIT	MEASURE	DOCUMENTATION REQUIRED
D2710	CROWN - RESIN BASED COMPOSITE (INDIRECT)	ALL	02-15, 18-31	YES	NO	1 D2710-D2799 PER TOOTH EVERY 5 YEARS	PER PATIENT	SUBMIT A DIAGNOSTIC X-RAY, EITHER A PERIAPICAL OR BITEWING. INCLUDE A NARRATIVE OF HOW A CONVENTIONAL RESTORATION OR STAINLESS-STEEL CROWN WOULD NOT BE ADEQUATE TO RESTORE. COVERED FOR ANTERIOR AND BICUSPID TEETH WHEN OTHER RESTORATION IS NOT POSSIBLE. ONLY COVERED FOR MOLAR TEETH THAT HAVE HAD ENDODONTIC TREATMENT THAT CANNOT BE ADEQUATELY RESTORED WITH A STAINLESS-STEEL CROWN, AMALGAM OR RESIN RESTORATION. A REQUEST SHOULD NOT BE SUBMITTED FOR UNUSUAL OR EXCEPTIONAL SITUATIONS NOT COVERED HEREIN. CROWNS ARE NOT COVERED FOR THIRD MOLARS. A REPLACEMENT CROWN FOR THE SAME TOOTH IN LESS THAN 1,825 DAYS, DUE TO FAILURE OF THE CROWN, IS NOT COVERED AND IS THE RESPONSIBILITY OF THE DENTIST WHO ORIGINALLY PLACED THE CROWN.
D2720	CROWN-RESIN WITH HIGH NOBLE METAL	ALL	02-15, 18-31	YES	NO	1 D2710-D2799 PER TOOTH EVERY 5 YEARS	PER PATIENT	SUBMIT A DIAGNOSTIC X-RAY, EITHER A PERIAPICAL OR BITEWING. INCLUDE A NARRATIVE OF HOW A CONVENTIONAL RESTORATION OR STAINLESS-STEEL CROWN WOULD NOT BE ADEQUATE TO RESTORE. COVERED FOR ANTERIOR AND BICUSPID TEETH WHEN OTHER RESTORATION IS NOT POSSIBLE. ONLY COVERED FOR MOLAR TEETH THAT HAVE HAD ENDODONTIC TREATMENT THAT CANNOT BE ADEQUATELY RESTORED WITH A STAINLESS-STEEL CROWN, AMALGAM OR RESIN RESTORATION. A REQUEST SHOULD NOT BE SUBMITTED FOR UNUSUAL OR EXCEPTIONAL SITUATIONS NOT COVERED HEREIN. CROWNS ARE NOT COVERED FOR THIRD MOLARS. A REPLACEMENT CROWN FOR THE SAME TOOTH IN LESS THAN 1,825 DAYS, DUE TO FAILURE OF THE CROWN, IS NOT COVERED AND IS THE RESPONSIBILITY OF THE DENTIST WHO ORIGINALLY PLACED THE CROWN.

CODE	DESCRIPTION	AGE	TEETH/ COMMENT	PA	PREPAY REVIEW REQUIRED	BENEFIT LIMIT	MEASURE	DOCUMENTATION REQUIRED
D2721	CROWN-RESIN WITH PREDOMINANTLY BASE METAL	ALL	02-15, 18-31	YES	NO	1 D2710-D2799 PER TOOTH EVERY 5 YEARS	PER PATIENT	SUBMIT A DIAGNOSTIC X-RAY, EITHER A PERIAPICAL OR BITEWING. INCLUDE A NARRATIVE OF HOW A CONVENTIONAL RESTORATION OR STAINLESS-STEEL CROWN WOULD NOT BE ADEQUATE TO RESTORE. COVERED FOR ANTERIOR AND BICUSPID TEETH WHEN OTHER RESTORATION IS NOT POSSIBLE. ONLY COVERED FOR MOLAR TEETH THAT HAVE HAD ENDODONTIC TREATMENT THAT CANNOT BE ADEQUATELY RESTORED WITH A STAINLESS-STEEL CROWN, AMALGAM OR RESIN RESTORATION. A REQUEST SHOULD NOT BE SUBMITTED FOR UNUSUAL OR EXCEPTIONAL SITUATIONS NOT COVERED HEREIN. CROWNS ARE NOT COVERED FOR THIRD MOLARS. A REPLACEMENT CROWN FOR THE SAME TOOTH IN LESS THAN 1,825 DAYS, DUE TO FAILURE OF THE CROWN, IS NOT COVERED AND IS THE RESPONSIBILITY OF THE DENTIST WHO ORIGINALLY PLACED THE CROWN.
D2722	CROWN-RESIN WITH NOBLE METAL	ALL	02-15, 18-31	YES	NO	1 D2710-D2799 PER TOOTH EVERY 5 YEARS	PER PATIENT	SUBMIT A DIAGNOSTIC X-RAY, EITHER A PERIAPICAL OR BITEWING. INCLUDE A NARRATIVE OF HOW A CONVENTIONAL RESTORATION OR STAINLESS-STEEL CROWN WOULD NOT BE ADEQUATE TO RESTORE. COVERED FOR ANTERIOR AND BICUSPID TEETH WHEN OTHER RESTORATION IS NOT POSSIBLE. ONLY COVERED FOR MOLAR TEETH THAT HAVE HAD ENDODONTIC TREATMENT THAT CANNOT BE ADEQUATELY RESTORED WITH A STAINLESS-STEEL CROWN, AMALGAM OR RESIN RESTORATION. A REQUEST SHOULD NOT BE SUBMITTED FOR UNUSUAL OR EXCEPTIONAL SITUATIONS NOT COVERED HEREIN. CROWNS ARE NOT COVERED FOR THIRD MOLARS. A REPLACEMENT CROWN FOR THE SAME TOOTH IN LESS THAN 1,825 DAYS, DUE TO FAILURE OF THE CROWN, IS NOT COVERED AND IS THE RESPONSIBILITY OF THE DENTIST WHO ORIGINALLY PLACED THE CROWN.
D2740	CROWN-PORCELAIN/CERAMIC SUBSTRATE	ALL	02-15, 18-31	YES	NO	1 D2710-D2799 PER TOOTH EVERY 5 YEARS	PER PATIENT	SUBMIT A DIAGNOSTIC X-RAY, EITHER A PERIAPICAL OR BITEWING. INCLUDE A NARRATIVE OF HOW A CONVENTIONAL RESTORATION OR STAINLESS-STEEL CROWN WOULD NOT BE ADEQUATE TO RESTORE. COVERED FOR ANTERIOR AND BICUSPID TEETH WHEN OTHER RESTORATION IS NOT POSSIBLE. ONLY COVERED FOR MOLAR TEETH THAT HAVE HAD ENDODONTIC TREATMENT THAT CANNOT BE ADEQUATELY RESTORED WITH A STAINLESS-STEEL CROWN, AMALGAM OR RESIN RESTORATION. A REQUEST SHOULD NOT BE SUBMITTED FOR UNUSUAL OR EXCEPTIONAL SITUATIONS NOT COVERED HEREIN.

CODE	DESCRIPTION	AGE	TEETH/ COMMENT	PA	PREPAY REVIEW REQUIRED	BENEFIT LIMIT	MEASURE	DOCUMENTATION REQUIRED
								CROWNS ARE NOT COVERED FOR THIRD MOLARS. A REPLACEMENT CROWN FOR THE SAME TOOTH IN LESS THAN 1,825 DAYS, DUE TO FAILURE OF THE CROWN, IS NOT COVERED AND IS THE RESPONSIBILITY OF THE DENTIST WHO ORIGINALLY PLACED THE CROWN.
D2750	CROWN-PORCELAIN FUSED TO HIGH NOBLE METAL	ALL	02-15, 18-31	YES	NO	1 D2710-D2799 PER TOOTH EVERY 5 YEARS	PER PATIENT	SUBMIT A DIAGNOSTIC X-RAY, EITHER A PERIAPICAL OR BITEWING. INCLUDE A NARRATIVE OF HOW A CONVENTIONAL RESTORATION OR STAINLESS-STEEL CROWN WOULD NOT BE ADEQUATE TO RESTORE. COVERED FOR ANTERIOR AND BICUSPID TEETH WHEN OTHER RESTORATION IS NOT POSSIBLE. ONLY COVERED FOR MOLAR TEETH THAT HAVE HAD ENDODONTIC TREATMENT THAT CANNOT BE ADEQUATELY RESTORED WITH A STAINLESS-STEEL CROWN, AMALGAM OR RESIN RESTORATION. A REQUEST SHOULD NOT BE SUBMITTED FOR UNUSUAL OR EXCEPTIONAL SITUATIONS NOT COVERED HEREIN. CROWNS ARE NOT COVERED FOR THIRD MOLARS. A REPLACEMENT CROWN FOR THE SAME TOOTH IN LESS THAN 1,825 DAYS, DUE TO FAILURE OF THE CROWN, IS NOT COVERED AND IS THE RESPONSIBILITY OF THE DENTIST WHO ORIGINALLY PLACED THE CROWN.
D2751	CROWN - PORCELAIN FUSED TO PREDOMINANTLY BASE METAL	ALL	02-15, 18-31	YES	NO	1 D2710-D2799 PER TOOTH EVERY 5 YEARS	PER PATIENT	SUBMIT A DIAGNOSTIC X-RAY, EITHER A PERIAPICAL OR BITEWING. INCLUDE A NARRATIVE OF HOW A CONVENTIONAL RESTORATION OR STAINLESS-STEEL CROWN WOULD NOT BE ADEQUATE TO RESTORE. COVERED FOR ANTERIOR AND BICUSPID TEETH WHEN OTHER RESTORATION IS NOT POSSIBLE. ONLY COVERED FOR MOLAR TEETH THAT HAVE HAD ENDODONTIC TREATMENT THAT CANNOT BE ADEQUATELY RESTORED WITH A STAINLESS-STEEL CROWN, AMALGAM OR RESIN RESTORATION. A REQUEST SHOULD NOT BE SUBMITTED FOR UNUSUAL OR EXCEPTIONAL SITUATIONS NOT COVERED HEREIN. CROWNS ARE NOT COVERED FOR THIRD MOLARS. A REPLACEMENT CROWN FOR THE SAME TOOTH IN LESS THAN 1,825 DAYS, DUE TO FAILURE OF THE CROWN, IS NOT COVERED AND IS THE RESPONSIBILITY OF THE DENTIST WHO ORIGINALLY PLACED THE CROWN.

CODE	DESCRIPTION	AGE	TEETH/ COMMENT	PA	PREPAY REVIEW REQUIRED	BENEFIT LIMIT	MEASURE	DOCUMENTATION REQUIRED
D2752	CROWN-PORCELAIN FUSED TO NOBLE METAL	ALL	02-15, 18-31	YES	NO	1 D2710-D2799 PER TOOTH EVERY 5 YEARS	PER PATIENT	SUBMIT A DIAGNOSTIC X-RAY, EITHER A PERIAPICAL OR BITEWING. INCLUDE A NARRATIVE OF HOW A CONVENTIONAL RESTORATION OR STAINLESS-STEEL CROWN WOULD NOT BE ADEQUATE TO RESTORE. COVERED FOR ANTERIOR AND BICUSPID TEETH WHEN OTHER RESTORATION IS NOT POSSIBLE. ONLY COVERED FOR MOLAR TEETH THAT HAVE HAD ENDODONTIC TREATMENT THAT CANNOT BE ADEQUATELY RESTORED WITH A STAINLESS-STEEL CROWN, AMALGAM OR RESIN RESTORATION. A REQUEST SHOULD NOT BE SUBMITTED FOR UNUSUAL OR EXCEPTIONAL SITUATIONS NOT COVERED HEREIN. CROWNS ARE NOT COVERED FOR THIRD MOLARS. A REPLACEMENT CROWN FOR THE SAME TOOTH IN LESS THAN 1,825 DAYS, DUE TO FAILURE OF THE CROWN, IS NOT COVERED AND IS THE RESPONSIBILITY OF THE DENTIST WHO ORIGINALLY PLACED THE CROWN.
D2790	CROWN-FULL CAST HIGH NOBLE METAL	ALL	02-15, 18-31	YES	NO	1 D2710-D2799 PER TOOTH EVERY 5 YEARS	PER PATIENT	SUBMIT A DIAGNOSTIC X-RAY, EITHER A PERIAPICAL OR BITEWING. INCLUDE A NARRATIVE OF HOW A CONVENTIONAL RESTORATION OR STAINLESS-STEEL CROWN WOULD NOT BE ADEQUATE TO RESTORE. COVERED FOR ANTERIOR AND BICUSPID TEETH WHEN OTHER RESTORATION IS NOT POSSIBLE. ONLY COVERED FOR MOLAR TEETH THAT HAVE HAD ENDODONTIC TREATMENT THAT CANNOT BE ADEQUATELY RESTORED WITH A STAINLESS-STEEL CROWN, AMALGAM OR RESIN RESTORATION. A REQUEST SHOULD NOT BE SUBMITTED FOR UNUSUAL OR EXCEPTIONAL SITUATIONS NOT COVERED HEREIN. CROWNS ARE NOT COVERED FOR THIRD MOLARS. A REPLACEMENT CROWN FOR THE SAME TOOTH IN LESS THAN 1,825 DAYS, DUE TO FAILURE OF THE CROWN, IS NOT COVERED AND IS THE RESPONSIBILITY OF THE DENTIST WHO ORIGINALLY PLACED THE CROWN.

CODE	DESCRIPTION	AGE	TEETH/ COMMENT	PA	PREPAY REVIEW REQUIRED	BENEFIT LIMIT	MEASURE	DOCUMENTATION REQUIRED
D2791	CROWN-FULL CAST PREDOMINANTLY BASE METAL	ALL	02-15, 18-31	YES	NO	1 D2710-D2799 PER TOOTH EVERY 5 YEARS	PER PATIENT	SUBMIT A DIAGNOSTIC X-RAY, EITHER A PERIAPICAL OR BITEWING. INCLUDE A NARRATIVE OF HOW A CONVENTIONAL RESTORATION OR STAINLESS-STEEL CROWN WOULD NOT BE ADEQUATE TO RESTORE. COVERED FOR ANTERIOR AND BICUSPID TEETH WHEN OTHER RESTORATION IS NOT POSSIBLE. ONLY COVERED FOR MOLAR TEETH THAT HAVE HAD ENDODONTIC TREATMENT THAT CANNOT BE ADEQUATELY RESTORED WITH A STAINLESS-STEEL CROWN, AMALGAM OR RESIN RESTORATION. A REQUEST SHOULD NOT BE SUBMITTED FOR UNUSUAL OR EXCEPTIONAL SITUATIONS NOT COVERED HEREIN. CROWNS ARE NOT COVERED FOR THIRD MOLARS. A REPLACEMENT CROWN FOR THE SAME TOOTH IN LESS THAN 1,825 DAYS, DUE TO FAILURE OF THE CROWN, IS NOT COVERED AND IS THE RESPONSIBILITY OF THE DENTIST WHO ORIGINALLY PLACED THE CROWN.
D2792	CROWN-FULL CAST NOBLE METAL	ALL	02-15, 18-31	YES	NO	1 D2710-D2799 PER TOOTH EVERY 5 YEARS	PER PATIENT	SUBMIT A DIAGNOSTIC X-RAY, EITHER A PERIAPICAL OR BITEWING. INCLUDE A NARRATIVE OF HOW A CONVENTIONAL RESTORATION OR STAINLESS-STEEL CROWN WOULD NOT BE ADEQUATE TO RESTORE. COVERED FOR ANTERIOR AND BICUSPID TEETH WHEN OTHER RESTORATION IS NOT POSSIBLE. ONLY COVERED FOR MOLAR TEETH THAT HAVE HAD ENDODONTIC TREATMENT THAT CANNOT BE ADEQUATELY RESTORED WITH A STAINLESS-STEEL CROWN, AMALGAM OR RESIN RESTORATION. A REQUEST SHOULD NOT BE SUBMITTED FOR UNUSUAL OR EXCEPTIONAL SITUATIONS NOT COVERED HEREIN. CROWNS ARE NOT COVERED FOR THIRD MOLARS. A REPLACEMENT CROWN FOR THE SAME TOOTH IN LESS THAN 1,825 DAYS, DUE TO FAILURE OF THE CROWN, IS NOT COVERED AN D IS THE RESPONSIBILITY OF THE DENTIST WHO ORIGINALLY PLACED THE CROWN.
D2910	RE-CEMENT OR RE-BOND INLAY, ONLAY, VENEER OR PARTIAL COVERAGE RESTORATION	ALL	01-32	NO	NO	1 PER CODE PER TOOTH EVERY 6 MONTHS	PER PATIENT	NOT PAYABLE FOR THE INITIAL SIX MONTHS AFTER ORIGINAL RESTORATION PLACEMENT
D2915	RE-CEMENT OR RE-BOND INDIRECTLY FABRICATED OR	ALL	01-32	NO	NO	1 PER CODE PER TOOTH EVERY 6 MONTHS	PER PATIENT	NOT PAYABLE FOR THE INITIAL SIX MONTHS AFTER ORIGINAL RESTORATION PLACEMENT

CODE	DESCRIPTION	AGE	TEETH/ COMMENT	PA	PREPAY REVIEW REQUIRED	BENEFIT LIMIT	MEASURE	DOCUMENTATION REQUIRED
	PREFABRICATED POST AND CORE							
D2920	RE-CEMENT OR RE-BOND CROWN	ALL	01-32, A-T	NO	NO	1 PER CODE PER TOOTH EVERY 6 MONTHS	PER PATIENT	NOT PAYABLE FOR THE INITIAL SIX MONTHS AFTER ORIGINAL RESTORATION PLACEMENT
D2929	PREFABRICATED PORCELAIN/CERAMIC CROWN PRIMARY TOOTH	ALL	C-H, M-R	NO	NO	1 PER CODE PER TOOTH EVERY 2 YEARS	PER PATIENT	
D2930	PREFABRICATED STAINLESS STEEL CROWN - PRIMARY TOOTH	ALL	A-T	NO	NO	1 PER CODE PER TOOTH EVERY 2 YEARS	PER PATIENT	
D2931	PREFABRICATED STAINLESS STEEL CROWN - PERMANENT TOOTH	ALL	01-32	NO	NO	1 PER CODE PER TOOTH EVERY 2 YEARS	PER PATIENT	
D2932	PREFABRICATED RESIN CROWN	ALL	C-H, M-R	NO	NO	1 PER CODE PER TOOTH EVERY 2 YEARS	PER PATIENT	
D2933	PREF. STAINLESS STEEL CROWN WITH RESIN WINDOW.	ALL	C-H, M-R	NO	NO	1 PER CODE PER TOOTH EVERY 2 YEARS	PER PATIENT	
D2934	PREFABRICATED ESTHETIC COATED STAINLESS-STEEL CROWN - PRIMARY TOOTH	ALL	C-H, M-R	NO	NO	1 PER CODE PER TOOTH EVERY 2 YEARS	PER PATIENT	
D2940	PROTECTIVE RESTORATION	ALL	01-32, A-T	NO	NO	1 PER CODE PER TOOTH PER LIFETIME		
D2950	CORE BUILDUP, INCLUDING ANY PINS	ALL	2-5,18-31	NO	NO	1 PER CODE PER TOOTH EVERY 60 MONTHS		

CODE	DESCRIPTION	AGE	TEETH/ COMMENT	PA	PREPAY REVIEW REQUIRED	BENEFIT LIMIT	MEASURE	DOCUMENTATION REQUIRED
D2951	PIN RETENTION - PER TOOTH, IN ADDITION TO RESTORATION	ALL	01-32	NO	NO	3 PER CODE PER TOOTH EVERY 12 MONTHS		
D2954	PREFABRICATED POST AND CORE IN ADDITION TO CROWN	ALL	01-32, A-T	NO	NO	1 PER CODE PER TOOTH EVERY 60 MONTHS		
D2980	CROWN REPAIR- BY REPORT	ALL	A DESCRIPTION OF THE TREATMENT PROVIDED MUST BE SUBMITTED ON OR WITH THE CLAIM. THIS SERVICE IS REVIEWED PRIOR TO PAYMENT.	NO	YES	1 PER CODE PER TOOTH PER DAY		A DESCRIPTION OF THE TREATMENT PROVIDED MUST BE SUBMITTED ON OR WITH THE CLAIM. THIS SERVICE IS REVIEWED PRIOR TO PAYMENT.
D2999	UNSPECIFIED RESTORATIVE PROCEDURE, BY REPORT	ALL	A DESCRIPTION OF THE TREATMENT PROVIDED MUST BE SUBMITTED ON OR WITH THE CLAIM. THIS SERVICE IS REVIEWED PRIOR TO PAYMENT.	NO	YES			A DESCRIPTION OF THE TREATMENT PROVIDED MUST BE SUBMITTED ON OR WITH THE CLAIM. THIS SERVICE IS REVIEWED PRIOR TO PAYMENT.
D3220	THERAPEUTIC PULPOTOMY (EXCLUDING FINAL RESTORATION) (PRIMARY TEETH ONLY)	ALL	A-T	NO	NO	1 PER CODE PER TOOTH PER LIFETIME		
D3230	PULPAL THERAPY (RESORBABLE FILLING) - ANTERIOR, PRIMARY TOOTH	ALL	C-H, M-R	NO	NO	1 PER CODE PER TOOTH PER LIFETIME		

CODE	DESCRIPTION	AGE	TEETH/ COMMENT	PA	PREPAY REVIEW REQUIRED	BENEFIT LIMIT	MEASURE	DOCUMENTATION REQUIRED
	(EXCLUDING FINAL RESTORATION)							
D3240	PULPAL THERAPY (RESORBABLE FILLING) - POSTERIOR, PRIMARY TOOTH (EXCLUDING FINAL RESTORATION)	ALL	A-B, I-L, S-T	NO	NO	1 PER CODE PER TOOTH PER LIFETIME		
D3310	ENDODONTIC THERAPY, ANTERIOR TOOTH (EXCLUDING FINAL RESTORATION)	ALL	06-11, 22-27	NO	NO	1 PER CODE PER TOOTH PER LIFETIME		POST OP X-RAY OF COMPLETED ROOT CANAL MUST BE AVAILABLE FOR REVIEW UPON REQUEST
D3320	ENDODONTIC THERAPY, PREMOLAR TOOTH (EXCLUDING FINAL RESTORATION)	ALL	04-05, 12-13, 20-21, 28-29	NO	NO	1 PER CODE PER TOOTH PER LIFETIME		POST OP X-RAY OF COMPLETED ROOT CANAL MUST BE AVAILABLE FOR REVIEW UPON REQUEST
D3330	ENDODONTIC THERAPY, MOLAR (EXCLUDING FINAL RESTORATION)	ALL	02-03, 14-15, 18-19, 30-31	NO	NO	1 PER CODE PER TOOTH PER LIFETIME		POST OP X-RAY OF COMPLETED ROOT CANAL MUST BE AVAILABLE FOR REVIEW UPON REQUEST
D3346	RETREATMENT OF PREVIOUS ROOT CANAL THERAPY - ANTERIOR	ALL	06-11, 22-27	NO	YES	1 PER CODE PER TOOTH PER LIFETIME		NOT PAYABLE WITHIN 365 DAYS OF ORIGINAL TREATMENT SUBMIT PRE/POST OP FILMS WITH CLAIM
D3347	RETREATMENT OF PREVIOUS ROOT CANAL THERAPY - PREMOLAR	ALL	04-05, 12-13, 20-21, 28-29	NO	YES	1 PER CODE PER TOOTH PER LIFETIME		NOT PAYABLE WITHIN 365 DAYS OF ORIGINAL TREATMENT SUBMIT PRE/POST OP FILMS WITH CLAIM
D3348	RETREATMENT OF PREVIOUS ROOT CANAL THERAPY - MOLAR	ALL	02-03, 14-15, 18-19, 30-31	NO	YES	1 PER CODE PER TOOTH PER LIFETIME		NOT PAYABLE WITHIN 365 DAYS OF ORIGINAL TREATMENT SUBMIT PRE/POST OP FILMS WITH CLAIM

CODE	DESCRIPTION	AGE	TEETH/ COMMENT	PA	PREPAY REVIEW REQUIRED	BENEFIT LIMIT	MEASURE	DOCUMENTATION REQUIRED
D3351	APEXIFICATION/RE CALCIFICATION-INITIAL VISIT (APICAL CLOSURE/CALCIFIC REPAIR OF PERFORATIONS, ROOT RESORPTION, ETC.)	ALL	2-15, 18-31	NO	YES	1 PER CODE PER TOOTH PER LIFETIME		SUBMIT PRE/POST OP FILMS WITH CLAIM
D3410	APICOECTOMY/PER IRADICULAR SURGERY-ANTERIOR	ALL	06-11,22-27	NO	YES	1 PER CODE PER TOOTH PER LIFETIME		SUBMIT PRE/POST OP FILMS WITH CLAIM
D3999	UNSPECIFIED ENDODONTIC PROCEDURE, BY REPORT	ALL	01-32, A-T	NO	YES	2 PER CODE PER TOOTH EVERY YEAR	PER PATIENT PER (PROVIDER OR LOCATION)	NOT PAYABLE WITH ANY OTHER TREATMENT ON THAT TOOTH ON THE SAME DOS SUBMIT PRE/POST OP FILMS WITH RATIONALE
D4210	GINGIVECTOMY OR GINGIVOPLASTY, 4 OR MORE CONTIGUOUS TEETH OR TOOTH BONDED SPACES PER QUADRANT	ALL	LL, LR, UL, UR	NO	NO	1 PER CODE PER QUAD PER YEAR		
D4211	GINGIVECTOMY OR GINGIVOPLASTY, 1 TO 3 CONTIGUOUS TEETH OR TOOTH BONDED SPACES PER QUADRANT	ALL	LL, LR, UL, UR	NO	NO	1 PER CODE PER QUAD PER YEAR		
D4323	SPLINT EXTRA-CORONAL NATURAL TEETH OR PROSTHETIC CROWNS	ALL	LA, UA	NO	YES	COVERED FOR STABILIZATION MOBILE OR SUBLUXATED TEETH DUE TO TRAUMATIC INJURY. COVERED FOR BOTH ADULT AND CHILD. NOT COVERED TO STABILIZE PRIMARY TEETH, ADULT TEETH ONLY. IDENTIFICATION OF THE ARCH IS MANDATORY.		DOCUMENTATION REQUIRED TO SUBSTANTIATE MEDICAL NECESSITY. INCLUDE VISIT NOTES DOCUMENTING TRAUMA AND ANY RADIOLOGY.

CODE	DESCRIPTION	AGE	TEETH/ COMMENT	PA	PREPAY REVIEW REQUIRED	BENEFIT LIMIT	MEASURE	DOCUMENTATION REQUIRED
D4341	PERIODONTAL SCALING AND ROOT PLANING - FOUR OR MORE TEETH PER QUADRANT	ALL		YES	NO	BENEFIT COVERS 4 QUADRANTS ONCE EVERY 365 DAYS. EACH QUADRANT IS COVERED 1 TIME PER CLIENT.	PER PATIENT	THE REQUEST FOR APPROVAL MUST BE ACCOMPANIED BY THE FOLLOWING: 1. A PERIODONTAL TREATMENT PLAN 2. A COMPLETED COPY OF A PERIODONTIC PROBE CHART THAT EXHIBITS POCKET DEPTHS OF 4MM OR GREATER 3. A HISTORY, INCLUDING HOME ORAL CARE THAT DEMONSTRATES THAT CURETTAGE, SCALING, OR ROOT PLANING IS REQUIRED IN ADDITION TO A ROUTINE PROPHYLAXIS 4. PERIAPICAL X-RAYS DEMONSTRATING SUBGINGIVAL CALCULUS AND/OR LOSS OF CRESTAL BONE. FOR SCALING AND ROOT PLANING THAT REQUIRES THE USE OF LOCAL ANESTHESIA, NE MEDICAID DOES NOT COVER MORE THAN ONE HALF OF THE MOUTH IN ONE DAY, EXCEPT ON HOSPITAL CASES. DENIED IF PROVIDED WITHIN 21 DAYS OF D4355
D4342	PERIODONTAL SCALING AND ROOT PLANING - ONE TO THREE TEETH, PER QUADRANT	ALL		YES	NO	BENEFIT COVERS 4 QUADRANTS ONCE EVERY 365 DAYS. EACH QUADRANT IS COVERED 1TIME PER CLIENT.	PER PATIENT	THE REQUEST FOR APPROVAL MUST BE ACCOMPANIED BY THE FOLLOWING: 1. A PERIODONTAL TREATMENT PLAN 2. A COMPLETED COPY OF A PERIODONTIC PROBE CHART THAT EXHIBITS POCKET DEPTHS OF 4MM OR GREATER 3. A HISTORY, INCLUDING HOME ORAL CARE THAT DEMONSTRATES THAT CURETTAGE, SCALING, OR ROOT PLANING IS REQUIRED IN ADDITION TO A ROUTINE PROPHYLAXIS 4. PERIAPICAL X-RAYS DEMONSTRATING SUBGINGIVAL CALCULUS AND/OR LOSS OF CRESTAL BONE. FOR SCALING AND ROOT PLANING THAT REQUIRES THE USE OF LOCAL ANESTHESIA, NE MEDICAID DOES NOT COVER MORE THAN ONE HALF OF THE MOUTH IN ONE DAY, EXCEPT ON HOSPITAL CASES. DENIED IF PROVIDED WITHIN 21 DAYS OF D4355
D4355	FULL MOUTH DEBRIDEMENT TO ENABLE COMPREHENSIVE EVALUATION AND DIAGNOSIS	ALL		NO	NO	1 PER CODE EVERY 12 MONTHS	PER PATIENT	NOT PAYABLE WITH ANY EXAM EXCEPT D0140. NOT PAYABLE WITH ANY OTHER D4000 SERIES CODE

CODE	DESCRIPTION	AGE	TEETH/ COMMENT	PA	PREPAY REVIEW REQUIRED	BENEFIT LIMIT	MEASURE	DOCUMENTATION REQUIRED
D4910	PERIODONTAL MAINTENANCE PROCEDURES (FOLLOWING SCALING & ROOT PLANING)	ALL	NOT PAYABLE WITHIN 30 DAYS OF D1110, D1120, OR D4355	YES	NO	COVERED FOR CLIENTS THAT HAVE HAD MEDICAID APPROVED PERIODONTAL SCALING AND ROOT PLANING.		DATE THE MEDICAID APPROVED SCALING AND ROOT PLANING COMPLETED; PERIODONTAL HISTORY; AND FREQUENCY THE DENTAL PROVIDER IS REQUESTING THAT THE CLIENT MUST BE SEEN FOR MAINTENANCE PROCEDURE
D5110	COMPLETE DENTURE-MAXILLARY	ALL		YES	NO	1 D5110 OR 5130 EVERY 5 YEARS	PER PATIENT	COVERED 180 DAYS AFTER PLACEMENT OF INTERIM DENTURES. SUBMIT WITH ADA CLAIM FORM PRIOR AUTHORIZATION REQUEST: 1. DATE OF PREVIOUS DENTURE PLACEMENT 2. INFORMATION ON CONDITION OF EXISTING DENTURE; AND 3. FOR INITIAL PLACEMENTS, SUBMIT PANOREX OR FULL MOUTH X-RAYS.
D5120	COMPLETE DENTURE - MANDIBULAR	ALL		YES	NO	1 CODE EVERY 5 YEARS	PER PATIENT	COVERED 180 DAYS AFTER PLACEMENT OF INTERIM DENTURES. SUBMIT WITH ADA CLAIM FORM PRIOR AUTHORIZATION REQUEST: 1. DATE OF PREVIOUS DENTURE PLACEMENT 2. INFORMATION ON CONDITION OF EXISTING DENTURE; AND 3. FOR INITIAL PLACEMENTS, SUBMIT PANOREX OR FULL MOUTH X-RAYS.
D5130	IMMEDIATE DENTURE - MAXILLARY	ALL		YES	NO	1 CODE PER LIFETIME	PER PATIENT	CONSIDERED A PERMANENT DENTURE. NOT AN INTERIM OR TEMPORARY.
D5140	IMMEDIATE DENTURE - MANDIBULAR	ALL		YES	NO	1 CODE PER LIFETIME	PER PATIENT	CONSIDERED A PERMANENT DENTURE. NOT AN INTERIM OR TEMPORARY.

CODE	DESCRIPTION	AGE	TEETH/ COMMENT	PA	PREPAY REVIEW REQUIRED	BENEFIT LIMIT	MEASURE	DOCUMENTATION REQUIRED
D5211	UPPER PARTIAL DENTURE-RESIN BASE (INC. ANY CONVENTIONAL CLASPS, RESTS AND TEETH)	ALL		YES	NO	1 D5211 OR D5213 EVERY 5 YEARS	PER PATIENT	NARRATIVE OF MEDICAL NECESSITY TO INCLUDE LISTING OF MISSING TEETH OR CHART NOTES OF MISSING TEETH AND X-RAYS. SUBMIT WITH ADA CLAIM FORM PRIOR AUTHORIZATION REQUEST: 1. CHART OR LIST MISSING TEETH OR TEETH TO BE EXTRACTED 2. PROVIDE AGE OF ANY EXISTING PARTIAL AND CONDITION OF THAT PARTIAL OR A NARRATIVE IDENTIFYING THE PARTIAL AS AN INITIAL PLACEMENT AND DOCUMENTING HOW THERE IS NOT ADEQUATE OCCLUSION 3. X-RAYS OF REMAINING TEETH
D5212	LOWER PARTIAL DENTURE-RESIN BASE (INC. ANY CONVENTIONAL CLASPS, RESTS AND TEETH)	ALL		YES	NO	1 D5212 OR D5214 EVERY 5 YEARS	PER PATIENT	NARRATIVE OF MEDICAL NECESSITY TO INCLUDE LISTING OF MISSING TEETH OR CHART NOTES OF MISSING TEETH AND X-RAYS. SUBMIT WITH ADA CLAIM FORM PRIOR AUTHORIZATION REQUEST: 1. CHART OR LIST MISSING TEETH OR TEETH TO BE EXTRACTED 2. PROVIDE AGE OF ANY EXISTING PARTIAL AND CONDITION OF THAT PARTIAL OR A NARRATIVE IDENTIFYING THE PARTIAL AS AN INITIAL PLACEMENT AND DOCUMENTING HOW THERE IS NOT ADEQUATE OCCLUSION 3. X-RAYS OF REMAINING TEETH
D5213	MAXILLARY PARTIAL DENTURE-CAST METAL FRAMEWORK WITH RESIN DENTURE BASES (INCLUDING ANY CONVENTIONAL CLASPS, RESTS AND TEETH)	ALL	REPLACED ONE TIME IF LOST OR STOLEN. RELINES, REBASES AND ADJUSTMENTS ARE NOT COVERED FOR 6 MONTHS	YES	NO	1 D5211 OR D5213 EVERY 5 YEARS	PER PATIENT	NARRATIVE OF MEDICAL NECESSITY TO INCLUDE LISTING OF MISSING TEETH OR CHART NOTES OF MISSING TEETH AND X-RAYS. SUBMIT WITH ADA CLAIM FORM PRIOR AUTHORIZATION REQUEST: 1. CHART OR LIST MISSING TEETH OR TEETH TO BE EXTRACTED. 2. PROVIDE AGE OF ANY EXISTING PARTIAL AND CONDITION OF THAT PARTIAL OR A NARRATIVE IDENTIFYING THE PARTIAL AS AN INITIAL PLACEMENT AND DOCUMENTING HOW THERE IS NOT ADEQUATE OCCLUSION; 3. X-RAYS OF REMAINING TEETH.

CODE	DESCRIPTION	AGE	TEETH/ COMMENT	PA	PREPAY REVIEW REQUIRED	BENEFIT LIMIT	MEASURE	DOCUMENTATION REQUIRED
D5214	MANDIBULAR PARTIAL DENTURE-CASE METAL FRAMEWORK WITH RESIN DENTURE BASES (INCLUDING ANY CONVENTIONAL CLASPS, REST & TEETH)	ALL	REPLACED ONE TIME IF LOST OR STOLEN. RELINES, REBASES AND ADJUSTMENTS ARE NOT COVERED FOR 6 MONTHS	YES	NO	1 D5212 OR D5214 EVERY 5 YEARS	PER PATIENT	NARRATIVE OF MEDICAL NECESSITY TO INCLUDE LISTING OF MISSING TEETH OR CHART NOTES OF MISSING TEETH AND X-RAYS. SUBMIT WITH ADA CLAIM FORM PRIOR AUTHORIZATION REQUEST: 1. CHART OR LIST MISSING TEETH OR TEETH TO BE EXTRACTED. 2. PROVIDE AGE OF ANY EXISTING PARTIAL AND CONDITION OF THAT PARTIAL OR A NARRATIVE IDENTIFYING THE PARTIAL AS AN INITIAL PLACEMENT AND DOCUMENTING HOW THERE IS NOT ADEQUATE OCCLUSION; 3. X-RAYS OF REMAINING TEETH.
D5410	ADJUST COMPLETE DENTURE - MAXILLARY	ALL		NO	NO			
D5411	ADJUST COMPLETE DENTURE - MANDIBULAR	ALL		NO	NO			
D5421	ADJUST PARTIAL DENTURE - MAXILLARY	ALL		NO	NO			
D5422	ADJUST PARTIAL DENTURE - MANDIBULAR	ALL		NO	NO			
D5511	REPAIR BROKEN COMPLETE DENTURE BASE, MANDIBULAR	ALL		NO	NO	2 PER CODE EVERY 365 DAYS	PER PATIENT	NOT REIMBURSABLE WITHIN 180 DAYS OF INITIAL PLACEMENT
D5512	REPAIR BROKEN COMPLETE DENTURE BASE, MAXILLARY	ALL		NO	NO	2 PER CODE EVERY 365 DAYS	PER PATIENT	NOT REIMBURSABLE WITHIN 180 DAYS OF INITIAL PLACEMENT

CODE	DESCRIPTION	AGE	TEETH/ COMMENT	PA	PREPAY REVIEW REQUIRED	BENEFIT LIMIT	MEASURE	DOCUMENTATION REQUIRED
D5520	REPLACE MISSING OR BROKEN TEETH - COMPLETE DENTURE (EACH TOOTH)	ALL	01-32	NO	NO	2 PER CODE PER TOOTH EVERY 365 DAYS	PER PATIENT	NOT REIMBURSABLE WITHIN 180 DAYS OF INITIAL PLACEMENT
D5611	REPAIR RESIN PARTIAL DENTURE BASE, MANDIBULAR	ALL		NO	NO	2 PER CODE EVERY 365 DAYS	PER PATIENT	NOT REIMBURSABLE WITHIN 180 DAYS OF INITIAL PLACEMENT
D5612	REPAIR RESIN PARTIAL DENTURE BASE, MAXILLARY	ALL		NO	NO	2 PER CODE EVERY 365 DAYS	PER PATIENT	NOT REIMBURSABLE WITHIN 180 DAYS OF INITIAL PLACEMENT
D5621	REPAIR CAST PARTIAL FRAMEWORK, MANDIBULAR	ALL		NO	NO	2 PER CODE EVERY 365 DAYS	PER PATIENT	NOT REIMBURSABLE WITHIN 180 DAYS OF INITIAL PLACEMENT
D5622	REPAIR CAST PARTIAL FRAMEWORK, MAXILLARY	ALL		NO	NO	2 PER CODE EVERY 365 DAYS	PER PATIENT	NOT COVERED WITHIN 180 DAYS OF PLACEMENT
D5630	REPAIR OR REPLACE BROKEN CLASP - PARTIAL PER TOOTH	ALL	01-32	NO	NO	2 PER CODE PER TOOTH EVERY 365 DAYS	PER PATIENT	NOT COVERED WITHIN 180 DAYS OF PLACEMENT
D5640	REPLACE BROKEN TEETH - PER TOOTH	ALL	01-32	NO	NO	2 PER CODE PER TOOTH EVERY 365 DAYS	PER PATIENT	NOT COVERED WITHIN 180 DAYS OF PLACEMENT
D5650	ADD TOOTH TO EXISTING PARTIAL DENTURE	ALL	01-32	NO	NO	2 PER CODE PER TOOTH EVERY 365 DAYS	PER PATIENT	NOT COVERED WITHIN 180 DAYS OF PLACEMENT
D5660	ADD CLASP TO EXISTING PARTIAL DENTURE PER TOOTH	ALL	01-32	NO	NO	2 PER CODE PER TOOTH EVERY 365 DAYS	PER PATIENT	NOT COVERED WITHIN 180 DAYS OF PLACEMENT
D5710	REBASE COMPLETE MAXILLARY DENTURE	ALL		NO	NO	1 PER CODE EVERY 365 DAYS	PER PATIENT	NOT COVERED WITHIN 180 DAYS OF PLACEMENT

CODE	DESCRIPTION	AGE	TEETH/ COMMENT	PA	PREPAY REVIEW REQUIRED	BENEFIT LIMIT	MEASURE	DOCUMENTATION REQUIRED
D5711	REBASE COMPLETE MANDIBULAR DENTURE	ALL		NO	NO	1 PER CODE EVERY 365 DAYS	PER PATIENT	NOT COVERED WITHIN 180 DAYS OF PLACEMENT
D5720	REBASE MAXILLARY PARTIAL DENTURE	ALL		NO	NO	1 PER CODE EVERY 365 DAYS	PER PATIENT	NOT COVERED WITHIN 180 DAYS OF PLACEMENT
D5721	REBASE MANDIBULAR PARTIAL DENTURE	ALL		NO	NO	1 PER CODE EVERY 365 DAYS	PER PATIENT	NOT COVERED WITHIN 180 DAYS OF PLACEMENT
D5730	RELINE COMPLETE MAXILLARY DENTURE (CHAIRSIDE)	ALL		NO	NO	1 PER CODE EVERY 365 DAYS	PER PATIENT	NOT COVERED WITHIN 180 DAYS OF PLACEMENT
D5731	RELINE COMPLETE MANDIBULAR DENTURE (CHAIRSIDE)	ALL		NO	NO	1 PER CODE EVERY 365 DAYS	PER PATIENT	NOT COVERED WITHIN 180 DAYS OF PLACEMENT
D5740	RELINE MAXILLARY PARTIAL DENTURE (CHAIRSIDE)	ALL		NO	NO	1 PER CODE EVERY 365 DAYS	PER PATIENT	NOT COVERED WITHIN 180 DAYS OF PLACEMENT
D5741	RELINE MANDIBULAR PARTIAL DENTURE (CHAIRSIDE)	ALL		NO	NO	1 PER CODE EVERY 365 DAYS	PER PATIENT	NOT COVERED WITHIN 180 DAYS OF PLACEMENT
D5750	RELINE COMPLETE MAXILLARY DENTURE (LABORATORY)	ALL		NO	NO	1 PER CODE EVERY 365 DAYS	PER PATIENT	NOT COVERED WITHIN 180 DAYS OF PLACEMENT
D5751	RELINE COMPLETE MANDIBULAR DENTURE (LABORATORY)	ALL		NO	NO	1 PER CODE EVERY 365 DAYS	PER PATIENT	NOT COVERED WITHIN 180 DAYS OF PLACEMENT
D5760	RELINE MAXILLARY PARTIAL DENTURE (LABORATORY)	ALL		NO	NO	1 PER CODE EVERY 365 DAYS	PER PATIENT	NOT COVERED WITHIN 180 DAYS OF PLACEMENT

CODE	DESCRIPTION	AGE	TEETH/ COMMENT	PA	PREPAY REVIEW REQUIRED	BENEFIT LIMIT	MEASURE	DOCUMENTATION REQUIRED
D5761	RELINE MANDIBULAR PARTIAL DENTURE (LABORATORY)	ALL		NO	NO	1 PER CODE EVERY 365 DAYS	PER PATIENT	NOT COVERED WITHIN 180 DAYS OF PLACEMENT
D5765	SOFT LINER FOR COMPLETE OR REMOVABLE DENTURE	ALL	LA, UA	NO	NO	1 PER CODE PER ARCH EVERY 365 DAYS	PER PATIENT	SOFT LINER IS FOR ADULTS ONLY, ARCH IS REQUIRED. COVERAGE CRITERIA IS 180 DAYS AFTER PLACEMENT OF A NEW PROSTHESIS AND THEN COVERED EVERY 365 DAYS. DOCUMENTATION REQUIRED TO SUBSTANTIATE MEDICAL NECESSITY, INCLUDE VISIT NOTES SUBSTANTIATING NEED FOR REBASE PROSTHESIS.
D5810	INTERIM COMPLETE DENTURE (MAXILLARY)	ALL	NOT A PERMANENT DENTURE. CAN BE REPLACED WITH A COMPLETE DENTURE 180 DAYS AFTER PLACEMENT OF THE INTERIM DENTURE. COMPLETE DENTURES REQUIRE PA.	YES	NO	1 PER CODE EVERY 5 YEARS	PER PATIENT	DATE AND LIST OF TEETH TO BE EXTRACTED; AND NARRATIVE DOCUMENTING THE MEDICAL NECESSITY; AND PANOREX OR FULL MOUTH X-RAYS. RELINES, REBASES, AND ADJUSTMENTS ARE NOT COVERED FOR 180 DAYS AFTER PLACEMENT OF PROSTHESIS.
D5811	INTERIM COMPLETE DENTURE (MANDIBULAR)	ALL	NOT A PERMANENT DENTURE. CAN BE REPLACED WITH A COMPLETE DENTURE 180 DAYS AFTER PLACEMENT OF THE INTERIM DENTURE. COMPLETE DENTURES REQUIRE PA.	YES	NO	1 PER CODE EVERY 5 YEARS	PER PATIENT	DATE AND LIST OF TEETH TO BE EXTRACTED; AND NARRATIVE DOCUMENTING THE MEDICAL NECESSITY; AND PANOREX OR FULL MOUTH X-RAYS. RELINES, REBASES, AND ADJUSTMENTS ARE NOT COVERED FOR 180 DAYS AFTER PLACEMENT OF PROSTHESIS.

CODE	DESCRIPTION	AGE	TEETH/ COMMENT	PA	PREPAY REVIEW REQUIRED	BENEFIT LIMIT	MEASURE	DOCUMENTATION REQUIRED
D5820	INTERIM PARTIAL DENTURE (MAXILLARY) (FLIPPER PARTIAL)	ALL	CONSIDERED A PERMANENT REPLACEMENT FOR 1 TO 3 MISSING ANTERIOR TEETH. NOT COVERED FOR TEMPORARY REPLACEMENT OF MISSING TEETH.	YES	NO	1 PER CODE EVERY 5 YEARS CONSIDERED A PERMANENT REPLACEMENT FOR 1 TO 3 MISSING ANTERIOR TEETH.	PER PATIENT	DATE AND LIST OF TEETH TO BE EXTRACTED; AND NARRATIVE DOCUMENTING THE MEDICAL NECESSITY; AND PANOREX OR FULL MOUTH X-RAYS. RELINES, REBASES, AND ADJUSTMENTS ARE NOT COVERED FOR 180 DAYS AFTER PLACEMENT OF PROSTHESIS.
D5821	INTERIM PARTIAL DENTURE (MANDIBULAR) (FLIPPER PARTIAL	ALL	CONSIDERED A PERMANENT REPLACEMENT FOR 1 TO 3 MISSING ANTERIOR TEETH. NOT COVERED FOR TEMPORARY REPLACEMENT OF MISSING TEETH.	YES	NO	1 PER CODE EVERY 5 YEARS CONSIDERED A PERMANENT REPLACEMENT FOR 1 TO 3 MISSING ANTERIOR TEETH.	PER PATIENT	DATE AND LIST OF TEETH TO BE EXTRACTED; AND NARRATIVE DOCUMENTING THE MEDICAL NECESSITY; AND PANOREX OR FULL MOUTH X-RAYS. RELINES, REBASES, AND ADJUSTMENTS ARE NOT COVERED FOR 180 DAYS AFTER PLACEMENT OF PROSTHESIS.
D5850	TISSUE CONDITIONING, MAXILLARY	ALL		NO	NO	2 PER CODE EVERY 365 DAYS	PER PATIENT	
D5851	TISSUE CONDITIONING, MANDIBULAR	ALL		NO	NO	2 PER CODE EVERY 365 DAYS	PER PATIENT	
D5899	UNSPECIFIED REMOVABLE PROSTHODONTIC	ALL	ALL	YES	YES	BY REPORT		CODE TO ONLY BE USED WHEN REQUESTING PARTIAL PAYMENT OF A DENTURE DURING INTERRUPTED TREATMENT
D6930	RE-CEMENT OR RE-BOND FIXED PARTIAL DENTURE OR FIXED BRIDGE	ALL	01-32	NO	NO	1 CODE PER YEAR		NOT COVERED FOR 180 DAYS AFTER PLACEMENT
D7111	CORONAL REMNANTS - DECIDUOUS TOOTH	ALL	A-T, AS-TS	NO	NO	1 CODE PER TOOTH PER LIFETIME		

CODE	DESCRIPTION	AGE	TEETH/ COMMENT	PA	PREPAY REVIEW REQUIRED	BENEFIT LIMIT	MEASURE	DOCUMENTATION REQUIRED
D7140	EXTRACTION, ERUPTED TOOTH OR EXPOSED ROOT (ELEVATION AND/OR FORCEPS REMOVAL)	ALL	01-32, A-T, 51-82, AS-TS	NO	NO	1 CODE PER TOOTH PER LIFETIME		
D7210	SURGICAL REMOVAL OF ERUPTED TOOTH REQUIRING ELEVATION OF MUCOPERIOSTEAL FLAP AND REMOVAL OF BONE AND/OR SECTION OF TOOTH	ALL	01-32, A-T, 51-82, AS-TS	NO	YES	1 CODE PER TOOTH PER LIFETIME		REQUIRES X-RAYS AND MEDICAL NECESSITY ATTACHED
D7220	REMOVAL OF IMPACTED TOOTH--SOFT TISSUE	ALL	01-32, A-T, 51-82, AS-TS	NO	YES	1 CODE PER TOOTH PER LIFETIME		REQUIRES X-RAYS AND MEDICAL NECESSITY ATTACHED
D7230	REMOVAL OF IMPACTED TOOTH - PARTIALLY BONY	ALL	A-T, AS-TS	NO	YES	1 CODE PER TOOTH PER LIFETIME		REQUIRES X-RAYS AND MEDICAL NECESSITY ATTACHED
D7240	REMOVAL OF IMPACTED TOOTH - COMPLETELY BONY	ALL	01-32, A-T, 51-82, AS-TS	NO	YES	1 CODE PER TOOTH PER LIFETIME		REQUIRES X-RAYS AND MEDICAL NECESSITY ATTACHED
D7241	REMOVAL OF IMPACTED TOOTH-COMPLETELY BONY, WITH UNUSUAL SURGICAL COMPLICATIONS	ALL	A-T, AS-TS	NO	YES	1 CODE PER TOOTH PER LIFETIME		REQUIRES X-RAYS AND MEDICAL NECESSITY ATTACHED
D7250	SURGICAL REMOVAL OF RESIDUAL TOOTH ROOTS (CUTTING PROCEDURE)	ALL	01-32, A-T, 51-82, AS-TS	NO	YES	1 CODE PER TOOTH PER LIFETIME		REQUIRES X-RAYS AND MEDICAL NECESSITY ATTACHED

CODE	DESCRIPTION	AGE	TEETH/ COMMENT	PA	PREPAY REVIEW REQUIRED	BENEFIT LIMIT	MEASURE	DOCUMENTATION REQUIRED
D7270	TOOTH REIMPLANTATION AND/OR STABILIZATION OF ACCIDENTLY AVULSED OR DISPLACED TOOTH AND/OR ALVEOLUS	ALL	01-32	NO	YES			REQUIRES X-RAYS AND MEDICAL NECESSITY ATTACHED
D7280	SURGICAL ACCESS OF AN UNERUPTED TOOTH	ALL	02-15, 18-31	NO	YES			REQUIRES X-RAYS AND MEDICAL NECESSITY ATTACHED
D7282	MOBILIZATION OF ERUPTED OR MALPOSITIONED TOOTH TO AID ERUPTION	ALL	01-32	NO	YES			REQUIRES X-RAYS AND MEDICAL NECESSITY ATTACHED
D7283	PLACEMENT OF DEVICE TO FACILITATE ERUPTION OF IMPACTED TOOTH	0-20	02-15, 18-31	NO	YES			REQUIRES X-RAYS AND MEDICAL NECESSITY ATTACHED
D7285	INCISIONAL BIOPSY OF ORAL TISSUE - HARD (BONE, TOOTH)	ALL		NO	YES			REQUIRES X-RAYS AND MEDICAL NECESSITY ATTACHED
D7286	INCISIONAL BIOPSY OF ORAL TISSUE - SOFT	ALL		NO	YES			REQUIRES X-RAYS AND MEDICAL NECESSITY ATTACHED
D7310	ALVEOLOPLASTY IN CONJUNCTION WITH EXTRACTIONS - FOUR OR MORE TEETH OR TOOTH SPACES PER QUADRANT	ALL	LL, LR, UL, UR	NO	YES			REQUIRES X-RAYS MEDICAL NECESSITY ATTACHED AND QUAD MUST BE DONE IN CONJUNCTION WITH THE FABRICATION OF A PROSTHODONTIC APPLIANCE

CODE	DESCRIPTION	AGE	TEETH/ COMMENT	PA	PREPAY REVIEW REQUIRED	BENEFIT LIMIT	MEASURE	DOCUMENTATION REQUIRED
D7311	ALVEOLOPLASTY IN CONJUNCTION WITH EXTRACTIONS - ONE TO THREE TEETH OR TOOTH SPACES, PER QUADRANT	ALL	LL, LR, UL, UR	NO	YES			REQUIRES X-RAYS MEDICAL NECESSITY ATTACHED AND QUAD MUST BE DONE IN CONJUNCTION WITH THE FABRICATION OF A PROSTHODONTIC APPLIANCE
D7320	ALVEOLOPLASTY NOT IN CONJUNCTION WITH EXTRACTIONS - FOUR OR MORE TEETH OR TOOTH SPACES PER QUADRANT	ALL	LL, LR, UL, UR	NO	YES			REQUIRES X-RAYS MEDICAL NECESSITY ATTACHED AND QUAD MUST BE DONE IN CONJUNCTION WITH THE FABRICATION OF A PROSTHODONTIC APPLIANCE
D7321	ALVEOLOPLASTY NOT IN CONJUNCTION WITH EXTRACTIONS - ONE TO THREE TEETH OR TOOTH SPACES, PER QUADRANT	ALL	LL, LR, UL, UR	NO	YES			REQUIRES X-RAYS MEDICAL NECESSITY ATTACHED AND QUAD MUST BE DONE IN CONJUNCTION WITH THE FABRICATION OF A PROSTHODONTIC APPLIANCE
D7410	EXCISION OF BENIGN LESION UP TO 1.25 CM (1-3-03)	ALL	BY REPORT	NO	YES			REQUIRES COLOR PHOTOS
D7411	EXCISION OF BENIGN LESION GREATER THAN 1.25 CM	ALL	BY REPORT	NO	YES			REQUIRES COLOR PHOTOS AND MEDICAL NECESSITY ATTACHED
D7412	EXCISION OF BENIGN LESION, COMPLICATED	ALL	BY REPORT	NO	YES			REQUIRES COLOR PHOTOS
D7413	EXCISION OF MALIGNANT	ALL	BY REPORT	NO	YES			REQUIRES COLOR PHOTOS AND MEDICAL NECESSITY ATTACHED

CODE	DESCRIPTION	AGE	TEETH/ COMMENT	PA	PREPAY REVIEW REQUIRED	BENEFIT LIMIT	MEASURE	DOCUMENTATION REQUIRED
	LESION UP TO 1.25 CM							
D7414	EXCISION OF MALIGNANT LESION GREATER THAN 1.25 CM	ALL	BY REPORT	NO	YES			REQUIRES COLOR PHOTOS AND MEDICAL NECESSITY ATTACHED
D7415	EXCISION OF MALIGNANT LESION, COMPLICATED	ALL	BY REPORT	NO	YES			REQUIRES PATHOLOGY REPORT
D7440	EXCISION OF MALIGNANT TUMOR - LESION DIAMETER UP TO 1.25 CM	ALL	BY REPORT	NO	YES			REQUIRES PATHOLOGY REPORT
D7441	EXCISION OF MALIGNANT TUMOR - LESION DIAMETER GREATER THAN 1.25 CM	ALL	BY REPORT	NO	YES			REQUIRES PATHOLOGY REPORT
D7450	REMOVAL OF BENIGN OR ODONTOGENIC CYST OR TUMOR-LESION DIAMETER UP TO 1.25 CM (1-3-03)	ALL	BY REPORT	NO	YES			REQUIRES PATHOLOGY REPORT
D7451	REMOVAL OF BENIGN ODONTOGENIC CYST OR TUMOR-LESION DIAMETER GREATER THAN 1.25 CM (1-3-03)	ALL	BY REPORT	NO	YES			REQUIRES PATHOLOGY REPORT
D7460	REMOVAL OF BENIGN NONODONTOGENIC CYST OR TUMOR	ALL	BY REPORT	NO	YES			REQUIRES PATHOLOGY REPORT

CODE	DESCRIPTION	AGE	TEETH/ COMMENT	PA	PREPAY REVIEW REQUIRED	BENEFIT LIMIT	MEASURE	DOCUMENTATION REQUIRED
	- LESION DIAMETER GREATER THAN 1.25 CM (1-3-03)							
D7461	REMOVAL OF BENIGN NONODONTOGENIC CYST OR TUMOR-LESION DIAMETER GREATER THAN 1.25 CM (1-3-03)	ALL	BY REPORT	NO	YES			REQUIRES PATHOLOGY REPORT
D7465	DESTRUCTION OF LESION(S) BY PHYSICAL OR CHEMICAL METHOD, BY REPORT	ALL	BY REPORT	NO	YES			REQUIRES PATHOLOGY REPORT
D7471	REMOVAL OF LATERAL EXOSTOSIS (MAXILLA OR MANDIBLE)	ALL	LA, UA	NO	YES			REQUIRES X-RAYS AND MEDICAL NECESSITY ATTACHED
D7510	INCISION & DRAINAGE OF ABSCESS, INTRAORAL SOFT TISSUE	ALL	1-32, 51-82, A-T, AS-AT	NO	NO			
D7880	OCCLUSAL ORTHOTIC DEVICE, BY REPORT	ALL	BY REPORT	NO	YES			REQUIRES MEDICAL NECESSITY ATTACHED AND TYPE OF APPLIANCE MADE. ORAL CAVITY DESIGNATOR 01,02,10,20,30, AND 40.
D7961	BUCCAL LABIAL FRENECTOMY (FRENULECTOMY)	ALL		NO	NO	2 CODES PER ARCH PER LIFETIME		
D7962	LINGUAL FRENECTOMY (FRENULECTOMY)	ALL		NO	NO	1 CODE PER ARCH PER LIFETIME		

CODE	DESCRIPTION	AGE	TEETH/ COMMENT	PA	PREPAY REVIEW REQUIRED	BENEFIT LIMIT	MEASURE	DOCUMENTATION REQUIRED
D8020	LIMITED ORTHODONTIC TREATMENT/TRANS. DENTITION	0-20	FEE DETERMINED BY APPROVED TREATMENT PLAN-BY REPORT	YES	NO			REQUIRED DOCUMENTATION TO SUBMIT: 1. ADA CLAIM FORM PRIOR AUTHORIZATION REQUEST. 2. COMPLETE HLD FORM 3. NARRATIVE OF NECESSITY. 4. X-RAYS AND PHOTOS THAT SHOW QUALIFYING CONDITIONS.
D8080	COMPREHENSIVE ORTHODONTIC TREATMENT OF THE ADOLESCENT DENTITION	0-20	FEE DETERMINED BY APPROVED TREATMENT PLAN-BY REPORT	YES	NO			
D8080, D8090	COMPREHENSIVE ORTHODONTIC TREATMENT OF THE ADULT DENTITION	0-20	FEE DETERMINED BY APPROVED TREATMENT PLAN-BY REPORT	YES	NO			REQUIRED DOCUMENTATION TO SUBMIT: 1. ADA CLAIM FORM PRIOR AUTHORIZATION REQUEST. 2. COMPREHENSIVE TREATMENT ORTHO REQUEST FORM OUTLINING ALL REQUESTED TREATMENT TO BE COMPLETED AND ESTIMATE OF TIME. 3. COMPLETED HLD FORM THAT MEETS THE CRITERIA FOR POSSIBLE APPROVAL. 4. NARRATIVE OF NECESSITY, DIAGNOSIS, AND PROGNOSIS. 5. DIAGNOSTIC RECORDS: CASTS AND/OR ORAL FACIAL PHOTOGRAPHIC IM**AGES**. PANOREX AND CEPHALOMETRIC X- RAYS ON SURGICAL CASES INCLUDE A DESCRIPTION OF THE PROCEDURE TO BE COMPLETED. FOLLOWING COMPLETED SURGERY, A SURGICAL LETTER OF DOCUMENTATION IS REQUIRED ACCOMPANYING AN ADDITIONAL PRIOR AUTHORIZATION REQUEST FOR THE ADDED SURGICAL FEE.
D8080, D8090 (PROCEDURES COVERED UNDER CODE D8080, D8090)	CONSTRUCTING AND PLACING FIXED MAXILLARY APPLIANCE, ACTIVE TREATMENT			YES	NO			REQUIRED DOCUMENTATION TO SUBMIT: 1. ADA CLAIM FORM PRIOR AUTHORIZATION REQUEST. 2. COMPREHENSIVE TREATMENT ORTHO REQUEST FORM OUTLINING ALL REQUESTED TREATMENT TO BE COMPLETED AND ESTIMATE OF TIME. 3. COMPLETED HLD FORM THAT MEETS THE CRITERIA FOR POSSIBLE APPROVAL. 4. NARRATIVE OF NECESSITY, DIAGNOSIS, AND PROGNOSIS. 5. DIAGNOSTIC RECORDS: CASTS AND/OR ORAL FACIAL PHOTOGRAPHIC IM**AGES**. PANOREX AND CEPHALOMETRIC X- RAYS ON SURGICAL CASES INCLUDE A DESCRIPTION OF THE PROCEDURE TO BE COMPLETED. FOLLOWING COMPLETED SURGERY, A SURGICAL LETTER OF DOCUMENTATION IS

CODE	DESCRIPTION	AGE	TEETH/ COMMENT	PA	PREPAY REVIEW REQUIRED	BENEFIT LIMIT	MEASURE	DOCUMENTATION REQUIRED
								REQUIRED ACCOMPANYING AN ADDITIONAL PRIOR AUTHORIZATION REQUEST FOR THE ADDED SURGICAL FEE.
	CONSTRUCTING AND PLACING FIXED MANDIBULAR APPLIANCE, ACTIVE TREATMENT			YES	NO			
	EACH ONE-MONTH PERIOD OF ACTIVE TREATMENT-MAXILLARY ARCH			YES	NO			
	EACH ONE-MONTH PERIOD OF ACTIVE TREATMENT-MAXILLARY ARCH, UNUSUAL SERVICE (SURGICAL CORRECTION CASE)			YES	NO			
	EACH ONE-MONTH PERIOD OF ACTIVE TREATMENT-MANDIBULAR ARCH			YES	NO			
	EACH ONE-MONTH PERIOD OF ACTIVE TREATMENT-MANDIBULAR ARCH, UNUSUAL SERVICE (SURGICAL CORRECTION CASE)			YES	NO			
	RETAINER OR RETENTION APPLIANCE			YES	NO			
	EACH ONE-MONTH PERIOD OF RETENTION APPLIANCE			YES	NO			

CODE	DESCRIPTION	AGE	TEETH/ COMMENT	PA	PREPAY REVIEW REQUIRED	BENEFIT LIMIT	MEASURE	DOCUMENTATION REQUIRED
	TREATMENT-MAXILLARY ARCH							
	EACH ONE-MONTH PERIOD OF RETENTION APPLIANCE TREATMENT-MANDIBULAR ARCH			YES	NO			
	RAPID PALATAL EXPANDER (RPE) OR CROSS-BITE CORRECTING (FIXED) APPLIANCE			YES	NO			
	HERBST APPLIANCE			YES	NO			
	PROTRACTION FACEMASK			YES	NO			
	SLOW EXPANSION APPLIANCE			YES	NO			
	HEADGEAR			YES	NO			
	INCLINED PLANE (HAWLEY) APPLIANCE, BITE PLANE, WITH CLASPS			YES	NO			
	ORTHODONTIC APPLIANCE, NOT LISTED			YES	NO			
	ORTHODONTIC PROCEDURE, NOT LISTED			YES	NO			

CODE	DESCRIPTION	AGE	TEETH/ COMMENT	PA	PREPAY REVIEW REQUIRED	BENEFIT LIMIT	MEASURE	DOCUMENTATION REQUIRED
	SPACE MAINTAINER-FIXED-UNILATERAL, PART OF COMPREHENSIVE ORTHODONTIC TREATMENT PLAN			YES	NO			
	SPACE MAINTAINER-FIXED-BILATERAL, PART OF COMPREHENSIVE ORTHODONTIC TREATMENT PLAN			YES	NO			
D8210	REMOVABLE APPLIANCE THERAPY (THUMB-SUCKING & TONGUE THRUST)	0-20		NO	YES	1 CODE PER LIFETIME		REQUIRES X-RAYS AND MEDICAL NECESSITY ATTACHED
D8220	FIXED APPLIANCE THERAPY (THUMB-SUCKING AND TONGUE THRUST)	0-20		NO	YES	1 CODE PER LIFETIME		REQUIRES X-RAYS AND MEDICAL NECESSITY ATTACHED
D8696	REPAIR OF ORTHODONTIC APPLIANCE-MAXILLARY	0-20	FEE IS BY REPORT	NO	NO	5 PER LIFETIME		
D8697	REPAIR OF ORTHODONTIC APPLIANCE-MANDIBULAR	0-20	FEE IS BY REPORT	NO	NO	5 PER LIFETIME		
D8698	RE-CEMENT OF RE-BOND FIXED RETAINER-MAXILLARY	0-20		NO	NO	5 PER LIFETIME		
D8699	RE-CEMENT OR RE-BOND FIXED	0-20		NO	NO	5 PER LIFETIME		

CODE	DESCRIPTION	AGE	TEETH/ COMMENT	PA	PREPAY REVIEW REQUIRED	BENEFIT LIMIT	MEASURE	DOCUMENTATION REQUIRED
	RETAINER-MANDIBULAR							
D8703	REPLACEMENT OF LOST OR BROKEN RETAINER-MAXILLARY	0-20		NO	YES	1 PER LIFETIME	PER PATIENT	REQUIRES MEDICAL NECESSITY ATTACHED
D8704	REPLACEMENT OF LOST OR BROKEN RETAINER-MANDIBULAR	0-20		NO	YES	1 PER LIFETIME	PER PATIENT	REQUIRES MEDICAL NECESSITY ATTACHED
D8999	UNSPECIFIED ORTHODONTIC PROCEDURE, BY REPORT	0-20	BY REPORT	YES	YES			REQUIRES MEDICAL NECESSITY ATTACHED
D9110	PALLIATIVE (EMERGENCY) TREATMENT OF DENTAL PAIN-PER VISIT	ALL		NO	YES	1 PER CODE EVERY DAY	PER PATIENT PER LOCATION	REQUIRES MEDICAL NECESSITY ATTACHED AND TID OR AREA
D9219	EVALUATION FOR DEEP SEDATION OR GENERAL ANESTHESIA(GA)	ALL	AKK	NO	NO	1 PER YEAR	PER PATIENT PER PROVIDER	PROVIDER MUST HAVE A DEEP SEDATION/GA PERMIT ON FILE TO PROVIDE THIS SERVICE
D9222	DEEP SEDATION/GENERAL ANESTHESIA - FIRST 15 MIN	ALL		NO	YES	1 D9222, D9230, D9239, D9248 PER DAY	PER PATIENT	MUST HAVE APPROPRIATE PERMITS D9223, D9243, D9248 NARRATIVE OF MED NEC, MONITORED VITAL SIGNS, ANESTHESIA TIME LOG, INCLUDING START AND STOP TIMES, MEDICATION, AND DOSE
D9223	DEEP SEDATION/GENERAL ANESTHESIA - EACH 15 MIN. INCREMENT	ALL		NO	YES	1 TYPE OF ANESTHESIA PER DAY D9222+D9223, D9230, D9239+D9243 OR D9248	PER PATIENT	
D9230	INHALATION OF NITROUS	ALL		NO	NO	1 TYPE OF ANESTHESIA PER DAY D9222+D9223, D9230, D9239+D9243 OR D9248	PER PATIENT	

CODE	DESCRIPTION	AGE	TEETH/ COMMENT	PA	PREPAY REVIEW REQUIRED	BENEFIT LIMIT	MEASURE	DOCUMENTATION REQUIRED
	OXIDE/ANXIOLYSIS, ANALGESIA							
D9239	INTRAVENOUS MODERATE (CONSCIOUS) SEDATION/ANALGESIA- FIRST 15 MIN	ALL		NO	YES	1 TYPE OF ANESTHESIA PER DAY D9222+D9223, D9230, D9239+D9243 OR D9248	PER PATIENT	MUST HAVE APPROPRIATE PERMITS D9223, D9243, D9248 NARRATIVE OF MED NEC, MONITORED VITAL SIGNS, ANESTHESIA TIME LOG, INCLUDING START AND STOP TIMES, MEDICATION, AND DOSE
D9243	INTRAVENOUS MODERATE (CONSCIOUS) SEDATION/ANALGESIA - EACH 15 MIN INCREMENT	ALL		NO	NO	1 TYPE OF ANESTHESIA PER DAY D9222+D9223, D9230, D9239+D9243 OR D9248	PER PATIENT	MUST HAVE APPROPRIATE PERMITS D9223, D9243, D9248 NARRATIVE OF MED NEC, MONITORED VITAL SIGNS, ANESTHESIA TIME LOG, INCLUDING START AND STOP TIMES, MEDICATION, AND DOSE
D9248	NON-INTRAVENOUS MODERATE (CONSCIOUS) SEDATION	ALL		NO	NO	1 TYPE OF ANESTHESIA PER DAY D9222+D9223, D9230, D9239+D9243 OR D9248	PER PATIENT	
D9310 (EFF. 7/1/2025)	CONSULTATION-DIAGNOSTIC SERVICE PROVIDED BY DENTIST OR PHYSICIAN OTHER THAN REQUESTING DENTIST OR PHYSICIAN	ALL		NO	NO	1 PER YEAR		
D9410	HOUSE/EXTENDED CARE FACILITY	ALL		NO	YES	1 PER DAY PER FACILITY REGARDLESS OF THE NUMBER OF PATIENTS SEEN.		REQUIRES MEDICAL NECESSITY ATTACHED AND ADDRESS OF FACILITY OR HOME WHERE TREATMENT TOOK PLACE.
D9420	HOSPITAL CALL	ALL		NO	YES	1 PER DAY PER FACILITY		REQUIRES MEDICAL NECESSITY ATTACHED
D9440	OFFICE VISIT-AFTER REGULAR HOURS	ALL		NO	YES			MEDICAL NECESSITY ATTACHED INCLUDING THE TIME OF PATIENT ARRIVAL
D9944	OCCLUSAL GUARD HARD APPLIANCE FULL ARCH REMOVABLE DENTAL APPLIANCE	ALL		NO	YES			REQUIRES MEDICAL NECESSITY ATTACHED

CODE	DESCRIPTION	AGE	TEETH/ COMMENT	PA	PREPAY REVIEW REQUIRED	BENEFIT LIMIT	MEASURE	DOCUMENTATION REQUIRED
D9945	OCCLUSAL GUARD SOFT APPLIANCE FULL ARCH REMOVABLE DENTAL APPLIANCE	ALL		NO	YES			REQUIRES MEDICAL NECESSITY ATTACHED
D9946	OCCLUSAL GUARD HARD APPLIANCE PARTIAL ARCH REMOVABLE DENTAL APPLIANCE	ALL		NO	YES			REQUIRES MEDICAL NECESSITY ATTACHED
D9997	DENTAL CASE MANAGEMENT - PATIENTS WITH SPECIAL HEALTH CARE NEEDS	ALL	NO REIMBURSEMENT FOR THIS CODE. USED TO IDENTIFY A MEMBER WITH SPECIAL HEALTHCARE NEED(S). A NARRATIVE INDICATING THE MEMBER'S SPECIAL HEALTH CONDITION	NO	NO			USED TO INDICATE SPECIAL NEEDS INCLUDE A NARRATIVE INDICATING THE MEMBER'S SPECIAL HEALTH CONDITION
D9999	UNSPECIFIED ADJUNCTIVE PROCEDURE	ALL		NO	YES			REQUIRES MEDICAL NECESSITY ATTACHED, AND INVOICE, REIMBURSEMENT IS DETERMINED ON A CASE-BY-CASE BASIS BY THE DENTAL DIRECTOR.
T1015	FQHC ENCOUNTER PAYMENT-ADA	ALL		NO	NO			FQHC/IHS ONLY

Dental Value-Added Benefits

Value added services are not Medicaid-funded, and as such, are not subject to appeal and fair hearing rights. The table below outlines Molina's value-added services:

Program	Value-added Benefit	Description	Eligible Populations
Pregnancy: Dental services	1 additional cleaning (D1110) for pregnant moms	Pregnant women can receive an additional cleaning during pregnancy.	Pregnant Members
Dental exams: Problem-focused	2 additional problem-focused oral exams (D1120)	2 additional problem-focused oral exams to supplement existing Medicaid dental benefits.	All Members

The following web link provides access to all basic benefit information for the Heritage Health program offered by Molina in Nebraska:

MolinaHeathcare.com/members

Services Not Covered by Molina

A provider may bill a member for non-covered services if the provider obtains a Non-Covered Services Agreement form from the Member prior to rendering such services. The agreement must include:

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

The non-covered Services agreement can be found on SKYGEN's Dental HUB and Molina's Healthcare Website.

Emergency Services

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

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

Emergency medical condition: A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in the following: (1) placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; (2) serious impairment to bodily functions; or (3) serious dysfunction of any bodily organ or part.

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

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

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

599 CHIP Services

The 599 CHIP program is designed for unborn children of pregnant women who are otherwise ineligible for coverage under Medicaid or CHIP. This program is not full Medicaid coverage and only applies to prenatal care and pregnancy-related services. These services are connected to the health of the unborn child (emergency benefits for unborn), including labor and delivery.

Post-Stabilization

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

Molina covers post-stabilization care services if they are:

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

Medical Necessity

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

- Necessary to meet the basic health needs of the Member.
- Rendered in the most cost-efficient manner and type of setting appropriate for the delivery of the Covered Service.

- Consistent in type, frequency, and duration of treatment with scientifically based guidelines of national dental, research, or health care coverage organizations or governmental agencies.
- Consistent with the diagnosis of the condition.
- Required for means other than convenience of the client or their provider.
- No more intrusive or restrictive than necessary to provide a proper balance of safety, effectiveness, and efficiency.
- Of demonstrated value.
- No more intensive level of service than can be safely provided.

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

1. In accordance with generally accepted standards of dental practice.
2. Clinically appropriate and clinically significant, in terms of type, frequency, extent, site and duration. They are considered effective for the patient's illness, injury, or disease.
3. Not primarily for the convenience of the patient, provider, 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 dental or allied goods or services does not, in itself, make such care, goods or services Medically Necessary, a Medical Necessity or a Covered Service/benefit.

Medical Necessity Review

Molina only reimburses for services that are Medically Necessary. Medical Necessity review may take place prospectively, as part of the inpatient admission notification/concurrent review, or retrospectively. To determine Medical Necessity, in conjunction with independent professional dental judgment, Molina uses nationally recognized evidence-based guidelines, third party guidelines, CMS guidelines, state guidelines, guidelines from recognized professional societies, and advice from authoritative review articles and textbooks.

Prior Authorization

Prior authorizations/ requests and status checks can be easily managed electronically.

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

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

Molina offers the following electronic prior authorizations requests submission options:

- Submit requests directly to Molina via the SKYGEN Dental HUB.
- Submit requests via 278 transactions. See the EDI transaction section of Molina's website for guidance.
- Submit requests via USPS at:

  Molina NE Auths
  PO Box 306
  Milwaukee, WI 53201

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

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

- Member demographic information (name, date of birth, Molina ID number).
- Provider demographic information (referring Provider and referred to Provider/facility, including address and NPI number).
- Requested service/procedure, including all appropriate CDT codes.
- Location where service will be performed.
- Clinical information sufficient to document the Medical Necessity of the requested service is required including:
  - Pertinent medical history (including treatment, diagnostic tests, examination data).
  - Requested length of stay (for inpatient requests).

- Rationale for expedited processing.

Services performed without authorization may not be eligible for payment. Services provided emergently (as defined by Federal and State Law) are excluded from the prior authorization requirements. Prior Authorization is not a guarantee of payment. Payment is contingent upon medical necessity and Member eligibility at the time of service. Molina retains the right to review benefit limitations and exclusions, beneficiary eligibility on the Date of Service, correct coding, billing practices and whether the service was provided in the most appropriate and cost-effective setting of care. Molina does not retroactively authorize services that require prior authorization.

Molina follows all prior authorization requirements related to care for newborns and their mothers in alignment with the Newborn Mothers Health Protection Act.

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

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

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

Providers who request prior authorization approval for patient services and/or procedures may request to review the criteria used to make the final decision. Molina has a full-time Dental Director available to discuss Medical Necessity decisions with the requesting Provider at (855) 806-5192 from 7:00 a.m. to 8:00 p.m. CT, Monday through Friday.

Upon approval, the requestor will receive an authorization number. The number may be provided by telephone or fax. If a request is denied, the requestor and the Member will receive

a letter explaining the reason for the denial and additional information regarding the grievance and appeals process. Denials are also communicated to the Provider via fax.

Requesting Prior Authorization

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

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

- Create and submit Prior Authorization Requests.
- Check status of Authorization Requests.
- Receive notification of change in status of Authorization Requests.
- Attach dental documentation required for timely dental review and decision making.

Prior authorization requests may be submitted through one of the following channels:

- SKYGEN Dental HUB
- Electronic submission via clearinghouse
  - Change Healthcare
  - DentalXChange
  - Payer ID: SKYGN
- 2012 or newer ADA claim form

Approved authorization does not guarantee payment. The Member and benefit must be eligible at the time services are rendered. Prior authorizations will be honored for 365 days from the date they are issued.

Prior authorizations can be initiated by contacting SKYGEN Provider Service sat (855) 806-5192 from 7:00 a.m. to 8:00 p.m. CT, Monday through Friday. It may be necessary to submit additional documentation before the authorization can be processed.

Prior Authorization Extensions

Molina Healthcare of Nebraska has made updates to the guidelines for prior authorization service requests, in an effort to reduce prior authorization denials.

If Molina Healthcare of Nebraska receives a prior authorization service request that requires additional information, outreach to the provider will be completed to obtain the required

clinical information (e.g., x-rays, perio chart, rationale). This change may extend our review time; however, a decision will be made no more than 25 days from the request date.

If, after the extension, the outstanding clinical information has not been received, the authorization will be denied, and the provider will be instructed to submit a new authorization.

If you have any questions or need assistance, please call the SKYGEN Provider Contact Center at 855-806-5192, Monday-Friday 7:00 a.m. to 8:00 p.m. CT.

Open Communication about Treatment

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

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

Communication and Availability to Members and Providers

During business hours Health Care Services HCS staff is available for inbound and outbound calls through an automatic rotating call system triaged by designated staff by calling Provider Services at (844) 782-2678 during normal business hours, Monday through Friday from 7:00 a.m. to 6:00 CT p.m. All staff Members identify themselves by providing their first name, and job title.

Molina offers TTY/TDD services for Members who are deaf, hard of hearing, or speech impaired. Language assistance is also always available for Members.

After business hours, Providers can also utilize fax and the SKYGEN Dental HUB for UM access.

Molina's Nurse Advice Line is available to Members and Providers 24 hours a day, seven days a week at (844) 782-2721. Molina's Nurse Advice Line handles post stabilization, urgent and emergent after-hours UM calls. PCD/PCPs are notified via fax of all Nurse Advice Line encounters.

Post Service Review

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

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

Non-network Providers may provide Emergency Services for a Member who is temporarily outside the service area, without prior authorization or as otherwise required by Federal or State Laws or regulations.

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

All out of network services except in the case of emergency, family planning or Indian Health protected services require prior authorization. Reimbursement to out of network providers, except when required by law or policy, will be reimbursed at ~~90~~100% of the current Medicaid FFS rate. Please see the Molina Nebraska Out-of-Network Policy available on our website.

Avoiding Conflict of Interest

The HCS department affirms its decision-making is based on 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.

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 Case Management (CM) 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 of Care and Transition of Members

It is Molina's policy to provide Members with advance notice when a Provider they are seeing will no longer be in-network. Members and Providers are encouraged to use this time to transition care to an in-network Provider. The Provider leaving the network shall provide all appropriate information related to course of treatment, dental treatment, etc. to the Provider(s) assuming care. Under certain circumstances, Members may be able to continue treatment with the out of network Provider for a given period of time and provide continued services to Members undergoing a course of treatment by a Provider that has terminated their contractual agreement if the following conditions exist at the time of termination. Under certain circumstances, Members may be able to continue treatment with the out-of-new Provider for a given period of time and provide continued services to Members undergoing a course of treatment by a Provider that has terminated their contractual agreement provided that termination was not related to quality of care."

For additional information regarding continuity of care and transition of Members, please contact SKYGEN Provider Services at (855) 806-5192 from 7:00 a.m. to 8:00 p.m. CT, Monday through Friday.

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, Dental Homes, and the Member's PCP/PCD. Information should be shared in such a manner as to facilitate communication of urgent needs or significant findings.

Case Manager Responsibilities

The case manager collaborates with the member and any additional participants as directed by the Member to develop an Individual Care Plan ICP that includes recommended interventions from member's Individual Care Treatment ICT as applicable. ICP interventions include the appropriate information to address dental and psychosocial needs and/or barriers to accessing

care, care coordination to address Member's health care goals, health education to support self-management goals, and a statement of expected outcomes. Jointly, the case manager and the member/authorized representative(s) are responsible for implementing the care plan. Additionally, the case manager:

- Assesses the Member to determine if the Member's needs warrant care management.
- Monitors and communicates the progress of the implemented ICP to the Member's ICT as Member needs warrant.
- Serves as a coordinator and resource to the Members, their representative and ICT participants throughout the implementation of the ICP and revises the plan as suggested and needed.
- Coordinates appropriate education and encourages the Member's role in self-management.
- Monitors progress toward the Member's achievement of ICP goals to determine an appropriate time for the Member's graduation from the CM program.

Member Newsletters

Member Newsletters are posted on the MolinaHealthcare.com website at least twice a year. Suggested topics may include but are not limited to:

- Educational information on chronic illnesses and ways to self-manage care;
- Behavioral health information;
- Reminders of flu shots and other prevention measures at appropriate times;
- Medicare Part D issues;
- Cultural competency issues;
- Tobacco cessation information and programs;
- Human immunodeficiency virus (HIV) and acquired immunodeficiency syndrome(AIDS) testing for pregnant women,

Member Health Education Materials

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

Program Eligibility Criteria and Referral Source

Health Management (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:

- 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 health risk assessments (HRA) for newly enrolled Members.
- External referrals from Provider(s), caregivers, or community-based organizations.
- Internal referrals from 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.

Specialty Providers

Molina maintains a network of specialty Providers to care for its members. Some specialty care Providers may require a referral for a member to receive specialty services; however, no prior authorization is required. Members are allowed to directly access women health specialists for routine and preventive health without a referral for services.

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 SKYGEN Provider Services at (855) 806-5192from 7:00 a.m. to 8:00 p.m. CT, Monday through Friday. Referrals to specialty care outside the network require prior authorization from Molina.

Interdisciplinary Care Coordination

In order to provide care for the whole person, Molina emphasizes the importance of collaboration amongst all Providers on the Member's treatment team. Behavioral Health, Primary Care, and other specialty Providers shall collaborate and coordinate care amongst each other for the benefit of the Member. Collaboration of the treatment team will increase communication of valuable clinical information, enhance the Member's experience with service delivery, and create opportunity for optimal health outcomes. Molina's Care Management program may assist in coordinating care and communication amongst all Providers of a Member's treatment team.

CLINICAL PRACTICE GUIDELINES

Molina adopts and disseminates Clinical Practice Guidelines (CPG) to reduce inter-Provider variation in diagnosis and treatment. CPG adherence is measured at least annually. All guidelines are based on scientific evidence, review of dental literature and/or appropriately established authority. Clinical Practice Guidelines are reviewed at least annually, and more frequently as needed when clinical evidence changes, and approved by the Quality Improvement Committee.

Molina Clinical Practice Guidelines include the following:

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

Utilization Management

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

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

These criteria are approved and annually reviewed by Molina Dental Services Utilization Management Committee. They are designed as guidelines for authorization and payment decisions and are not intended to be absolute. Please refer to the section of this manual titled, "Covered Services," for a list of all codes covered under the program and additional limitations and requirements for coverage. All services covered are in accordance with 471 NAC 6.

Guidelines for X-Rays

- Must be of diagnostic quality
- Must be marked right and left and indicate tooth ID
- Must have the patient's name

- Must have the date x-rays were taken

Guidelines for Crowns

Criteria for crowns will be met only for permanent teeth needing multi-surface restorations where other restorative materials have a poor prognosis.
Permanent molar teeth must have pathologic destruction to the tooth by caries or trauma and should involve four (4) or more surfaces and two (2) or more cusps.
Permanent bicuspid teeth must have pathologic destruction to the tooth by caries or trauma and should involve three (3) or more surfaces and at least one (1) cusp.
Permanent anterior teeth must have pathologic destruction to the tooth by caries or trauma and must involve four (4) or more surfaces and at least 50% of the incisal edge.

Note: To meet criteria, a crown must be opposed to a tooth or denture in the opposite arch or be an abutment for a partial denture.
Crowns will not meet criteria if:

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

Crowns following Root Canal Therapy

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

Guidelines for Endodontics

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

Retreatment of Root Canal

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

Other Considerations

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

Criteria for Apexification

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

Criteria for Apicoectomy and Retrograde Filling

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

Guidelines for Periodontal Treatment

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

Criteria for Gingivectomy

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

Criteria for Full Mouth Debridement

- Presence of significant gingival inflammation and/or supragingival calculus

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

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

Guidelines for Prosthodontic Services

Prosthetic Appliances

- Coverage of prosthetic appliances includes all materials, fitting, and placement of the prosthesis. The plan covers the following prosthetic appliances, subject to service specific coverage criteria:
    - Dentures that are immediate, replacement or complete, or interim or complete;
    - Resin base partial dentures, including metal clasps;
    - Flipper partials that are considered a permanent replacement of one to three anterior teeth only; and

- **Replacement:** Plan covers a one-time replacement within the five-year coverage limit for broken, lost, or stolen appliances. This one-time replacement is available once within each Patient's lifetime, and a prior authorization request must be submitted and marked as a one-time replacement request. Replacement of any prosthetic appliance is covered once every five years when:

- The client's dental history does not show that previous prosthetic appliances have been unsatisfactory to the client;
- The client does not have a history of lost prosthetic appliances;
- A repair will not make the existing denture or partial functional;
- A reline will not make the existing denture or partial functional; or
- A rebase will not make the existing denture or partial functional.

Complete Dentures Maxillary and Mandibular

- Complete dentures, maxillary and mandibular, are covered 180 days after placement of interim dentures.
    - DOCUMENTATION REQUIREMENTS. Providers must submit the following documentation with prior authorization request:
        - Date of previous denture placement;
        - Information on condition of existing denture; and
        - For initial placements, submit panorex or full mouth series radiographs.

Immediate Denture, Maxillary and Mandibular

- An immediate denture, maxillary and mandibular, is considered a permanent denture.
    - DOCUMENTATION REQUIREMENTS. Providers must submit the following documentation with prior authorization request:
        - Date and list of teeth to be extracted;
        - Submit panorex or full mouth series radiographs.
- Partial resin base, maxillary or mandibular, is covered if the client does not have adequate occlusion. Cast metal clasps are included on partial dentures. One to three missing anterior teeth should be replaced with a flipper partial which is considered a permanent replacement.
    - DOCUMENTATION REQUIREMENTS. Providers must submit the following documentation with prior authorization request:
        - Chart or list of missing teeth and teeth to be extracted;
        - Age and condition of any existing partial, or a statement identifying the prosthesis as an initial placement;

      Narrative documenting how there is not adequate occlusion;

Partial cast metal base, Maxillary or Mandibular

- Partial cast metal base, maxillary or mandibular is covered for all clients
    - More than one posterior tooth must be missing for partial placement.
    - One to three missing anterior teeth should be replaced with a flipper partial which is considered a permanent replacement.

Repair to Denture and Partials

- Plan covers two repairs per prosthesis every 365 days.

Rebase of Dentures and Partials

- Rebase of dentures and partials are covered
    - Once per prosthesis every 365 days.
    - Chair side and lab rebases are covered, but only one can be provided within the 365-day period.

Reline of Dentures and Partials

- Reline of dentures and partials are covered
    - Covered once per prostheses every 365 days.
    - Chair side and lab relines are covered, but only one can be provided within the 365-day period.

Interim Complete Dentures Maxillary and Mandibular

- Interim dentures can be replaced with a complete denture 180 days after placement of the interim denture. Complete dentures require prior authorization in accordance with this chapter.
    - MEDICAL NECESSITY DOCUMENTATION IS REQUIRED. Providers must submit the following documentation with prior authorization request:
        - Date and list of teeth to be extracted;
        - Submit panorex or full mouth series

Flipper Partial Dentures, Maxillary and Mandibular

- Flipper partial dentures, maxillary and mandibular are considered a permanent replacement for one to three anterior teeth.
    - It is not covered for temporary replacement of missing teeth.
    - DOCUMENTATION REQUIREMENTS. Providers must submit the following documentation with prior authorization request:
        - Chart or list missing teeth and teeth to be extracted;
        - Age and condition of existing partials, or a statement identifying the prosthesis as an initial placement; and
        - Radiographs

Tissue Conditioning

- Covered one time during the first 180 days following placement of a prosthetic appliance.
- Following the initial 180 days, necessary tissue conditioning may be covered two times per prosthesis every 365 days, with documentation in the dental record.

Guidelines for Interrupted Denture Delivery

MDS may reimburse providers in the event denture treatment is interrupted and the provider is unable to deliver the final dentures to the client. Providers may be reimbursed according to

how many stages of the covered denture service they were able to complete prior to interruption. Providers must keep diagnostic models and undelivered dentures for one year before they may discard them. The guidelines for interrupted denture treatment apply ONLY to codes D5110, D5120, D5211, D5212, D5213 and D5214.

Providers may submit claims for one of the following stages in denture treatment utilizing the appropriate code noted for this process in the Medicaid Dental Fee Schedule:

A) If treatment is interrupted after final impression but BEFORE initial jaw relations- 25% only of total rate
B) If treatment is interrupted after final jaw relation (e.g., wax try-in with denture teeth)- 50% only of total rate
C) If treatment is not interrupted, and the client remains Medicaid eligible, the provider should submit a single claim for full reimbursement nothing the date of delivery as the date of service.

Providers are required to maintain documentation of their attempts to reach the client to complete the denture service. They must make at least three attempts to contact the client within 30 days following the initial appointment-setting attempt. If contact is not made within this period, the provider must send a letter to the client. If there is no response from the client for 30 days after the letter is postmarked, the denture service may be classified as interrupted.

If a client returns within 180 days of an interrupted denture service and is still Medicaid eligible, the provider should complete the service and report the delivery at the remaining allowable rate. The total reimbursement will not exceed 100% of the provider's allowable rate for the denture service. After 180 days of interruption, the client must restart the denture process. A client may only be considered interrupted once every 5 years and should not routinely abandon care while in active treatment. If the provider decides to deliver the completed dentures to a member who is no longer Medicaid eligible, the provider may bill the member the remaining contract rate amount under these circumstances. It is the provider's responsibility to verify member eligibility with MLTC before delivering the dentures.

Procedure:

Providers must submit an authorization for D5899, indicating interrupted care and including documentation that supports:

- The level of service completion;
- The patient's death or failure to return within three months;
- Three attempts to contact the patient to schedule an appointment within 30 days of the initial attempt, followed by another 30-day waiting period after mailing a letter.

MDS will review the authorization and decide if sufficient documentation is provided. If approved, MDS will define a prorated amount for D5899 based on the allowable rate(s) and stage of completion.

Upon approval, the provider may submit a claim for D5899 to receive payment at the authorized amount for the interrupted denture service. If the client returns within 180 days after being considered interrupted, the provider should complete the denture service and submit a claim for the remaining allowable amount. Total reimbursement will not exceed 100% of the allowable rate. After 181 days, the client must restart the denture process. Further interruptions will not be covered by MLTC for five years, and clients may be liable for services beyond this date.

Guidelines for Oral Surgery

- Uncomplicated extractions, removal of soft tissue impactions or minor surgical procedures are considered basic services and are the responsibility of the general dentist or pediatric specialist. The member may be referred to a contracted Molina oral surgeon when it is beyond the scope of the general dentist or pediatric specialist.
- Any extractions that do not clearly meet these criteria should be submitted for preauthorization review.
- Covered for pain or infection
  Extractions to reduce crowding without a Molina-approved orthodontic case, must demonstrate clear evidence of impaction or the severe deflection of the unerupted permanent tooth. Prior authorization, panoramic x-ray, and narrative are required.
  Over-retention of a primary tooth where the succedaneous permanent is ectopically erupting into the arch and the primary tooth is not mobile.
- Irregular root resorption interfering with path of permanent tooth progression.
  Extraction of primary tooth to prevent potential impaction of permanent canines when canine is mesially progressing and is overlapping the root of the lateral incisor.
- Removal of 3rd molars prior to orthognathic surgery
- Supernumerary tooth.
- Radiographic pathology (cyst, abscess)
- Orthodontic extractions (requires approval of the orthodontic case)
- Carious lesion or fracture making tooth non-restorable
- No extractions of third molars if roots are not substantially formed
- Recurrent pericoronitis
- Untreatable periodontal disease
  Recoupment of restorative fees may be necessary if tooth is extracted within 6 months of restorative treatment.
- Extractions are not payable for deciduous teeth when normal loss is imminent.
- There is no benefit for the extraction of asymptomatic teeth

Guidelines for Orthodontia

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

- Handicapping Labiolingual Deviation (HLD) Index score sheet
- Accident causing a severe malocclusion;
- Injury causing a severe malocclusion;
- Condition that was present at birth causing a severe malocclusion;
- Medical condition causing a severe malocclusion; and
- Facial skeletal condition causing a severe malocclusion.

Authorization

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

Documentation Requirements

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

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

Continuation of Care

A continuation of care form, along with required clinical documentation must be submitted as a prior authorization for code D8999 and all applicable orthodontic codes (D8090 and D8020).

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

Required Documentation

- Continuation of Care Form. In addition, all forms can be found on SKYGEN's Dental HUB and Molina's Healthcare Website.
- Completed 2012 ADA Dental Claim Form listing
- D8999 and all applicable orthodontic codes.

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

Guidelines for Medical Immobilization Including Papoose Boards

The provider must obtain written informed consent from the legal guardian. Written informed consent must be documented in the patient's treatment record prior to medical immobilization. "Informed Consent Requirements Providers must understand and comply with applicable legal requirements regarding informed consent from members, as well as adhere to the policies of the dental community in which they practice. The provider must give Molina members adequate information and be reasonably sure the member has understood it before proceeding with any proposed treatment. Consent documents should be in writing and signed by the member and/or responsible party. The provider must obtain and maintain a specific written informed consent form signed by the member, or the responsible party if the member is a minor or has been adjudicated incompetent, prior to the utilization of a papoose board as part of the member's treatment. Such consent is required for the utilization of a papoose board and is strongly encouraged for all treatment plans and procedures where a reasonable possibility of complications from the proposed treatment or a procedure exists. Consent should disclose all risks or hazards that could influence a reasonable person in making a decision to give or withhold consent. Written consent must be given prior to the services being rendered and must not have been revoked. Members or their responsible parties who can give written informed consent must receive information about the dental diagnoses, scope of proposed treatment, including risks and alternatives, anticipated results, and the need for and risks of the administration of sedation or anesthesia. Additionally, they must receive a full explanation of the treatment plan and give written informed consent before treatment is initiated. As a provider, you may consider

seeking advice from an attorney to ensure the informed consent meets all applicable legal requirements. Molina urges all providers to comply with the AAPD's 2013 "Guideline on Protective Stabilization for Pediatric Dental Patients." You can find the guideline online at the AAPD's website (www.aapd.org).

Goals of behavior management:

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

Guidelines for Sedation Permits

Dentists providing sedation or anesthesia services must have the appropriate permit from the Nebraska Board of Dentistry for the level of sedation or anesthesia provided.

All practice locations where a dentist administers minimal sedation, moderate sedation, or deep sedation/general anesthesia, must have the required permit, and comply with the Nebraska Board of Dentistry guidelines.

Molina Dental Services must have on file a copy of the permit prior to rendering sedation services as follows:

- A licensed dentist may administer inhalation analgesia in the practice of dentistry without a permit pursuant to the act,
- Minimal sedation or moderate sedation shall not be administered by a dentist without the presence and assistance of a licensed dental hygienist or a dental assistant.
- Deep sedation/general anesthesia administration requires the presence of the operating dentist and a separate anesthesia provider.
- A licensed dental hygienist may administer and titrate nitrous oxide analgesia under the indirect supervision of a licensed dentist, unless otherwise specified by the state in which the provider practices.

Dental Providers who are providing sedation services for codes D9223, D9243, and D9248 must have the appropriate permits for the level of sedation provided.

Sedation Type	License/Permit	Codes	Code Description
Nitrous/Analgesia Gas	Nebraska Dental	D9230	Inhalation Of Nitrous/Analgesia, Anxiolysis

	License		
Non-IV Conscious Sedation (Level 1 and Level 2)	Minimal Sedation Permit	D9248	Non-Intravenous Conscious Sedation
IV Moderate Sedation (Level 3)	Moderate Sedation Permit	D9239	Intravenous Moderate (Conscious) Sedation/Analgesia - First 15 Minutes
		D9243	Intravenous Moderate (Conscious) Sedation/Analgesia - Each Subsequent 15 Minute Increment
Deep Sedation/General Anesthesia (Level 4)	General/Deep Sedation Permit	D9222	Deep Sedation/General Anesthesia - First 15 Minutes
		D9223	Deep Sedation / General Anesthesia - Each Subsequent 15 Minute Increment

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

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

Guidelines for Dental Services Rendered in a Hospital or Ambulatory Surgical Center (ASC)

Please ensure the following information is included with all claims:

1. **CDT Codes**: Submit all CDT codes for treatment completed, along with CDT code D9420 (electronic ADA form, 2012 ADA, or newer, claim form).

2. **Rationale:** Include rationale for the use of general anesthesia, including factors such as age, extent of caries, mental/physical handicap, description of accident, behavior/phobia, and documentation of any failed sedation.

3. **Location of Procedures**: Specify the location where the procedures were performed (hospital or ambulatory surgical center).

4. **Coding Guidelines**:

    - When treating a member in a hospital or ASC, submit code D9420 for each member along with all completed treatment. Do not submit codes D9222/D9223 for these cases, as the member's medical insurance will cover anesthesia costs in the hospital and ASC setting.

    - D9420 will only be paid once per day per facility per state regulations. If multiple members are seen in one day, D9420 will be paid for only one member and denied for the others.

5. **Prior Authorization**: Prior authorization is not required for D9420 or D9222/9223. Claims are subject to pre-payment review.

CLAIMS, PRIOR AUTHORIZATIONS AND COMPENSATION

Payor ID	**SKYGN**
SKYGEN Dental HUB	https://app.dentalHUB.com/app/login
Clean Claim Timely filling	**180 calendar days from the Date of Service**

Prior Authorizations

Prior authorizations/service requests and status checks can be easily managed electronically.

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

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

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

- Submit requests directly to Molina via the SKYGEN Dental HUB https://app.dentalHUB.com/app/login
- Submit requests via 278 transactions. See the EDI transaction section of Molina's website for guidance.
- Submit via paper on a 2012 or newer ADA claim form to:

    Molina Dental Services Prior Authorizations

PO Box 306
Milwaukee, WI 53201

SKYGEN Provider Phone: (855) 806-5192 from 7:00 a.m. to 8:00 p.m. CT, Monday through Friday.

Claims Submission

Participating Providers are required to submit Claims to Molina with appropriate documentation. Providers must follow the appropriate State and CMS Provider billing guidelines. Providers must utilize electronic billing though a clearinghouse or the SKYGEN Dental HUB whenever possible and use current HIPAA compliant ANSI X 12N format (e.g., 837D for dental Claims). Paper claims may be submitted on a 2012 or newer ADA claim form.

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

Molina offers the following Claims submission options:

- Submit Claims directly to Molina via the https://app.dentalHUB.com/app/login
- Submit Claims to Molina via your regular EDI clearinghouse
- Submit 2012 or newer ADA claim forms

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

- Helps to reduce operation costs associated with paper Claims (printing, postage, etc.).
- Increases accuracy of data and efficient information delivery.
- Reduces Claim delays since errors can be corrected and resubmitted electronically.
- Eliminates mailing time and Claims reach Molina faster.

SKYGEN Dental HUB

The SKYGEN Dental HUB is a no cost online platform that offers a number of Claims processing features:

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

Clearinghouse

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

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

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

When your Claims are filed via a Clearinghouse:

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

Paper Claim Submissions

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

Molina Dental Services Claims
PO Box 2136
Milwaukee, WI 53201

When submitting paper Claims:

- Paper Claim submissions are not considered to be “accepted” until received at the appropriate Claims PO Box. Claims received outside of the designated PO Box will be returned for appropriate submission.
- Paper Claims are required to be submitted on 2012 or newer ADA claim forms.
- Paper Claims not submitted on the required forms will be rejected and returned. This includes black and white forms, copied forms, and any altering to include Claims with handwriting.
- Claims must be typed with either 10- or 12-point Times New Roman font, using black ink.

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 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 coordination of benefits or third-party liability, Providers must submit Claims to Molina within 180 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.

Please Note the following concerning timely filing of Molina Dental Claims:

1. Molina will not deny provider claims on the basis of untimely filing for claims that involve coordination of services or subrogation (when the provider is pursuing payment from a third party). In situations of third-party benefits, the timeframes for filing a claim must begin on the date that the third party completes resolution of the claim.
2. Molina will not deny claims solely for failure to meet timely filing guidelines due to an error by MLTC or its subcontractors. If a provider files erroneously with another MCO but produces documentation verifying that the initial filing of the claim occurred in a timely manner, Molina will process the provider's claim and not deny for failure to meet timely filing guidelines.

Timely Claim Processing

Claims processing will be completed for contracted Providers in accordance with the timeliness provisions set forth in the Provider's contract. Unless the Provider and Molina have agreed in writing to an alternate schedule, Molina will process 90% of the Claims for service within 15 days and 99% of Claims for service within 60 days after receipt of Clean Claims.

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

Claims Recovery

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

Provider Overpayment Disputes/Refund checks	Molina Healthcare of Nebraska, Inc. Molina NE Refunds PO Box 641 Milwaukee, WI 53201
Phone:	(855) 806-5192
SKYGEN Dental HUB	https://app.dentalHUB.com/app/login

National Provider Identifier (NPI)

A valid NPI is required on all Claim submissions. Providers must report any changes in their NPI or subparts to Molina as soon as possible, not to exceed 30 calendar days from the change.

Required Elements

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

Electronic Claim submissions will adhere to specifications for submitting dental Claims data in standardized Accredited Standards Committee (ASC) X12N 837 formats. Electronic Claims are validated for Compliance SNIP levels 1 to 5.

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

- Member name, date of birth and Molina Member ID number
- Member's gender
- Member's address
- Date(s) of service
- Valid CDT codes
- Total billed charges
- Place and type of service code
- Days or units as applicable
- Provider tax identification number (TIN)
- 10-digit National Provider Identifier (NPI) or Atypical Provider Identifier (API)

- Rendering Provider information when different than billing
- Billing/Pay-to Provider name and billing address
- Place of service and type (for facilities)
- Disclosure of any other health benefit plans
- National Drug Code (NDC), unit of measure and quantity for medical injectables
- E-signature
- Service Facility Location information
- Any other state-required data

Provider and Member data will be verified for accuracy and active status. Be sure to validate this data in advance of Claims submission. This validation will apply to all Provider data submitted and also applies to atypical and out-of-state Providers. Provider information submitted on the claim must match the information on file with the Nebraska Medicaid and Long-Term Care Division (MLTC) in order for claim payment to be made. Changes to Provider information should be made to MLTC's Maximus Provider Enrollment Platform prior to claim submission to Molina.

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

Electronic Fund Transfers (EFT)

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

As a reminder, Molina's Payer ID is SKYGN.

To receive EFT, please complete and return this form: NE EFT Molina Form NE .pdf. The form is also available on the SKYGEN Dental HUB and on Molina's website at MolinaHealthcare.com.

EDI (Clearinghouse) Submission

Corrected Claim information submitted via EDI submission are required to follow electronic Claim standardized Accredited Standards Committee (ASC) X12N 837 formats. Electronic Claims are validated for Compliance SNIP levels 1 to 5. The 837 Claim format allows you to submit changes to Claims that were not included in the original adjudication.

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

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

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

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

EDI Claims Submission Issues

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

Provider Claims Inquiry Process

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

To request a Provider Claims Inquiry, please call our SKYGEN Provider Services Contact Center at (855) 806-5192 from 7:00 a.m. to 8:00 p.m. CT, Monday through Friday**.**

If you would like to (1) request adjustment of a claim that is related to a clinical decision, or (2) submit a formal request to adjust a claim, or (3) if you are dissatisfied with the outcome of your

claim processing or initial claim adjustment, please use Molina's Provider Grievances, and Appeals Process found below.

Corrected Claim Process

Providers may correct any necessary field of the ADA forms.

Molina strongly encourages Participating Providers to submit Corrected Claims electronically via EDI or the SKYGEN Dental HUB.

All corrected Claims:

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

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

The mailing address to submit paper 2012 or newer ADA Dental Corrected Claim Forms is:

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

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, or 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, with exception of certain programs (i.e., Indian Health Services, Ryan White Program, World Trade Center Health Program, and other federally designated programs) 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 first bill the primary payer and submit a primary explanation of benefits (EOB) to Molina for secondary Claim processing. In the event that coordination of benefits occurs, 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 preventive pediatric care (EPSDT) without requiring a primary EOB to be submitted and then seek reimbursement from third parties (pay and chase). 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 Optum at submitreferrals@optum.com.

Additional Molina Healthcare of Nebraska Specified Payment Policies

Providers are reimbursed according to the reimbursement methodology and terms specified in the contract in addition to what is described below. Reimbursement for Covered Services will be the lesser of the:

- Provider's submitted charge; or,
- Allowable amount for the service indicated on the applicable State of Nebraska Medicaid and Long-Term Care Fee Schedules per the Provider type in effect for the date service; or,
- If a rate for a Covered Service is not listed on the fee schedule, it is described as a manually priced code. Molina Healthcare of Nebraska shall follow the pricing logic established by the State of Nebraska Medicaid and Long-Term Care for manually priced codes.

Manually Priced Codes

Manually priced codes are identified on the State of Nebraska Medicaid and Long-Term Care Fee Schedules with an indicator as follows:

- BR – By Report

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

Table 1 – Manually Priced Codes

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

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

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

Non-Covered Services

Medicaid does not reimburse any non-covered service. Molina Healthcare of Nebraska considers a non-covered service to mean a CDT code that is:

- Listed on the published fee schedule as Non-Covered, Obsolete or Non-Covered by Medicaid or other similar language; and,
- A code not found on a published State of Nebraska Medicaid and Long-Term Care Fee Schedule.
- Cosmetic;
- More costly than another, equally effective available service;
- Not within the coverage criteria of these regulations;
- Determined to be not medically necessary by the Department; or
- Experimental, investigational, or not Food and Drug Administration (FDA) approved.
- Value-added services are considered covered when approved by Nebraska Medicaid

Reimbursement Guidance and Payment Guidelines

Providers are responsible for submission of accurate Claims.

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

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

- Manuals and Relative Value Unit (RVU) files published by the Centers for Medicare & Medicaid Services (CMS), including:
    - Current Code on Dental Procedures and Nomenclature (CDT Code) guidance published by the American Dental Association (ADA).
    - State-specific Claims reimbursement guidance.
    - Other coding guidelines published by industry-recognized resources.
    - Payment policies based on professional associations or other industry-recognized guidance for specific services. Such payment policies may be more stringent than State and Federal guidelines.
    - Molina policies based on the appropriateness of health care and Medical Necessity.
    - Payment policies published by Molina.

General Coding Requirements

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

CDT Codes

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

Place of Service (POS) Codes

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

Claim Auditing

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

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

In reviewing dental records for a procedure, Molina 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 any and all records necessary to determine compliance and accuracy of billing.

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

Overpayments and Incorrect Payments Refund Requests

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

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

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

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

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

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

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

Fraud, Waste, and Abuse

Failure to report instances of suspected fraud, waste, and abuse is a violation of the Law and subject to the penalties provided by Law. Please refer to the Compliance section of this Dental Provider Manual for more information.

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 Dental Health Quality Assessment and Process Improvement Program. and HEDIS® reporting.

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

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

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

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

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

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

PROVIDER GRIEVANCES, AND CLAIM APPEALS

A Provider grievance may include, but are not limited to, dissatisfaction with a policy, procedure, timeliness or processing of an authorization, and aspects of interpersonal relationships such as rudeness of an employee.

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

To file a grievance or request Molina's provider grievances policy and procedures:

- Call SKYGEN Provider Services toll free at (855) 806-5192 from 7:00 a.m. to 8:00 p.m. CT Monday through Friday
- Submit via the SKYGEN Dental HUB at https://app.dentalHUB.com/app/login
- Submit via USPS at:
  Molina Healthcare of Nebraska, Inc Appeals & Grievances Unit
  14748 W Center Rd, Suite 104
  Omaha NE 68144

Provider Claim Appeal Process and Timeline

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

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

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

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

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

- The Claim number is clearly marked on all supporting documents.

Providers are encouraged to submit claim appeals via the SKYGEN Dental HUB or verbally.

Cost Recovery Disputes and Correspondence:

Molina Healthcare of Nebraska, Inc.
Molina NE Refunds
PO Box 641
Milwaukee, WI 53201

Peer-to-Peer Request

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

A "peer" is considered a provider who is directly providing care to a Molina Member and can request a peer-to-peer telephone communication with a Nebraska licensed dentist by calling SKYGEN Provider Services at (855) 806-5192 from 7:00 a.m. to 8:00 p.m. CT, Monday through Friday.

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

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

Reporting Grievances, and Claim Appeals

Grievance and appeal trends are reported to the Quality Improvement Committee quarterly. This trend report includes a quantitative review of trends, qualitative or barriers analysis, and identification of interventions that address key drivers. An annual evaluation of grievance and appeal analysis is then completed and presented to the Quality Improvement Committee for evaluation. If required by the state or CMS, reporting is submitted to the appropriate Agency as needed.

COMPLIANCE

Fraud, Waste, and Abuse

Molina is dedicated to the detection, prevention, investigation, and reporting of potential health care fraud, waste, and abuse. As such, Molina's Compliance department maintains a

comprehensive plan, which addresses how Molina will uphold and follow State and Federal statutes and regulations pertaining to fraud, waste, and abuse. The plan also addresses fraud, waste and abuse prevention, detection, and correction along with 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.

Reporting Fraud, Waste, and Abuse

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

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

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

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

Remember to include the following information when reporting:

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

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

Suspected Fraud by Medicaid Recipients:

Nebraska Department of Health and Human Services
DHHS.InvestigationsSIU@nebraska.gov
By Phone: (402) 595-3789

Suspected fraud or abuse by a Provider:

ago.medicaid.fraud@nebraska.gov
Toll free: (800) 727-6432

Definitions

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

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

Abuse means Provider practices that are inconsistent with sound fiscal, business, or dental practices, and result in unnecessary costs to State and Federal health care programs, or in reimbursement for services that are not Medically Necessary or that fail to meet professionally recognized standards for health care. It also includes recipient practices that result in unnecessary cost to State and Federal health care programs. (42 CFR § 455.2)

Examples of Fraud, Waste, and Abuse by a Provider

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

- A Provider knowingly and willfully refers a member to health care facilities in which or with which the Provider has a financial relationship. (Stark Law)
- Altering Claims and/or dental record documentation in order to get a higher level of reimbursement.
- Balance billing a Molina Member for Covered Services. This includes asking the Member to pay the difference between the discounted and negotiated fees, and the Provider's usual and customary fees.

- Billing and providing services to Members that are not Medically Necessary.
- Billing for services, procedures and/or supplies that have not been rendered.
- Billing under an invalid place of service in order to receive or maximize reimbursement.
- Completing certificates of Medical Necessity for Members not personally and professionally known by the Provider.
- Concealing a member's misuse of a Molina identification card.
- Failing to report a member's forgery or alteration of a prescription or other medical document.
- False coding in order to receive or maximize reimbursement.
- Inappropriate billing of modifiers in order to receive or maximize reimbursement.
- Inappropriately billing of a procedure that does not match the diagnosis in order to receive or maximize reimbursement.
- Knowingly and willfully solicit or receiving payment of kickbacks or bribes in exchange for referring patients.
- Not following incident to billing guidelines in order to receive or maximize reimbursement.
- Overutilization.
- Participating in schemes that involve collusion between a Provider and a Member that result in higher costs or charges.
- Questionable prescribing practices.
- Unbundling services in order to get more reimbursement, which involves separating a procedure into parts and charging for each part rather than using a single global code.
- Underutilization, which means failing to provide services that are Medically Necessary.
- Upcoding, which is when a Provider does not bill the correct code for the service rendered and instead uses a code for a like services that costs more.
- Using the adjustment payment process to generate fraudulent payments.

Examples of Fraud, Waste, and Abuse by a Member

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

- Benefit sharing with persons not entitled to the Member's benefits.
- Conspiracy to defraud State and Federal health care programs.
- Doctor shopping, which occurs when a member consults a number of Providers for the purpose of inappropriately obtaining services.
- Falsifying documentation in order to get services approved.
- Forgery related to health care.
- Prescription diversion 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.

Provider Education

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

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

Regulatory Requirements

Federal False Claims Act

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

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

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

The act does not require proof of a specific intent to defraud the U.S. government. Instead, health care Providers can be prosecuted for a wide variety of conduct that leads to the submission of fraudulent Claims to the government, such as knowingly making false statements, falsifying records, double billing for items or services, submitting bills for services never performed or items never furnished or otherwise causing a false Claim to be submitted.

Deficit Reduction Act

The Deficit Reduction Act (DRA) aims to cut fraud, waste and abuse from the Medicare and Medicaid programs.

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

- The Federal False Claims Act and State Laws pertaining to submitting false Claims.
- How Providers will detect and prevent fraud, waste, and abuse.
- Employee protection rights as whistleblowers.

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

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

- Employment reinstatement at the same level of seniority.
- Two times the amount of backpay plus interest.
- Compensation for special damages incurred by the employee as a result of the employer's inappropriate actions.

Affected entities who fail to comply with the Law will be at risk of forfeiting all payments until compliance is met. Molina will take steps to monitor Molina contracted Providers to ensure compliance with the Law.

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

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.

Anti-Kickback Statute (AKS) is a criminal Law that prohibits the knowing and willful payment of "remuneration" to induce or reward patient referrals or the generation of business involving any item or service payable by the Federal health care programs (e.g., drugs, supplies, or health care services for Medicare or Medicaid patients). In some industries, it is acceptable to reward those who refer business to you. However, in the Federal health care programs, paying for

referrals is a crime. The statute covers the payers of kickbacks-those who offer or pay remuneration- as well as the recipients of kickbacks-those who solicit or receive remuneration.

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

Marketing Guidelines and Requirements

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

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

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

Stark Statute

The Providers 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 Provider Self-Referral Law [42 U.S.C. § 1395nn].

Sarbanes-Oxley Act of 2002

Sarbanes-Oxley Act of 2022 requires certification of financial statements by both the Chief Executive Officer and the Chief Financial Officer. The Act states that a corporation must assess the effectiveness of its internal controls and report this assessment annually to the Securities and Exchange Commission.

Pre and Post Claim Auditing

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

Molina has a pre-payment Claims auditing process that identifies frequent correct coding billing errors ensuring that Claims are coded appropriately according to State and Federal coding guidelines. Code edit relationships and edits are based on guidelines from specific State Medicaid Guidelines, Centers for Medicare & Medicaid Services (CMS), Federal CMS guidelines, AMA, and published specialty specific coding rules. Code Edit Rules are based on information received from the National Provider Fee Schedule Relative File (NPFS), the Medically Unlikely Edit (MUE) table, the National Correct Coding Initiative (NCCI) files, Local Coverage Determination/National Coverage Determination (LCD/NCD), and State-specific policy manuals and guidelines as specified by a defined set of indicators in the Medicare Provider Fee Schedule Data Base (MPFSDB).

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

Claim Auditing

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

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

In reviewing dental records for a procedure, Molina may select a statistically valid random sample, or smaller subset of the statistically valid random sample. This gives an estimate of the proportion of Claims that Molina paid in error. The estimated proportion, or error rate, may be projected across all Claims to determine the amount of Overpayment.

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

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

Review of Provider Claims and Claims System

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

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

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

Post-payment Recovery Activities

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

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

Provider will provide Molina, governmental agencies and their representatives or agents, access to examine, audit, and copy any and all records deemed by Molina, at Molina's sole discretion, necessary to determine compliance with the terms of the Provider Agreement, including for the purpose of investigating potential fraud, waste, and abuse. Documents and records must be

readily accessible at the location where Provider provides services to any Molina Members. Auditable documents and records include, but are not limited to, dental charts, patient charts, billing records, and coordination of benefits information. Production of auditable documents and records must be provided in a timely manner, as requested by Molina and without charge to Molina. In the event Molina identifies fraud, waste or abuse, Provider agrees to repay funds or Molina may seek recoupment.

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

Provider acknowledges that HIPAA specifically permits a covered entity, such as Provider, to disclose protected health information for its own payment purposes (see 45 CFR 164.502 and 45 CFR 154.501). Provider further acknowledges that in order to receive payment from Molina, Provider is required to allow Molina to conduct audits of its pertinent records to verify the services performed and the payment claimed, and that such audits are permitted as a payment activity of Provider under HIPAA and other applicable privacy Laws.

HIPAA (HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT)

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

Telehealth/telemedicine Providers: Telehealth transmissions are subject to HIPAA-related requirements outlined under State and Federal Law, including:

- 42 C.F.R. Part 2 Regulations

- Health Information Technology for Economic and Clinical Health Act, (HITECH Act)

Applicable Laws

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

1. **Federal Laws and Regulations**
   - HIPAA
   - The Health Information Technology for Economic and Clinical Health Act (HITECH)
   - 42 C.F.R. Part 2
   - Medicare and Medicaid Laws
   - The Affordable Care Act

2. **State Medical Privacy Laws and Regulations**

   Providers should be aware that HIPAA provides a floor for patient privacy, but that State Laws should be followed in certain situations, especially if the State Law is more stringent than HIPAA. Providers should consult with their own legal counsel to address their specific situation.

Uses and Disclosures of PHI

Member and patient PHI should only be used or disclosed as permitted or required by applicable Law. Under HIPAA, a Provider may use and disclose PHI for their own treatment, payment, and health care operations activities (TPO) without the consent or authorization of the patient who is the subject of the PHI. Uses and disclosures for TPO apply not only to the Provider's own TPO activities, but also for the TPO of another covered 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

[1] See Sections 164.506(c) (2) & (3) of the HIPAA Privacy Rule.

activities, such as preauthorization of services, concurrent review, and retrospective review of services[2].

2. A covered entity may disclose PHI to another covered entity for the health care operations activities of the covered entity that receives the PHI, if each covered entity either has or had a relationship with the individual who is the subject of the PHI being requested, the PHI pertains to such relationship, and the disclosure is for the following health care operations activities:

    - Quality Improvement
    - Disease Management
    - Case Management and Care Coordination
    - Training Programs
    - Accreditation, Licensing, and Credentialing

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

Confidentiality of Substance Use Disorder Patient Records

Federal Confidentiality of Substance Use Disorder Patient Records regulations apply to any entity or individual providing federally assisted alcohol or drug abuse prevention treatment. Records of the identity, diagnosis, prognosis, or treatment of any patient which are maintained in connection with substance use disorder treatment or programs are confidential and may be disclosed only as permitted by 42 CFR Part 2. Although HIPAA protects substance use disorder information, the Federal Confidentiality of Substance Use Disorder Patient Records regulations are more restrictive than HIPAA and they do not allow disclosure without the Member's written consent except as set forth in 42 CFR Part 2.

Inadvertent Disclosures of PHI

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

[2] See the definition of Payment, Section 164.501 of the HIPAA Privacy Rule

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 Uses and Disclosures of PHI**

   Patients may request that a health care Provider restrict its uses and disclosures of PHI. The Provider is not required to agree to any such request for restrictions.

3. **Requests for Confidential Communications**

   Patients may request that a health care Provider communicate PHI by alternative means or at alternative locations. Providers must accommodate reasonable requests 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 for PHI Disclosures**

   Patients may request an accounting of disclosures of PHI made by the Provider during the preceding six-year period. The list of disclosures does not need to include disclosures made for treatment, payment, or health care operations or made prior to April 14, 2003.

HIPAA Security

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

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

HIPAA Transactions and Code Sets

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

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

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

1. Click on the area titled "I'm a Health Care Professional."
2. Click the tab titled "HIPAA."

3. Click on the tab titled “HIPAA Transactions” or “HIPAA Code Sets.”

National Provider Identifier (NPI)

Providers must comply with the National Provider Identifier (NPI) Rule promulgated under HIPAA. The Provider must obtain an NPI from the National Plan and Provider Enumeration System (NPPES) for itself or for any subparts of the Provider. The Provider must report its NPI and any subparts to Molina and to any other entity that requires it. Any changes in its NPI or subparts information must be reported to NPPES within 30 days and should also be reported to Molina within 30 days of the change. Providers must use their NPI to identify with 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 Medical Care Management Services
- Claims Review
- Resolution of an Appeal and/Grievance
- Anti-Fraud Program Review
- Quality of Care Issues
- Regulatory Audits
- Risk Adjustment
- Treatment, Payment, and/or Operation Purposes
- Collection of HEDIS® dental records

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 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 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 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 (2) 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 at all times 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 any and 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 any and 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 any and 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 any and all Molina Information exchanged shall be used expressly and solely for the purposes enumerated in the Provider Agreement 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, manufactured, political and cybersecurity incidents.

   ii. To the extent that Molina Information is held by the Provider, the Provider shall maintain backups of such Molina Information that are adequately protected from unauthorized alterations or destruction consistent with applicable Industry Standards.
   iii. The 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. The 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. The 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. In the event that 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.
   c. Notification to Molin>'s Chief Information Security Officer shall be provided to:
      Molina Chief Information Security Officer
      Telephone: (844) 821-1942
      Email: CyberIncidentReporting@Molinahealthcare.com
      Molina Chief Information Security Officer
      Molina Healthcare, Inc.
      200 Oceangate Blvd., Suite 100
      Long Beach, CA 90802
   d. In the event of a Cybersecurity Event, Provider will, at Molin>'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
   e. 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.

f. 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 particular data elements including, for example, types of medical 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.

g. 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 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.

6. Other Provisions. The Provider acknowledges that there may be other information security and data protection requirements applicable to the Provider in the performance of services which may be addressed in an agreement between Molina and the 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 the Provider, the stricter of the conflicting provisions will control.

Artificial Intelligence

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 or not 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.

If you have additional questions, please contact your Molina Contract Manager.

Ongoing Monitoring of Sanctions and Exclusions

Molina monitors the following agencies for Provider sanctions and exclusions between recredentialing cycles for all Provider types and takes appropriate action against Providers when instances of poor quality are identified. If a Molina Provider is found to be sanctioned or excluded, the Provider's contract will be immediately terminated effective on the same date as the sanction or exclusion was implemented.

- The United States Department of Health & Human Services (HHS), Office of Inspector General (OIG) Fraud Prevention and Detection Exclusions Program – Monitor for individuals and entities that have been excluded from Medicare and Medicaid programs.
- The OIG High Risk list – Monitor for individuals or facilities who refused to enter into a Corporate Integrity Agreement (CIA) with the federal government on or after October 1, 2018.
- State Medicaid Exclusions – Monitor for state Medicaid exclusions through each state's specific Program Integrity Unit (or equivalent).
- Medicare Exclusion Database (MED) – Monitor for Medicare exclusions through the Centers for Medicare and Medicaid Services (CMS) MED online application site.
- Medicare Preclusion List – Monitor for individuals and entities that are reported on the Medicare Preclusion List.
- National Provider Database – Molina enrolls all credentialed practitioners with the NPDB Continuous Query service to monitor for adverse actions on license, DEA, hospital privileges and malpractice history between credentialing cycles.
- System for Award Management (SAM) – Monitor for Providers sanctioned by SAM.

Molina also monitors the following for all Provider types between the recredentialing cycles:

- Member Complaints/Grievances
- Adverse Events
- Medicare Opt Out
- Social Security Administration Death Master File

MEMBER RIGHTS AND RESPONSIBILITIES

Molina Dental Program

Providers must comply with the rights and responsibilities of Molina Members as outlined in the Molina Member Handbook and on the Molina website. The Member Handbook that is provided to Members annually is hereby incorporated into this Dental Provider Manual. The most current Member Rights and Responsibilities can be accessed via the following link: MolinaHealthcare.com/members/ne/en-us/mem/Medicaid/quality/rights.aspx.

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

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

Member Rights

Members have the right to:

- To be treated with courtesy and respect, with appreciation of your individual dignity, and with protection of your need for privacy.
- To request and obtain information on any limits of your freedom of choice among network providers.
- To a prompt and reasonable response to questions and requests.
- To know who provides medical services and who is responsible for your care.
- To know what patient support services are available, including whether an interpreter is available if you do not speak English.
- To know what rules and regulations apply to your conduct.
- To receive information in a manner and format that may be easily understood.
- To be given, by a health care provider, information concerning diagnosis, planned course of treatment, treatment options, alternatives, risks, and prognosis in a manner appropriate to your condition and ability to understand.
- To be able to take part in decisions about your health care.
- To have an open discussion about your medically necessary treatment options for your conditions, regardless of cost or benefit.
- To be free from any form of restraint or seclusion used as means of coercion, discipline, convenience, or retaliation, as specified in other Federal regulations on the use of restraints and seclusion.
- To request and receive a copy of your medical records, and request that they be amended or corrected.
- To request disenrollment.
- To be furnished health care services in accordance with federal and state regulations.
- To refuse any treatment, except as otherwise provided by law.
- To be given, upon request, full information, and necessary counseling on the availability of known financial resources for your care.
- If you are eligible for Medicare, know, upon request and in advance of treatment, whether the health care provider or health care facility accepts the Medicare assignment rate.

- To receive, upon request, prior to treatment, a reasonable estimate of charges for medical care.
- To receive a reasonably clear and understandable itemized bill
- To have your bill and medical charges explained, upon request.
- To impartial access to medical treatment or accommodations, regardless of race, national origin, religion, disability, or source of payment.
- To treat any emergency medical condition that will deteriorate from failure to provide treatment.
- To know if medical treatment is for purposes of experimental research and to give your consent or refusal to participate in such experimental research.
- To receive information about Molina Healthcare, its services, its practitioners and providers and members' rights and responsibilities.
- To exercise these rights without an adverse effect on the way Molina and its Providers treat you.
- To receive information about the structure and operation of Molina.
- To make recommendations about Molina Healthcare's member rights and responsibilities policies.
- To voice complaints or appeals about the organization or the care it provides.
- To express grievance regarding any violation of your rights, through the grievance procedure of the health care provider or health care facility which served you and to the appropriate state licensing agency listed below.

  Nebraska Department of Health and Human Services MLTC Appeal Coordinator
  PO Box 94967
  Lincoln, NE 68509-4967

OR

- eFAX (402) 742-1198
- Email: dhhs.mltcappeals@nebraska.gov

Members are responsible:

- For providing to the health care provider, to the best of your knowledge, accurate and complete information about present complaints, past illnesses, hospitalizations, medications, and other matters relating to your health.
- For the cost of unauthorized services obtained from non-participating providers.
- For reporting unexpected changes in your condition to the health care provider.
- For reporting to the health care provider whether you comprehend a contemplated course of action and what is expected of you.
- To follow the care plan that you have agreed on with your provider.

- For keeping appointments and, when you are unable to do so for any reason, to notify the health care provider or healthcare facility.
- For your actions if you refuse treatment or do not follow the health care provider's instructions.
- For assuring that the financial obligations of your health care are fulfilled as promptly as possible.
- For following health care facility rules and regulations affecting patient care and conduct.
- To understand your health problems and participate in developing mutually agreed-upon treatment goals to the degree possible.
- To report truthful and accurate information when applying for Medicaid. (You will be responsible for repaying capitation premium payments if your Enrollment is stopped due to failure to report truthful or accurate information.)

**You may request printed copies of all content posted on our website.*

Second Opinions

If Members do not agree with their Provider's plan of care, they have the right to get a second opinion from another Provider. Members should call Molina Member Services to find out how to get a second opinion, which is covered under Medicaid. Molina will coordinate the second opinion with a Molina Network Provider. If a qualified Dental Specialist Provider is not available within the network, Molina will coordinate and authorize the second opinion with a Provider outside of the network. Please note - MLTC Reg 471 NAC 6.004.02(A) (i). Oral evaluations are covered for new patients, emergency treatment, second opinions and specialists. All oral examinations must be provided by a dentist. A single exam code is covered per date of service. Not to be billed with any other exam codes on the same date of service.

MEMBER GRIEVANCE AND APPEALS PROCESS

Member Grievance Process

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

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

A member may file a grievance with Molina or MLTC at any time.

Grievance Timelines

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

Member Appeals Process

Appeals are a request for review of an action.

Members or a Provider acting on behalf of a Member (with written consent) may file an appeal verbally or in writing. At no time will a member be discriminated against because they have filed an appeal. Appeals must be filed within 60 calendar days from the date on the adverse benefit determination notice. Molina has only one level of member appeals. Molina will acknowledge each appeal within 10 calendar days from the date Molina received the appeal.

Standard Appeals Process and Timeline

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

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

Expedited Appeals Process and Timeline

Molina will resolve expedited appeals and provide notice as expeditiously as the Member's health condition requires, within seventy-two (72) hours after Molina receives the appeal. Molina will provide written notice of the disposition of the appeal. Molina will ensure that no punitive action is taken against a provider as a result of the provider's request for an expedited resolution or support of a member's appeal.

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

timeframe of no longer than thirty (30) calendar days from the day Molina receives the appeal with a possible extension of fourteen (14) calendar days, and will make a reasonable effort to give the member prompt verbal notice of the denial and written notice within two (2) calendar days

For any extension not requested by the member, Molina will make reasonable efforts to give the member prompt verbal notice of the delay; within two (2) calendar days, give the member written notice of the reason for the decision to extend the timeframe and inform the member of the right to file a grievance if they disagree with that decision; and resolve the appeal as expeditiously as the member's health condition requires and no later than the date on which the extension expires.

Submission of Member Appeals and Grievances

Providers shall submit a Member appeal or grievance at:

- Fax: (833) 635-2044
- Mail: Molina Healthcare of Nebraska, Inc
  Appeals & Grievances Unit
  14748 W Center Rd, Suite 104
  Omaha NE 68144
- Phone: (844) 782-2018

Continuation of Benefits During the Appeal or State Fair Hearing Process

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

- The Member files the request for an appeal timely in accordance with 42 CFR § 438.402(c)(1)(ii) and (c)(2)(ii)
- The appeal involves the termination, suspension, or reduction of previously authorized services;
- The services were ordered by an authorized Provider;
- The period covered by the original authorization has not expired; and
- The Member timely files for continuation of benefits. "Timely files" means on or before the later of the following:

  - within ten (10) Calendar Days of the Plan mailing the Notice of Adverse Benefit Determination, or
  - the intended effective date of Molina's proposed Adverse Benefit Determination Molina will provide benefits until one of the following occurs:

- The Member withdraws the appeal or request for State Fair Hearing;

- The Member fails to request a State Fair Hearing and continuation of benefits within ten calendar days after Molina sends the notice of adverse resolution to the Member's appeal; or
- The State Fair Hearing office issues a hearing decision not in the Member's favor.
  To ask for continuation of benefits during the appeal process, the Member may call us or can send their request in writing to:

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

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

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

State Fair Hearing

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

Nebraska Department of Health and Human Services (DHHS)
MLTC Appeal Coordinator
PO Box 94967
Lincoln, NE 68509-4967

OR

- eFAX: (402) 742-1198
- Email: dhhs.mltcappeals@nebraska.gov

Reversed Appeals

In accordance with 42 CFR §438.424, if Molina HealthCare Inc. or State Fair Hearing decision reverses a decision to deny, limit, or delay services, where such services were not furnished

while the appeal was pending, Molina HealthCare Inc will authorize the disputed services promptly and as expeditiously as the member's health condition requires. Additionally, in the event that services were continued while the appeal was pending, Molina HealthCare Inc will provide reimbursement for those services in accordance with the terms of the final decision rendered by the DHHS and applicable regulations.

Appointment of Representative Process

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