DENTAL PROVIDER MANUAL
Molina Healthcare of Wisconsin, Inc.
Molina Dental Services
Medicaid
2026

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

Molina Healthcare of Wisconsin, Inc. Medicaid Dental Provider Manual
Any reference to Molina Members means Molina Healthcare Medicaid Members.
Last updated: 06/2026

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WELCOME AND INTRODUCTION

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

This Provider Manual shall serve as a supplement as referenced thereto and incorporated therein, to the Molina Healthcare of Wisconsin, Inc. Services Agreement. For additional information, please see the Molina Healthcare of Wisconsin Provider Manual on MolinaHealthcare.com

The information contained within this manual is proprietary. The information is not to be copied as a whole or in part; nor is the information to be distributed without the express written consent of Molina.

The Provider Manual is a reference tool that contains eligibility, benefits, contact information, and policies/procedures for services that the Molina Healthcare of Wisconsin specifically provides and administers on behalf of Molina members.

CONTACT INFORMATION

Molina Healthcare of Wisconsin, Inc.
10201 W Innovation Dr Ste 100
Wauwatosa, WI 53226-9800

WI Medicaid Website:
https://www.forwardhealth.wi.gov/WIPortal/

SKYGEN Provider Services Department

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

SKYGEN Provider Phone: 855-326-5059 (8 a.m. to 5 p.m. CST, Monday through Friday) excluding state holidays which are:New Year's Day

- Martin Luther King Jr. Holiday
- Memorial Day Holiday
- Independence Day
- Labor Day
- Thanksgiving Day
- Day after Thanksgiving

- Christmas Day

Molina Dental Services

Provider Services Department
MDVSProviderServices@MolinaHealthcare.com
Phone: 844-862-4564
Fax: 855-297-3304

Contracting and Credentialing
Denta.Visiondevelopment@molinahealthcare.com
Phone: (844) 862-4564
Fax: 855-297-3304

Provider Information Management(PIM)
MDVSPIM@Molinahealthcare.com
Phone: (844) 862-4564
Fax: 855-297-3304

Translation Services

- Molina Member Services at (888) 999-2404.
- Hearing Impaired: 711

Transportation Services

- Molina Member Services at (866) 907-1493.
- Hearing Impaired: 711

Member Services Department

The Member Services Department handles all telephone and written inquiries regarding Member Claims, benefits, eligibility/identification, Pharmacy inquiries, selecting or changing Primary Care Providers (GENERAL DENTIST) and Member complaints. Member Services representatives are available 8 a.m. to 5 p.m. Monday through Friday. Eligibility verifications can be conducted at your convenience via the SKYGEN Provider Web Portal. The member services phone is (888) 999-2404 and TTY is 711.

Claims Department

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

- SKYGEN Provider Web Portal

- SKYGEN Provider Web EDI Payer ID SKYGN without the “E”

To verify the status of your Claims, please use the SKYGEN Provider Web portal. Claims questions can be submitted through the chat feature on the SKYGEN Provider Web portal or by contacting Provider Services.

Claims Recovery Department

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

Claims Recovery correspondence mailing address:

Molina Healthcare of Wisconsin, Inc
Claims Recovery Department
PO Box 641
Milwaukee, WI 53201

Phone: 855-326-5059

WISCONSIN SERVICE AREA
Molina Healthcare of Wisconsin offers dental benefits to Medicaid members residing in Milwaukee, Kenosha, Racine, Waukesha, Washington, and Ozaukee counties. Outside these areas, the state-administered Medicaid program handles dental services directly.

DELEGATION

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

1. Utilization Management
2. Credentialing and Recredentialing
3. Claims
4. Complex Case Management
5. CMS Preclusion List Monitoring
6. Other clinical and administrative functions

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

Delegation Reporting Requirements

Delegated entities contracted with Molina must submit monthly and quarterly reports. Such reports will be determined by the function(s) delegated and 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.

Providers with questions related to delegated functions should contact their Molina Contract Manager.

CREDENTIALING AND RE-CREDENTIALING

Credentialing

High-quality dental providers are essential to the success of the Molina Healthcare of Wisconsin's dental network, and even more importantly, essential to the health of members enrolled in its Medicaid benefit plans.

Molina offers electronic credentialing through SKYGEN's Credentialing Portal. First register on the Credentialing Portal to complete the electronic credentialing process.

Register at: https://providercap.skygenusasystems.com/CAP
CAQH REGISTRATION LINK: https://proview.caqh.org/PR/Registration
(Indicate "global" authorization to allow access to your data profile to all healthcare organizations)

To submit your paper credentialing application/CAQH and required documents, you may send an email with attachments to: mdvspim@molinahealthcare.com

- Copy of the Provider's active Dental license
- Copy of the Provider's DEA or DEA Completed Waiver
- Certificate of Professional/Liability/Malpractice Insurance

Re-credentialing

- Re-credentialing occurs every 36 months
- Providers will receive notification 6 months in advance
- Molina Healthcare follows NCQA guidelines for re-credentialing

All re-credentialing applications must be completely approved before the lapse date to avoid any claim or payment impact.

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 via email by completing a Contract Update Form (CUF).
    - Immediate notification to changes in license status, board actions, address or name changes, DBA or Tax ID.
    - Add a new dentist to your practice (must be credentialed PRIOR to rendering treatment); Roster required for group practice(s).

- 90 days' notice to terminate participation in writing to allow time for continuity of care issues and to notify members.

Submit changes and updates by emailing the **Contract Update Form (CUF)** to: mdvspim@molinahealthcare.com

1) For additional information regarding credentialing and re-credentialing, please see the Molina Healthcare of Wisconsin Provider Manual on MolinaHealthcare.com.

PROVIDER RESPONSIBILITIES

Compliance and Fraud AlertLine

If you suspect cases of fraud, waste, or abuse, you must report it to Molina. You may do so by contacting the Molina AlertLine or submitting an electronic complaint using the website listed below. For more information about fraud, waste, and abuse, please see the Compliance Section of this Provider Manual.

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

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

Artificial Intelligence

The Provider shall comply with all applicable state and federal laws and regulations related to artificial intelligence and the use of artificial intelligence tools (AI). Artificial Intelligence or AI means a machine-based system that can, with respect to a given set of human-defined objectives, input or prompt, as applicable, make predictions, recommendations, data sets, work product (whether 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.

In addition, the Provider shall **not** use AI-generated voice technology, including but not limited to AI voice bots, voice cloning, or synthetic speech systems to initiate or conduct outbound communications to Molina. The prohibition includes, but is not limited to, communications for billing, eligibility verification, prior authorization, or any other administrative function.

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.

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 and that necessary information is readily available in the dental record. All entries will be indelibly added to the Member's record. PCDs should maintain the following dental record components, that include, but are not limited to:

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

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.
- Dental records are stored away from patient areas and preferably locked.
- Dental records are available on each visit and archived records are available within 24 hours.
- If hard copy, pages are securely attached in the dental record and records are organized by dividers or color-coded when thickness of the record dictates.
- If electronic, all those with access have individual passwords.
- Record keeping is monitored for Quality and HIPAA compliance.
- Storage maintenance for the determined timeline and disposal per record management processes.
- Process for archiving dental records and implementing improvement activities.
- Dental records are kept confidential and there is a process for release of dental records.

Content

Providers must remain consistent in their practices with Molina's dental record documentation guidelines. Dental records are maintained and should include the following information:

- Each page in the record contains the patient's name or ID number.
- Member name, date of birth, sex, marital status, address, employer, home and work telephone numbers, and emergency contact.
- Legible signatures and credentials of Provider and other staff members within a paper chart.
- All Providers who participate in the Member's care.
- Information about services delivered by these Providers.
- A problem list that describes the Member's dental and behavioral health conditions.
- Presenting complaints, diagnoses, and treatment plans, including follow-up visits and referrals to other Providers.
- Prescribed medications, including dosages and dates of initial or refill prescriptions.
- Medication reconciliation within 30 days of an inpatient discharge should include evidence of current and discharge medication reconciliation and the date performed.
- Allergies and adverse reactions (or notation that none are known).
- Documentation that Advance Directives, Power of Attorney and Living Will have been discussed with Member, and a copy of Advance Directives when in place.
- Past dental and surgical history, including physical examinations, treatments, preventive services, and risk factors.
- Treatment plans that are consistent with diagnosis.
- A working diagnosis that is recorded with the clinical findings.
- Pertinent history for the presenting problem.
- Pertinent physical exam for the presenting problem.
- Lab and other diagnostic tests that are ordered as appropriate by the Provider.
- Clear and thorough progress notes that state the intent for all ordered services and treatments.
- Notations regarding follow-up care, calls, or visits. The specific time of return is noted in weeks, months or as needed, included in the next preventative care visit when appropriate.
- Notes from consultants if applicable.
- Up-to-date immunization records and documentation of appropriate history.
- All staff and Provider notes are signed physically or electronically with either name or initials.
- All entries are dated.
- All abnormal lab/imaging results show explicit follow up plan(s).
- All ancillary services reports.
- Documentation of all emergency care provided in any setting.
- Documentation of all hospital admissions, inpatient, and outpatient, including the hospital discharge summaries, hospital history and physicals and operative report.
- Labor and Delivery Record for any child seen since birth.

- A signed document stating with whom protected health information may be shared.

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.

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 applicable State and/or Federal agency and the External Quality Review Organization upon request.
- The dental record is available to the Member upon their request.
- 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 or pursuant to court orders or subpoenas.
- Maintain records and information in an accurate and timely manner.
- Ensure timely access by members to the records and information that pertain to them.
- Abide by all Federal and State Laws regarding confidentiality and disclosure of dental records or other health and enrollment information.
- Dental Records are protected from unauthorized access.
- Access to computerized confidential information is restricted.
- Precautions are taken to prevent inadvertent or unnecessary disclosure of protected health information.
- Education and training for all staff on handling and maintaining protected health care information.

Additional information on dental records is available from your local Molina Quality department.

HIPAA (HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT)

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

Confidentiality

- Using a release form, only release information at the request of a member in response to a legal request for information.
- Store and restrict access to dental records in secured files.
- Educate employees regarding confidentiality of dental records and patient information

Access To Care

Molina maintains access to care standards and processes for ongoing monitoring of access to health care provided by contracted PCDs and participating specialists. Providers 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 standards are based on 80 percent availability for Emergency Services and 80 percent or greater for all other services. The PCD or their designee must be available 24 hours a day, seven days a week to Members.

ACCESS TO CARE

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

Appointment Types	Access Standard
Dental Emergency/Urgent	24 hours/7 days a week
Routine Dental	30 days

For additional information regarding provider responsibilities, please see the Molina Healthcare of Wisconsin Provider Manual at MolinaHealthcare.com.

MEMBER RIGHTS & RESPONSIBILITIES

Providers must comply with the rights and responsibilities of Molina Members as outlined in the Molina Member Handbook and on the Molina website. The Member Handbook that is provided to Members annually is hereby incorporated into this Provider Manual. The most current Member Rights and Responsibilities can be accessed at MolinaHealthcare.com. 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.

For additional information, please contact Molina's Provider Contact Center at (855) 326-5059 or TTY/TDD 711 for persons with hearing impairments.

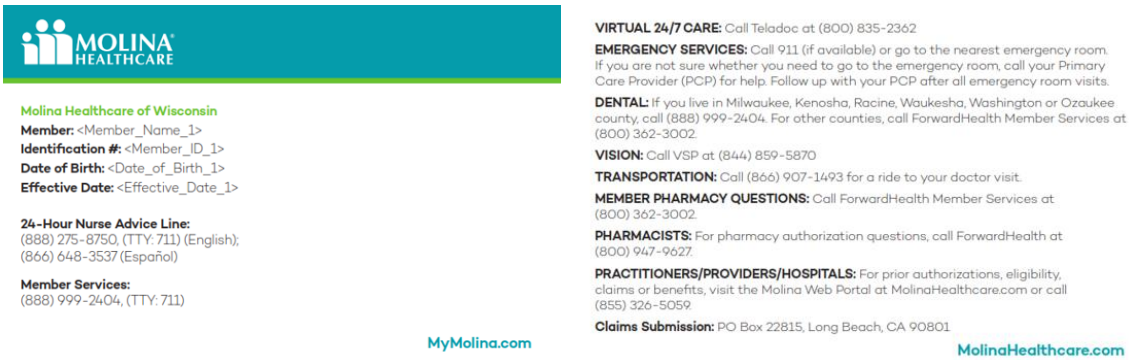
Second Opinions

If Members do not agree with their Provider's plan of care, the Member has the right to request, at no cost, a second opinion from another Provider. Members should call Molina's Member Services Center to find out how to get a second opinion. Second opinions may require prior authorization.

ELIGIBILITY, ENROLLMENT, DISENROLLMENT

Member Eligibility & ID Cards

Card Front **Card Back**



Provider offices are responsible for verifying member eligibility and benefit coverage before providing services. Eligibility and coverage can be verified the following ways:

- 24 hours a day/7 days a week/365 days electronically on SKYGEN Provider Portal at SKYGEN Provider Web Portal
- 24 hours a day/7 days a week/365 days by calling SKYGEN automated eligibility line at (855) 326-5059
- Molina Interactive Voice Response System (IVR): (888) 999-2404

Possession of a Medicaid 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.

- Member eligibility varies by month
- Each individual State makes all eligibility determinations
- The Molina Healthcare Member ID card is not proof of eligibility

For additional information on eligibility, enrollment and disenrollment, please see the Molina Healthcare of Wisconsin Provider Manual on MolinaHealthcare.com.

CLAIMS AND COMPENSATION

Payer ID	SKYGN
SKYGEN Provider Web Portal	SKYGEN Provider Web Portal
Clean Claim Timely Filling	90 days from date of service

Electronic Claims Submission Requirement

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

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

Molina offers the following electronic Claims submission options:

- Via the SKYGEN Provider Web Portal.
- Via an EDI clearinghouse using Payer ID SKYGN, refer to our website MolinaHealthcare.com for additional information.
- Via USPS

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

Clearinghouse

Molina uses Change Healthcare as its gateway clearinghouse. Change Healthcare 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 Provider Web Portal.

Molina accepts EDI transactions through our gateway clearinghouse for Claims via the 837D. 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 original 2019 ADA Dental Claim Forms.
- Paper Claims not submitted on the required forms will be rejected. This includes black and white forms, copied forms, and any altering to include Claims with handwriting.
- Claims must be typed with either 10- or 12-point Times New Roman font, using black ink.

Corrected Claims Process

Providers may correct any necessary field of the 2019 ADA Dental Claim Forms.

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

All Corrected Claims:

- Must be free of handwritten or stamped verbiage (paper Claims)
- Must be submitted on a standard 2019 ADA Dental Claim Forms

Corrected Claims must be received within the contractual claim submission timely filing limit.

Corrected Claims submission options:

- Via the SKYGEN Provider Web Portal
- Via your regular EDI clearing house

- Via USPS to:
  Corrected Claims
  PO Box 641
  Milwaukee, WI 53201

- For additional information on claims and compensation, please see Molina Healthcare of Wisconsin Provider Manual at MolinaHealthcare.com.

Electronic Payment (EFT/ERA) Requirement

Participating Providers are required 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.

Additional instructions on how to register are available under the EDI/ERA/EFT tab on Molina's website at https://pwp.skygenusasystems.com/PWP/Landing

BENEFITS AND COVERED SERVICES

Dental Service Covered by Molina

Molina covers dental services outlined on the state website located here: WI DENTAL BENEFITS If there are questions as to whether a service is covered or requires prior authorization, please reference the state website. You may also contact Molina at (855) 326-5059, 8 a.m. to 5 p.m. Monday through Friday.

Molina requires D9997 (Dental Case Management—Patients with Special Health Care Needs) on claims to consider additional benefits for SHCN members receiving D1110 and D1120 services. SHCN individuals are defined as those unable to independently maintain oral health due to a disability or high-risk dental diagnosis.

When submitting Dental Prophylaxis (D1110/D1120) claims beyond standard limits for SHCN patients, include a narrative justifying medical necessity, clearly outlining the patient's special health care need or high-risk status. Up to four D1110/D1120 services per 12 months are allowed per member, per provider, for permanently disabled members. These codes are not reimbursed when provided with periodontal scaling/root planing (D4341/D4342) or maintenance (D4910). Special considerations:

- Retain documentation verifying disabilities affecting oral hygiene.
- Benefit is available to Medicaid-enrolled dental hygienists

Non-Covered Services

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

- The services to be provided
- Molina Dental Services will not pay for or be liable for these services
- Member will be financially liable for such services

The Non-Covered Services agreement can be found on the SKYGEN's Payee Web Portal (https://pwp.skygenusasystems.com/PWP/) and Molina Healthcare Website

Prior Authorizations

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

- For additional information on health care services, please see the Molina Healthcare of Wisconsin Provider Manual at MolinaHealthcare.com.

Prostheses Care Instructions

As part of any prosthetic service, dentists are expected to instruct the member on the proper care of the prostheses. Six months of post-insertion follow-up care is included in the reimbursement for complete and partial dentures and relining complete and partial dentures. Providers performing denture and partial denture adjustments after six months of post-insertion follow-up care may submit claims to ForwardHealth using procedure code D9110 for these services.

Lost, Stolen, Or Severely Damaged Prostheses

Removable prosthodontic services are provided at considerable expense to BadgerCare Plus. BadgerCare Plus does not intend to repeatedly replace lost, severely damaged, or stolen

prostheses. PA (prior authorization) requests for lost, severely damaged, or stolen prostheses are only approved when:

- The member has exercised reasonable care in maintaining the denture.
- The prosthesis was being used up to the time of loss or theft.
- The loss or theft is not a repeatedly occurring event.
- A reasonable explanation is given for the loss or theft of the prosthesis.
- A reasonable plan to prevent future loss is outlined by the member or the facility where the member lives.

In these situations, BadgerCare Plus will reimburse only for the first lost, damaged, or stolen prosthesis per arch. Subsequent lost, damaged, or stolen prostheses are payable by the member.

Prior Authorization Requirements for Lost, Stolen, Or Severely Damaged Prostheses

When submitting a PA request involving a lost, stolen, or severely damaged prosthesis, give special attention to the need for the prosthesis. The request must include a police report, accident report, fire report, or hospital, nursing home, or group home (community based residential facility) administrator statement or member statement on the loss. Such statements should include how, when, and where the prosthesis was lost or damaged, and what attempts were made to recover the loss and plans to prevent future loss. Note: Real-time review and approval on the ForwardHealth Portal is not allowed for PA requests for replacement of lost, stolen, or severely damaged prostheses.

Orthodontia

PA Requirements

All orthodontic services require PA with the following exceptions:

- The use of orthodontic automatic qualifiers (AQs) as the primary way to identify medically necessary orthodontic care. The AS's replace the Salzmann Index, please visit the state website for details located here: Orthodontic Automatic Qualifiers
- Pre-orthodontic treatment visits (D8660) include an examination, consultation, and the obtaining of diagnostic photos. This service is limited to members with an orthodontic diagnosis only. Providers may submit claims for these services before submitting a PA request for orthodontia.
- Periodic orthodontic treatment visits (D8670) only require PA for the 25th unit or more. (Note: No PA is required for the first 24 units.)
- Panoramic x-ray (D0330), cephalometric x-ray (D0340), and oral/facial photographic images (D0350) for members with an orthodontic diagnosis do not require PA. Claims for these services may be submitted before submission of a PA request for orthodontia.

Documentation

The following documentation must be submitted with all PA requests for orthodontic services:

- Orthodontic records of the examination, consultation, and diagnostic photos
- A completed ADA claim form
- A specific orthodontic treatment plan that addresses appliance(s) to be used during treatment

Fixed or Removable Appliances

Limited Orthodontic Treatment

Limited treatment services are for correction of a minor malocclusion in which one to four teeth are involved. It is considered especially for children under the age of 12 in the transitional dentition stage of development. Services may be used to correct anterior crossbites, ectopic eruption of permanent first molars, and bite plates.

Interceptive Orthodontic Treatment

Interceptive orthodontic treatment is for the correction of a minor malocclusion in which one to four teeth are involved and is considered especially for children under the age of 12 in the transitional dentition stage of development. The correction of posterior cross bites, orthopedic orthodontics, and 2 x 4 interceptive procedures are allowed services under this procedure. Interceptive procedures are not inclusive of comprehensive orthodontic treatment of this malocclusion. Interceptive orthodontic treatment of adolescent or adult dentition is not a covered service.

Minor Treatment to Control Harmful Habits

Correction of harmful habits such as thumb, finger, tongue, or lip sucking is considered especially for children under the age of 12 in the transitional dentition stage of development. Fixed appliances only are encouraged.

Initial Treatment and Billing Date

When billing for the initial orthodontic banding service, the date used is the day the treatment started. This is defined as the date when the bands, brackets, or appliances are placed in the member's mouth. The member must be BadgerCare Plus eligible on this DOS (date of service).

Retainers

Retainers can be authorized for limited, interceptive, or comprehensive orthodontic services requested. If retainers are separately identified on an approved PA (prior authorization) for orthodontic service, they may be separately reimbursed. However, when submitting the PA request, the provider may include the placement, fees, and follow-up for retainers in the initial fee and monthly adjustments. In this case, a separate request for retainers will not be granted. Using either way of billing, the maximum fee for orthodontic treatment will be the same.

Lost or Damaged Retainers

ForwardHealth covers the replacement of lost or damaged retainers without PA for members under 21 years of age.

Severe Malocclusion

The following criteria are considered when reviewing PA (prior authorization) requests for orthodontia:

- In extenuating circumstances, the dental consultant may, after comprehensive review of the case, determine that a severe handicapping malocclusion does exist, and approve the orthodontia treatment
- Transfer cases from out-of-state or within state must fulfill BadgerCare Plus criteria of age at time of initial treatment (banding).
- Certain cases of minor treatment (1-4 teeth) can be approved for limited or interceptive orthodontic treatment using either fixed or removable appliances.
- If the request for orthodontic services is the result of a personality or psychological problem or condition and a member does not meet the criteria listed above, then a referral from a mental health professional is required.

Orthodontic treatment is **not** authorized for cosmetic reasons. Transfer cases from one enrolled provider to another enrolled provider are reimbursed at the maximum fee authorized minus the fees reimbursed to the original provider.

Terminated Treatment

If any orthodontic treatment is terminated prior to completion, the provider is required to notify BadgerCare Plus in writing within 30 days of termination. The notification must include the reason(s) for termination and a copy of the treatment progress notes.

Please note: The dental procedure codes listed below are covered at the time of this publication. Each service may potentially have specific limitations (such as maximum allowance, number of procedures, and/or frequency of services). These covered dental procedure codes may require prior authorization. There may be changes to benefits during the year, and covered services are subject to modification. For updates in benefit coverage, please consult the state Medicaid website.

GRIEVANCE AND APPEALS PROCESS

Provider Appeals

Providers disputing a Claim previously adjudicated must request such action within 90 calendar days of Molina's original remittance advice date. Regardless of type of denial/dispute (service denied, incorrect payment, administrative, etc.); all Claim disputes must be submitted on the

Molina Appeals Form found on the Molina Provider website and the Provider Portal. *The form must be filled out completely to be processed*. Additionally, the item(s) being resubmitted should be clearly marked as an appeal and must include the following:

- Provider's name
- Date of service
- Date of billing
- Date of payment and/or Nonpayment
- Member's name
- Claim number- Services cannot be appealed without a claim on file
- BadgerCare Plus ID number

The reason(s) the claim merits reconsideration. If the appeal relates to dental emergency, medical necessity and/or prior authorization, dental records or substantiating documentation must accompany your request for reconsideration which must include but is not limited to the following:

- Provider Notes

The Claim number clearly marked on all supporting documents.

Appeals MUST be submitted via the Provider Portal (preferred method), secure email, or USPS.

NOTE: Corrected claims are considered new claims and are NOT considered an appeal or dispute and will be rejected.

Provider Appeals:

All BadgerCare Plus providers must first appeal to the HMO and then to the Department of Health Services (DHS) if they disagree with the HMO's payment or nonpayment of a claim.

A dispute/appeal is a request for a clinical review of a claim that has been denied for determinations related to medical necessity. Appeal requests must be submitted in writing and include additional supporting documentation such as x-rays or rationale.

- Call Provider Services toll free at 855-326-5059
- Submit your complaint in writing to:

Molina Healthcare of Wisconsin
Attention: Provider Complaints and Appeals
PO Box 649
Milwaukee, WI 53201

- Or via email at MWI.Appeals@MolinaHealthCare.com

Appeals to the Department of Health Services (DHS) must be submitted through the Provider Appeals portal at https://wi-appeals.entellitrak.com/. Providers are required to submit appeals with legible copies of all supporting documentation as outlined in the "Appeals to BadgerCare Plus HMOs and Medicaid SSI HMOs" (#384) and "Appeals to ForwardHealth" (#385) topics of the ForwardHealth Online Handbook.

The decision to overturn an HMO's denial must be clearly supported by the documentation the provider submits. Submitting incomplete or insufficient documentation may lead to ForwardHealth upholding the HMO's denial. Appeals to DHS must be received within 60 calendar days of Molina's final decision or in the case of no response, within 60 calendar days from the 45-calendar day timeline allotted to Molina to respond. DHS has 45 days from the date of receipt to inform you and Molina of the final decision.

BadgerCare Plus and Medicaid SSI
Managed Care Unit – Provider Appeal
PO Box 6470
Madison, WI 537I6-0470

Member Appeals

Standard appeals may be received orally or in writing within 60 calendar days following the date of the notice of action. An Appeal may be filed by a Member, Member's Authorized Representative, or a provider. Oral Appeals must be followed by a written request, except when a provider requests an Expedited Appeal.

The Member or Authorized Representative must be a party to all Appeals. If member is being represented in their appeal, Member must provide their written, signed consent for someone to act on their behalf.

Written requests should be submitted to:

Member Appeals
Molina Healthcare of Wisconsin, Inc.
Attn: Grievance Coordinator
PO Box 242480
Milwaukee, WI 53224

Email: WIMemberAppeals@MolinaHealthCare.Com

Written acknowledgement of an Appeal received is sent to the Member or his/her Authorized Representative within 10 business days of receipt. A resolution letter is sent within 30 calendar days of initially receiving the Appeal unless the Member is notified in writing of the need for an

additional 14-day extension, along with the reason for the delay. The Member is notified of his/her right to request a hearing at Molina Healthcare and that the Member may attend or send representation for him/her to the hearing. The Member is also notified that interpretation would be provided free of charge should he/she decide to exercise this option.

In the case of Expedited Appeals, a determination is made within 72 hours of appeal request and the Member is notified within two business days.

If the appealing party is dissatisfied with the outcome of an Appeal, A State Fair Hearing may be requested.

- For additional information regarding grievance and appeals, please see the Molina Healthcare of Wisconsin Provider Manual at MolinaHealthcare.com.

RISK ADJUSTMENT MANAGEMENT PROGRAM

What is Risk Adjustment?

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

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

Why is Risk Adjustment Important?

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

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

Interoperability

The Provider agrees to deliver relevant clinical documents (Clinical Document Architecture (CDA) or Continuity of Care Document (CCD) format) at encounter close for Molina Members by using one of the automated methods available and supported by Provider's Electronic Dental

Records (EMR), including, but not limited to, Epic Payer Platform, Direct protocol, Secure File Transfer Protocol (sFTP), query or Web service interfaces such as Simple Object Access Protocol (External Data Representation), or Representational State Transfer (Fast Healthcare Interoperability Resource).

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

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

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

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

Your Role as a Provider

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

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

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

Contact Information

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

CULTURAL COMPETENCY AND LINGUISTIC SERVICES

Background

Molina works to ensure all Members receive culturally competent care across the service continuum to reduce health disparities and improve health outcomes. The Culturally and Linguistically Appropriate Services in Health Care (CLAS) standards published by the 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, and national origin, sex, age, and disability per Title VI of the Civil Rights Act of 1964, Title IX of the Education Amendments of 1972 (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 local Provider relations representatives and by calling the Molina Provider Contact Center at (855) 326-5059.

Non-discrimination in Health Care Service Delivery

Molina complies with Section 1557 of the ACA. As a Provider participating in Molina's Provider Network, Providers and their staff must also comply with the nondiscrimination provisions and guidance set forth by the Department of Health and Human Services, Office for Civil Rights (HHS-OCR), state law and federal program rules, including Section 1557 of the ACA.

You are required to do, at a minimum, the following:

1. You **MAY NOT** limit your practice because of a Member's dental (physical or mental) condition or the expectation for the need of frequent or high-cost care.

2. You **MUST** post in a conspicuous location in your office, a Nondiscrimination Notice. A sample of the Nondiscrimination Notice that you will post can be found in the Member Handbook located at molinahealthcare.com/members/wi/en-us/mem/medicaid/badger/handbook.aspx.
3. You **MUST** post in a conspicuous location in your office, a Tagline Document, which explains how to access non-English language services. A sample of the Tagline Document that you will post can be found in the Member Handbook located at molinahealthcare.com/members/wi/en-us/mem/medicaid/badger/handbook.aspx.
4. If a Molina Member is in need of language assistance services while at your office, and you are a recipient of federal financial assistance, you **MUST** take reasonable steps to make your services accessible to persons with limited English proficiency (LEP). You can find resources on meeting your LEP obligations at hhs.gov/civil-rights/for-individuals/special-topics/limited-english-proficiency/index.html and hhs.gov/civil-rights/for-providers/clearance-medicare-providers/technical-assistance/limited-english-proficiency/index.html.
5. If a Molina Member complains of discrimination, you **MUST** provide them with the following information so that they may file a complaint with Molina's Civil Rights Coordinator or the HHS-OCR:

Civil Rights Coordinator Molina Healthcare, Inc. 200 Oceangate, Suite 100 Long Beach, CA 90802 Phone (866) 606-3889 TTY/TDD: 711 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/smartscreen/main.jsf Complaint Form: hhs.gov/ocr/complaints/index.html

If you or a Molina Member need additional help or more information call the Office of Civil Rights at (800) 368-1019 or TTY/TDD (800) 537-7697 for persons with hearing impairments.

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 Molina Members, service delivery and program development so that cultural competency becomes a part of everyday thinking.

Provider and Community Training

Molina offers educational opportunities in cultural competency concepts for Providers, their staff, and community-based organizations. Molina conducts Provider training during Provider orientation, with annual reinforcement training offered through Provider Relations and/or online/web-based training modules. Web-based training modules can be found on Molina's website at: molinahealthcare.com/providers/wi/medicaid/resource/diverse_pop.aspx.

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 non-discrimination of service delivery into Provider communications.

Integrated Quality Improvement

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

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

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

Access to Interpreter Services

Providers may request interpreters for Members whose primary language is other than English by calling Molina's Member Contact Center at (888) 999-2404. If Molina Member Contact Center representatives are unable to interpret in the requested language, the representative will immediately connect the Provider and the Member to a qualified language service provider.

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

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

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

Molina Members are entitled to:

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

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

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

- Verify the Member's eligibility and dental benefits.
- Inform the Member that an interpreter, limited hearing, and/or limited reading service are available.
- Molina is available to assist Providers with locating these services if needed:
    - Providers needing assistance finding onsite interpreter services.
    - Providers needing assistance finding translations services.

- Providers with Members who cannot hear or have limited hearing ability may use the National TTY/TDD Relay Service at 711.
- Providers with Members with limited vision may contact Molina for documents in large print, Braille, or audio version.
- Providers with Members with limited reading proficiency.
- The Molina Member Contact Center representative will verbally explain the information, up to and including reading the documentation to the Members or offer the documents in audio version.

Documentation

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

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

Members Who Are Deaf or Hard of Hearing

TTY/TDD connection is accessible by dialing 711. This connection provides access to Molina's Member and Provider Contact Center, Quality, Health Care Services, and all other health plan functions.

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

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

24-hour Nurse Advice Line

Molina provides nurse advice services for Members 24 hours per day, seven days per week. The 24-hour nurse advice line provides access to 24-hour interpretive services. Members may call the 24-hour nurse advice line directly at: English line (888) 275-8750, Spanish line (866) 648-

3537. The 24-hour Nurse Advice Line telephone numbers are also printed on Molina Member ID 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 Healthcare Effectiveness Data and Information Set (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® survey results for potential cultural and linguistic disparities that prevent Members from obtaining the recommended key chronic and preventive services.

COMPLIANCE

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

QUALITY

Maintaining Quality Improvement Processes and Programs

Molina works with Members and Providers to maintain a comprehensive Quality Improvement (QI) Program. You can contact the Molina Quality department at (888) 999-2402 (TTY/TDD: 711) for additional information.

The address for mail requests is:

Molina Healthcare of Wisconsin, Inc.
Quality Department
PO Box 242480
Milwaukee, WI 53224

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

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

Patient Safety Program

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

Quality of Care

Molina has established a systematic process to identify, investigate, review, and report any quality of care, adverse event/never event, critical incident (as applicable), and/or service issues affecting Member care. Molina will research, resolve, track, and trend issues. Confirmed adverse events/never events are reportable when related to an error in dental care that is clearly identifiable, preventable and/or found to have caused serious injury or death to a patient.