CareSource | NETWORK Notification

Notice Date: November 21, 2023
To: Georgia Medicaid Providers
From: CareSource
Subject: Dental: Post-Treatment (Retrospective Review) – Process Clarification
Effective Date: January 1, 2024 (Revised Effective Date)

Summary
Thank you for your continued participation with CareSource serving Georgia Medicaid, PeachCare for Kids® and Planning for Healthy Babies® (P4HB®) programs. As communicated in previous notifications and resources, some procedures require retrospective (post-treatment review) or prior authorization before initiating treatment. CareSource and SKYGEN recently implemented a more simplified process for post-treatment review as communicated in notices posted on May 22 and May 30, and wanted to clarify this process due to some adverse determinations and submission confusion incurred.

Impact
The previous process for retrospective review for dental services noted in the 2022 and 2023 Dental Office Reference Manual **Compendium** Coverage Resources as "post-review" required or allowed the provider to submit a request for retrospective review via the SKYGEN portal, which were reviewed within 30 calendar days (per the Georgia Department of Community Health (DCH) timeline policy). **Effective July 1, 2023**, we have eliminated the extra administrative step. You no longer have to submit a request for retrospective review if you filed a claim. Post-treatment review authorization is automatically generated based on information from the originating claim. The original claim is closed with an exception code stating that the service is awaiting review. As soon as the post-treatment review authorization is approved or denied, it is matched to the corresponding service, and processing of the claim continues.

When billing for these procedures, please note it is essential you submit the claim with the required documentation. Whether you are using the retrospective authorization process or submitting the claim as post-review, per state guidelines, retrospective or post-treatment reviews must be received within **30 days** from the date of service.

Services that require post-treatment review, or where retrospective review is allowed, are outlined in the Dental Office Reference Manual Compendium Coverage Grid. As a reminder, current iterations are available upon logging into your SKYGEN portal account and accessing "insurer documents." We recently copied current notices and resources to the SKYGEN landing page in the alerts.

Claims submitted for services that require post-treatment review need to be submitted with the appropriate documentation. Below are examples of documentation that may be required:

- Radiographs (pre-op, post-op or opposing arch x-rays as indicated in the compendium grid)
- Intraoral/extraoral images
- Narrative of Medical Necessity **(must be submitted as an attached Word document or PDF)**
- Perio charting

- Operative and/or anesthesia report
- Scorecards/Index

Importance
Please follow the published coverage and policies in the most current iterations of the CareSource office reference resources. **Any claim for post-treatment review submitted without the required documents will be denied** (as service authorization required or missing documentation) and must be resubmitted as a corrected claim with required documentation for reimbursement.

If you are submitting via a clearinghouse, use the SKYGEN payor ID “SCION” and follow the attachment service process for that clearinghouse. Update your software to the current SKYGEN mailing address and ADA 2019 claim form.

The Dental Consultant/Clinical Reviewer reviews the documentation to ensure the services rendered meet the clinical criteria requirements, as outlined in the Dental Office Reference Manual. Once the clinical review is completed, the claim is either paid or denied and notification will be sent to the provider via the provider remittance statement.

If there is any question as to whether a procedure that is subject to retrospective review may not meet criteria and may not be paid, you have the option to submit the procedure for prior authorization first. It is important to list the “From” and “To” dates of service accurately on the request. Do not submit services via prior authorization that are not demarcated as post-review or prior authorization.

Note: prior or pre-authorizations are reviewed within three **business** days.

Questions?
For questions, please call Provider Services or contact your Provider Engagement Representative at: **1-855-202-1058** (Monday through Friday, 7 a.m. to 7 p.m. Eastern Time).

GA-MED-P-2409054a DCH Approved: 11/20/2023