CareSource®

CARESOURCE DENTAL
GEORGIA MEDICAID

At CareSource®, our goal is to help you improve and maintain the oral health of our members. This guide for our dental providers shares general information and requirements on key administrative processes and includes an overview of covered services and authorizations. This document does not replace the detailed information and complete guidelines in the CareSource Dental Office Reference Manual.

Quick Reference Guide 2025

Covered Dental Services

GEORGIA FAMILIES® MEDICAID AND PEACHCARE FOR KIDS®
GEORGIA PATHWAYS TO COVERAGE™

Both adults and children who are enrolled in Georgia Medicaid, PeachCare for Kids® and Georgia Pathways are eligible for comprehensive dental services. CareSource still offers value - added services.

- Oral evaluations and radiographs
- Dental cleanings
- Tobacco and Substance Use Counseling Services*
- Restorative Services (i.e. fillings, prefabricated crowns)
- Root Canal Therapy
- Periodontal Services
- Dentures and Partials
- Extractions and Oral Surgery
- Orthodontia (Comprehensive and Limited) (Children Only)
- General Anesthesia and Sedation Services
- Other Limited Adjunctive Services

** Georgia Families® Medicaid (RSM) for Pregnant Women benefits provides some additional services.*
** CareSource covers some enhanced value-added dental services. See the Provider Office Reference Manual/Compendium Benefit Grid. Annual $700 allowance applicable to non-preventive value-add expanded benefits.*

PLANNING FOR HEALTHY BABIES®

Dental services are covered only for members enrolled in the Interpregnancy Care Component of Planning for Healthy Babies® (P4HB). Members enrolled in the Resource Mother only Component of P4HB should check their Medicaid benefits for dental services.

- Oral evaluations and radiographs
- Dental cleanings
- Temporary Fillings*
- Scaling and Root Planing (High Risk Chronic Disease Members)*
- Extractions Routine and Surgical*
- Nitrous Oxide or Non-intravenous Conscious Sedation (For Surgical Cases)*
- Palliative Treatment of dental pain*

** CareSource also covers some enhanced value-added dental services for P4HB as indicated above. Annual $700 allowance applicable to non-preventive value-add expanded benefits. Dental Benefits are subject to exclusions, frequency/age limits.*

Dental Services That Require Prior Authorization*

- Porcelain crowns
- Root canal therapy and apioectomy surgery
- All periodontal services
- Removable dentures and partials (ASC) calls
- Fixed partial dentures (bridges)
- Removal of impacted tooth – soft, partial, complete bony
- Surgical extractions and removal of residual tooth roots
- Alveoloplasty
- Surgical access of unerupted tooth
- Removal of lateral exostosis (maxilla or mandible)
- Excisional Biopsy of salivary glands
- Frenulectomy (frenectomy or frenotomy)
- Excision of hyperplastic and pericoronal tissue
- Orthodontia services
- General anesthesia/deep sedation
- Non IV sedation
- Nitrous ages 13 and older
- Hospital/Answering Service Care
- Therapeutic Drug Injections
- Other drugs and medication by report
- Adjunctive or miscellaneous services by report

Some services may require prior authorization for specific age groups, and some may require post review.

Contracting and Credentialing	Before contracting with CareSource, the Georgia Department of Community Health (DCH) must credential first time dental Medicaid providers. Providers can easily do so online using the DCH Enrollment Wizard. Once issued a Medicaid provider number, providers can contract with CareSource directly at www.CareSource.com/ga/providers/education/become-caresource-provider/medicaid/. If you have any questions related to the contracting process or need assistance, you can contact your dedicated Dental Health Partner/Provider Contracting Manager for your region or Provider Services at **1-800-202-1058**. If you would like to contact Provider Relations for any questions not answered on our website or policy manuals, contact the Georgia Dental Provider Relations team in writing at GAProviderRelations@CareSource.com.
Provider Portal	CareSource offers a Dental Provider Web Portal through our partnership with Skygen USA (formerly Scion Dental). The provider web portal is accessible directly at: https://pwp.sciondental.com/PWP/Landing. Providers can streamline patient management with the Portal by: • Submitting electronic claims and authorizations • Viewing and downloading guidelines, manual and resources • Verifying patient eligibility • Viewing patient service history • Viewing Provider dental home member panels • Viewing fee schedules • Viewing Quality Metric reports • Receiving remittance advice reports For Skygen provider portal questions please contact the web portal team at: ProviderPortal@scion.com or call **1-855-434-9239**. You may also visit the CareSource website provider page for newsletters and other resources and use the CareSource provider portal at https://providerportal.CareSource.com/GA for other services. You must register to use the CareSource Provider Portal. For questions on the CareSource portal, contact CareSource Provider Services department at **1-800-202-1058**.
Dental Claims	**Online:** Submit claims at https://pwp.sciondental.com/PWP/Landing **Mail:** CareSource Claims Department P.O. Box 1174 Milwaukee, WI 53201 **Clearinghouse:** The **Payor ID** is **"SCION"**. This ID should be used for all clearinghouse dental claims. For dental claims questions, please contact one of our CareSource team members at **1-855-202-1058**. Follow the prompt to "healthcare provider", "claims" and when prompted, state "dental claims".
Prior Authorization	**Online:** Submit authorization requests: https://pwp.sciondental.com/PWP/Landing **Mail:** CareSource GA: Authorization P.O. Box 474 Milwaukee, WI 53201 For dental authorization questions, please contact one of our CareSource PA team members at **1-855-202-1058**, follow the prompt to "authorizations" and then press prompt for "dental authorizations." See Provider Office Reference Manual (ORM) for Post Review/Prepayment Claim Review and Retrospective Authorization Processes.
Coordination of Benefits (COB)	If the patient has other insurance coverage, all claims must be filed with the primary payer first prior to filing claims for reimbursement for services rendered to CareSource member. **Online:** Submit COB claims at https://pwp.sciondental.com/PWP/Landing **Mail:** CareSource Claims Department P.O. Box 1174 Milwaukee, WI 53201 For claims submitted through the Provider Web Portal, the Explanation of Benefits (EOB) must be attached, uploaded and the COB fields per service line completed.

(COB) Continued	**EDI/Clearinghouse:** For electronic claim submissions via a clearinghouse, the primary payer information must be included on the claim submission. The electronic claim must have the primary payer information completed in the correct segments (loops) and entered by service line, according to the clearinghouse's "Companion Guide," in addition to the EOB attachment through NEA, FastAttach®, or your clearinghouse. If the COB fields are not completed, the claim will process incorrectly, and a corrected paper claim will need to be submitted with the primary insurer's EOB. CareSource must receive the claim within 90 calendar days of the date of the primary payer's remittance advice, but not more than 12 months from the date of service or discharge.
Corrected Claim	A corrected claim should ONLY be submitted when an original claim or service was **PAID** based upon incorrect information. A corrected claim must be submitted in order for the original claim to be adjusted with the correct information. As part of this process, the original claim will be recouped, and a new claim processed in its place with any necessary changes. Some examples of corrections that need to be made to a prior paid claim are: • Incorrect NPI or location, payee tax ID, incorrect member, or procedure codes • Services originally billed and paid at incorrect fees (including no fees) • Services originally billed and paid without primary insurance If a claim or service was originally **denied** due to incorrect or missing information, or was not previously processed for payment, **DO NOT submit a corrected claim. DENIED** claims should be resubmitted as a **new claim** with the updated information per your normal claim submission channels. Examples include **1)** If a claim or service was denied due to missing tooth or surface; **2)** Incomplete or incorrect information; **3)** You have since obtained preauthorization for services. If you received a claim or service denial which you do not agree with, including denials for no preauthorization, see the Grievances and Appeals section. **Online:** Providers can make corrections on original claims via the SKYGEN Provider Web Portal (PWP). Via the portal, you can: • Edit or correct American Dental Association (ADA) dental claim form fields • Review or remove attachments/documents associated with the original claim to determine if they should remain attached to the corrected claim Corrections will be allowed one time on an original dental claim when submitted via Provider Web Portal. **Mail:** CareSource ATTN: Corrected Claims Department P.O. Box 1174 Milwaukee, WI 53201 Identify the claim as "corrected" by boldly and clearly marking the claim as "Corrected Claim" across the top of a paper claim form. 1. Identify the original Claim/Encounter Number by writing it in the Remarks section (Box 35) on a paper ADA form. 2. Attach any supporting documentation and send documentation in the same package with the paper claim form. **EDI/Clearinghouse:** Submitting Corrected Claims via Clearinghouse will be accepted when a specific set of criteria are met to ensure the original claim can be identified. In order for a submission to be considered a corrected claim, it must include: 1) Claim frequency code of 7 (Replacement) or 8 (Void/Cancel) in CLM05-3 element along with claim or encounter identifier in REF*F8 element; 2) Original claim in a paid status; 3) Original claim does not have previously resubmitted services, or a corrected claim already processed; 4) Original claim does not have associated service adjustments or refunds; 5) Corrected claim must have a data match to the original claim on at least three of the four items: Enrollee ID, Provider ID, Location ID, and/or Tax ID. If a corrected claim submitted via Clearinghouse file does not meet these requirements, our system will consider the submission to be a new claim. Corrected claims must be received within 180 days from date of service.

Claim Dispute	If a service line on a claim was overpaid or underpaid. For example, if a claim is paid but Provider feels it was not paid at right amount, then a claim dispute can be filed. Adjustments to any overpayments will be made on subsequent reimbursements to the Health Partner/Provider, or the Provider can issue refund checks to CareSource for any overpayments via the Claim Recovery Refund Check Form https://www.CareSource.com/documents/ga-p-0484-claim-recovery-refund-check-form/. **Mail:** CareSource Attn: Provider Claims Disputes P.O. Box 2008 Dayton, OH 45401 Note: If faxed, all documentation including Radiographs and photos must be clear and readable. Faxes must be in accordance with confidentiality guidelines and governed by the same authorization requirements as any other release of health care information. Claim disputes must be submitted in writing within three months of the payment date on the claim. Your dispute request should include all grounds for appeal and be accompanied by supporting documentation and an explanation of why you disagree with our decision.
Claim Appeal	Claim Appeals are administrative appeals of an adverse decision regarding payment for a submitted claim or a denied claim for services rendered to a CareSource member. Examples include medical necessity not established, required authorization or documentation was not submitted, or if you have additional information that you believe may change the payment decision. To submit a Claims Appeal. Submit the Claims Appeal Form, Supporting Documentation, Original Remittance Advice **Mail:** CareSource Attn: Provider Claims Appeals P.O. Box 2008 Dayton, OH 45401 Note: If faxed, all documentation including radiographs and photos, must be clear and readable. Faxes must be in accordance with confidentiality guidelines and governed by the same authorization requirements as any other release of health care information. If you do not agree with the decision of a processed claim, you will have 30 calendar days from the date the adverse action, denial of payment, remittance advice or initial review determination was mailed to you. Your appeal request should include all grounds for appeal and be accompanied by supporting documentation and an explanation of why you disagree with our decision.
Authorization Appeal	If you disagree with a clinical decision regarding medical necessity, we make it easy for you to be heard. After receiving a letter from CareSource denying coverage, a provider or member can submit a pre-service or post-service clinical appeal. 1. **Peer-to-Peer (P2P):** Before submitting a request for a clinical appeal, the requesting provider may request a P2P conversation with the CareSource Dentist Reviewer or Dental Director at **1-833-230-2168**. This request must be made and occur within five business days of the determination. 2. **Pre-Service Appeal:** Denial of an authorization for a service prior to being completed. You have 60 days from the date of the authorization denial to submit a pre-service appeal The pre-service appeal must be accompanied with a member's written consent, specific to the service requested, only valid for that appeal and signed/dated by the member. You can use the Consent for Provider to File an Appeal on Patient/Member's Behalf form, available on our Forms webpage. 3. **Post-Service Appeal:** Denial of an authorization for a service that has already been completed. You have 30 days from the date of the authorization denial to submit a post-service appeal. Member consent is not required for post-service requests. **Mail:** CareSource Attn: Dental Appeals – Georgia P.O. Box 2008 Dayton, OH 45402 Use the Provider Appeal Request Form. All supporting documentation as to the justification of reversing the determination must be submitted with appeal.

Provider Complaints and Grievances	CareSource will thoroughly investigate each provider complaint using applicable statutory, regulatory, and contractual provisions, collecting all pertinent facts from all parties, and applying the CareSource written policies and procedures. Providers are permitted to submit complaints to CareSource regarding CareSource's policies, procedures, or any aspect of CareSource's administrative functions. All provider complaints should be clearly documented. Providers have 30 calendar days from the date of the incident to file a provider complaint: **Mail:** CareSource Attn: Provider Grievances P.O. Box 1947 Dayton OH 45401-1947 **Phone:** 1-855-202-1058
Electronic Funds Transfer	We encourage dental providers to enroll in Electronic Funds Transfer (EFT). SKYGEN offers several payment option solutions partnering with Zelis and via an E-Payment Center platform. Visit https://skygen.zelisenroll.com/ to register and enroll for EFT payments. For providers seeking an alternative payment solution, providers can enroll in SKYGEN's E-Payment Center. A no-fee Automated Clearing House (ACH) delivery of claim payments with access to remittance files via download. Delivery of 835 files to clearinghouses is available directly through the E-Payment Center enrollment portal. Enrollment instructions and a detailed question and answer guide are available for download at https://skygen.epayment.center/Registration.

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