# Medicaid Dental Provider Manual

**Manual Effective: November 1, 2025**

# Table of Contents

# Quick Reference Guide

## SKYGEN Dental Hub: Online, All the Time

Getting reimbursed for the high-quality care you've provided to patients should be quick, easy, and convenient. SKYGEN's user-friendly SKYGEN Dental Hub offers a full set of self-service tools that help you get more done, faster.

## Everything You Need - When You Need It - 24/7/365

Use the SKYGEN Dental Hub to:

- Check real-time eligibility for multiple patients—***at the same time***.
- Submit electronic authorization requests—***with attachments***.
- View a decision tree that shows you the same clinical guidelines our consultants use to evaluate your authorization requests.
- Use our claim estimator to find out in advance whether your claim will be paid or denied, and why—***before you render services***.
- Attach supporting documentation, such as EOBs and x-rays—***online, for no charge***.
- Submit ***pre-filled*** claim forms and review claim history—***with just a few clicks***.
- Check the real-time status of claims and authorizations—***no need to wait for paper letters to arrive by postal mail***.
- View and print provider manuals, remittance reports, and more.

**SKYGEN Dental Hub**:
https://app.dentalhub.com/app/login

When You Need Us – We'll Be There!

Contact us any time for assistance, training, or to arrange an onsite visit: Call Provider Services: **1-800-508-2072**, or email us at: providerservices@skygenusa.com

## Quick Contacts

| | |
|---|---|
| **Electronic Funds Transfer** | Email: providerservices@skygenusa.com |
| **Dental Hub Support** | Email: dentalhubsupport@skygenusa.com |
| **Contracting Portal** | https://www.skygenusaproviders.com (access code: GA) |
| **Fraud & Abuse Hotline** | **1-844-809-9449** |
| **Provider Services** | Email: providerservices@skygenusa.com |

## Quick Reference Information

| | |
|---|---|
| **SKYGEN Dental Hub** | For Training or help registering for or using the SKYGEN Dental Hub, please visit dentalhub.com/webinars to attend or view a webinar or view the Quick Start Guide. |
| **Member Eligibility** | To verify member eligibility:<br>Log on to SKYGEN Dental Hub:<br>https://app.dentalhub.com/app/login |
| **Claims Submission** | The timely filing requirement is six (6) months from the month of service. Corrected claims must be received within six (6) months from the month in which the service was rendered or within three (3) months of the month in which the denial occurred, whichever is later.<br><br>Submit claims through these formats:<br>• SKYGEN Dental Hub: https://app.dentalhub.com/app/login<br>• Electronic submission via clearinghouse –Payer ID: SCION<br>• CareSource Georgia: Claims<br>P.O. BOX 1174<br>Milwaukee, WI 53201 |

# Quick Reference Information

| | |
|---|---|
| **COB (Coordination of Benefits)** | 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.<br>• SKYGEN Dental Hub: https://app.dentalhub.com/app/login<br>• Electronic submission via clearinghouse –Payer ID: SCION<br>• CareSource Georgia<br>P.O. BOX 1174<br>Milwaukee, WI 53201<br><br>Claims originally filed timely with a third-party carrier, but were recouped, denied or paid insufficiently, must be billed to SKYGEN three (3) months of the date of the recoupment letter, denial or payment, but never more than twelve (12) months from the month of service. |
| **Authorization Submission** | Standard Service Authorization: Prior authorization determinations must be made within 3 calendar days from the date SKYGEN receives the request. An extension may be granted for an additional 14 calendar days if the member or provider requests a need for additional info and extension is in the member's best interest.<br><br>Expedited Service Authorization: Contractor must make an expedited authorization decision within 24 hours and provide notice as expeditiously as the member's health condition requires, and no later than 3 business days after receipt of request. The Contractor may extend the 24-hour period for up to 5 business days if the Contractor justifies to DCH a need for additional info and how extension is in the member's best interest.<br><br>Prior authorizations will be honored for 365 days from date they are determined.<br><br>Submit authorizations in one of the following formats:<br>• SKYGEN Dental Hub: https://app.dentalhub.com/app/login<br>• Electronic submission clearinghouse, Payer ID: SCION<br>• CareSource Georgia: Authorizations<br>P.O. Box 474<br>Milwaukee, WI 53201<br><br>Providers may request a peer-to-peer (P2P) conversation with the SKYGEN Dentist Reviewer by calling Provider Services Line **1-800-508-2072**. |
| **Provider Appeals – Claims** | Providers may submit a claim appeal to request reconsideration of a claim denial or a clinical appeal for a medical necessity decision, submit a written appeal to:<br>• CareSource Georgia Appeals<br>P.O. Box 1251<br>Milwaukee, WI 53201<br><br>You have (30) calendar days from the date the adverse action, denial of payment, remittance advice or initial review determination was mailed to you to submit a claim appeal. |
| **EFT (Direct** | The EFT Authorization Agreement form is found online in the |

| | |
|---|---|
| **Deposit) Enrollment** | SKYGEN Dental Hub: https://app.dentalhub.com/app/login |

# Welcome

***Welcome to the CareSource Georgia provider network!*** We are committed to providing our members with the best possible care, keeping them healthy, stable, and independent - it's our reason for being here. We are pleased to welcome you to our team.

SKYGEN is a nationwide leader in managed benefits administration. CareSource Georgia has chosen SKYGEN to administer dental benefits for members enrolled in the CareSource Georgia Dental Plan.

Throughout your ongoing relationship with SKYGEN refer to this provider manual for quick answers and useful information, including how to contact us, how to submit claims and authorizations, and what benefits are offered to members.

- When you need answers, log on to https://app.dentalhub.com/app/login
- Send an email message to providerservices@skygenusa.com, or call Provider Services at **1-800-508-2072**.

SKYGEN retains the right to add to, delete from, and otherwise modify this provider manual. Contracted providers must acknowledge this provider manual and any other written materials provided by SKYGEN as proprietary and confidential.

This manual describes SKYGEN policies and procedures that govern our administration of dental benefits. SKYGEN makes every effort to maintain accurate information in this manual; however, we will not be held liable for any damages due to unintentional errors. If you discover an error, please report it to us by calling **1-800-508-2072.** If information in this manual differs from your Participating Agreement, the Participating Agreement takes precedence and shall control.

# Member Rights & Responsibilities

## Member Rights

CareSource Georgia and SKYGEN are committed to the following core concepts in our approach to member care:

- Access to providers and services.
- Wellness Programs, which include member education and disease management initiatives. This includes the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) Program.
- Outreach Programs that educate members and give them the tools they need to make informed decisions about their dental care.
- Feedback that measures provider and member satisfaction.

We believe all members have the right to:

- Privacy, respectful treatment, and recognition of their dignity when receiving dental care.
- Participate fully with caregivers in making decisions about their health care.
- Be fully informed about the appropriate or medically necessary treatment options for any condition, regardless of the coverage or cost for the care discussed. For those children receiving EPSDT services, any limits on services may be exceeded when medically necessary.
- Members covered under EPSDT are entitled to receive any medically necessary service. If the service is medically necessary SKYGEN/CareSource Georgia will cover the cost of the service.
- Voice a complaint against CareSource Georgia/SKYGEN, or any of its participating dental offices, or any of the care provided by these groups or people, when their performance has not met the member's expectations.
- Appeal any decisions related to patient care and treatment.
- Make recommendations regarding our member rights and responsibilities policies.
- Receive relevant information about the CareSource Georgia Dental Plan, services provided, participating dentists and dental offices, as well as member rights and responsibilities.

## Member Responsibilities

Along with rights, members have important responsibilities, including:

- Becoming familiar with benefit plan coverage and rules.
- Giving dental providers complete and accurate information they need to provide care.
- Following treatment plans and instructions received from dental providers.
- Supporting the care given to other patients and behaving in a way that helps the clinic, dental office, and other dental locations run smoothly.
- Notifying Customer Service of any questions, concerns, problems, or suggestions.

# Provider Rights & Responsibilities

CareSource Georgia and SKYGEN have established the following core concepts in our approach to a positive provider experience:

- Access to flexible participation options in provider network.
- Outreach Programs that lower provider participation costs.
- Technology tools that increase efficiency and lower administrative costs.
- Feedback that measures provider and member satisfaction.

# Provider Rights

Enrolled participating providers have the right to:

- Communicate with patients about dental treatment options.
- Recommend a course of treatment to a member, even if the treatment is not a covered benefit or approved by the CareSource Georgia Dental Plan and SKYGEN.
- File an appeal or complaint about the procedures of CareSource Georgia and SKYGEN.
- Supply accurate, relevant, and factual information to a member in conjunction with an appeal or complaint filed by the member.
- Object to policies, procedures, or decisions made by CareSource Georgia and SKYGEN.
- Be informed of the status of their credentialing or re-credentialing application, upon request.

# Provider Responsibilities

Participating Providers have the following responsibilities:

- If a recommended treatment plan is not covered (not approved by CareSource Georgia/SKYGEN), the participating dentist, if intending to charge the member for the non-covered services, must notify and obtain agreement from the member in advance. (See Payment for Non-Covered Services).
- A provider may not bill both medical codes and dental codes for the same procedure.
- Providers must complete the CareSource Georgia Provider Participation Agreement (along with all supporting documentation) and provide requested information for registration on the Provider Portal.
- Providers are expected to use electronic options for claim and authorization submission, claim reimbursement, and receipt of remittance advice statements including enrolling in the EFT Program. (See the Electronic Payments section in the manual for more details).

**Primary Dental Providers (Dental Homes) responsibilities include:**

- Promoting and providing preventive care and educating on oral hygiene and healthy lifestyle choices. One primary CareSource goal is focusing on prevention and early intervention, partnering with our providers to offer the preventive services our members need to remain healthy.
- Providing phone coverage for handling patient calls 24 hours a day, 7 days a week.
- Making referrals to medical or dental specialists or other social services when necessary. As a managed health care organization, we strive to improve the health of our members by utilizing a contracted network of participating providers, both primary medical and primary dental care providers, to collaborate and provide a range of services to our members. Coordinating and referring them to specialists and support services offered by CareSource when needed.

# Provider Bill of Rights

- To be treated with respect
- To be paid accurately
- To be paid on time

# Dental Home

The Dental Home program is available to all eligible members in the CareSource GA region who will be assigned a Dental Home with a Primary Dental Practitioner. The goal of the program is to improve access to preventive care, enhance relationships between members and providers, and improve continuity of care to facilitate better oral health outcomes for members.

Members are not required to go specifically to their assigned dental home office. They can still go to any In-Network provider to be seen for covered services. Members are assigned to an active dental home location within the CareSource Georgia/SKYGEN provider network. Members can contact customer service to request a change in their dental home at any time.

If an office has closed or no longer has active CareSource Georgia/SKYGEN providers, it is essential to notify SKYGEN. This ensures that members currently assigned to that location as their dental home can be promptly reassigned to an active dental provider.

## Positive Provider Experience

Committed dentists are essential to the success of CareSource Georgia. The CareSource Georgia provider network is structured to give dentists the flexibility they need to participate in dental programs on their own terms. At SKYGEN, we are not only the benefits management partner for CareSource Georgia, but we also consider ourselves to be your partner in patient care.

At SKYGEN, we recognize the significant link between good dental care and overall patient health, and we advocate increasing provider funding while improving member education and outreach. We partner with thousands of providers across the country to deliver high-quality care to all members of CareSource Georgia.

## Cultural Competency

Your office and staff should demonstrate behaviors and policies of cultural competency by:

- Assessing and documenting cultural and/or language barriers to member care.
- Seeking information from community resources to assist in servicing the needs of culturally and ethnically diverse members and families.
- Displaying pictures, posters, and other materials to reflect the cultures and ethnic backgrounds of members and families.
- Providing magazines and brochures in the waiting area that emphasize diversity.
- Understanding that folk and religious beliefs may influence how families respond to illness, disease, death, and their reaction and approach to children with special health needs.
- Accepting that the family unit can be defined differently by diverse cultures.
- Seeking bilingual staff or trained personnel to serve as interpreters, when possible.
- Understanding that a limited English proficiency in no way reflects intellect.

# Access to Flexible Participation Options

CareSource Georgia invites all licensed dentists, regardless of their past commitment to government-sponsored dental programs, to participate in its provider network. Providers can choose their own level of participation for each of their practice locations.

Providers can choose to:

- Be listed in a directory and accept appointments for all new patients.
- Treat only emergencies or special needs cases on an individual basis.
- Access web-based applications

To make it easy to apply and be accepted into the program, we use our web portals and electronic documents to streamline the provider/clinic contracting.

# Recordkeeping Requirements

Dentists are required to maintain individual records, which fully disclose the type and extent of services provided to members in the CareSource Georgia Dental Plan. Providers must maintain and make these records available per state law, including details of all services rendered for each encounter date.

Member records must be kept in the dentist's office regardless of the actual place of service (dental office, long-term care facility, or hospital). Per state requirements, these records must be available for a minimum of ten years following the last date of service.
These records will include, but not be limited to, the following:

Member Identification and History

- Name, address, telephone number, birth date
- If the member is a minor, names of parents or guardians
- Documentation of any cultural or linguistic needs of the member
- Pertinent dental and medical history

Detailed clinical examination data to include, when applicable:

- Member's chief complaint
- Diagnosis
- Cavities
- Missing teeth (Periodontal charting, when necessary)
- Abnormalities

Radiographs

- Preoperative, progressive, and postoperative radiographs retained in accordance with state law for a minimum of seven years following the last date of service (to accommodate possible retention for longer periods, contact professional liability insurance companies.)
- Number and type of radiographs entered on the member's record
- Postoperative radiographs, taken only when dentally necessary and meriting diagnostic value

The treatment plan with description of treatment rendered, including:

- Tooth number
- Surfaces involved
- Site and size of treatment area (lesion, laceration, fracture, etc.)
- Materials used

- Dates of services
- Description of treatment or services rendered at each visit with the name of the dentist or hygienist
- All medications
- Diagnostic laboratory and/or radiographic procedures ordered and the results
- Copy of the dental prosthetic work authorizations (prescriptions) and dental prosthetic laboratory receipts
- Explanation for any duplication of services within one year (Prosthetic services within seven and a half years)
- Reasons for discontinuation of services, and attempts to complete treatment
- Referral and consultation reports

# SKYGEN Dental Hub

SKYGEN encourages providers to register on the Dental Hub today. The SKYGEN Dental Hub is the exclusive dental provider portal tool for CareSource Georgia dental practices. SKYGEN encourages providers to register for the Dental Hub as soon as possible to ensure a seamless transition.

**SKYGEN Dental Hub Webinars and Quick Start Guide**

Your SKYGEN team is ready to support you and your practice to help ensure the transition to the SKYGEN Dental Hub goes smoothly. SKYGEN conducts weekly webinars that cover basic functionalities of the Dental Hub and information regarding the registration process. Providers, can you use this link https://www.dentalhub.com/webinars and click the **Quick Start Guide** icon for more information. This guide was designed to help our users get their business/practice registered and understand some of the Dental Hub's basic functionality.

For additional support please contact:

- The SKYGEN Dental Hub Support Team at **1-855-609-5156** with questions not answered by our webinar, Quick Start Guide or imbedded help.

**Getting started on the SKYGEN Dental Hub!**

- Go to https://app.dentalhub.com/app/login and click "Log in"
- Click 'Sign up now"
- Use **your** email address to create **your** own account

Once you've created **your** own Dental Hub account, you're ready to set up your practice following the Dental Hub's easy, 3-step process:

1. Tell the Dental Hub you work for a dental office.
2. Tell the Dental Hub you want to set up a business.
3. Provide the basic information about your practice - you'll need the W-9 information for your practice and some basic information from a claim that SKYGEN previously processed or your SKYGEN Payee ID# located in the upper left corner of your remittance advice.

**Help navigating the SKYGEN Dental Hub**

A brief video tutorial at the SKYGEN Dental Hub home page explains the set-up process and delivers useful information, including how to:

- Add additional administrators who can share the work of managing your account

- Create practice locations
- Invite dental professionals to join your practice

# Automated Clearing House (ACH)

Effective April 1, 2021, SKYGEN began partnering with Zelis to offer CareSource Georgia providers options to simplify processing payments through ACH and Virtual Card electronic solutions. By using Zelis, providers can lower their overall costs and speed up their payments with fast, automatic electronic ACH (direct deposit) or virtual card payment. Providers can choose what payment methods work for them.

**Zelis Virtual Card** – Zelis has partnered with MasterCard to provide payments for card-based payments. This consolidated card option allows payments as a single transaction per payer per day. By utilizing the Zelis Virtual card office staff simply enters the virtual card information into the card terminal to receive payments for the claim(s) submitted. Card numbers and Explanations of Payment can either be delivered by fax or downloaded from the Zelis Payments secure web portal. Zelis Virtual Card benefits include:

- Easy Access - Providers have multiple options to access data and customize notifications.
- Easy-to-use Portal - offers providers dedicated customer service and a secure portal that allows payment history review anytime and anywhere.
- Easy Reconciliation - Integrated with the providers RCM and/or practice management system for automatic reconciliation using an electronic 835/ERA.
- Secure Technology HIPAA-compliant payment platform.
- Simplified Processes - All remittance information is available 24/7 and can be downloaded into a PDF, CSV, or standard 835 file format.

Providers who are already enrolled with Zelis do not need to make any changes and will automatically be paid through Zelis. Providers who are not enrolled will be contacted by a Zelis representative to help with the enrollment process.

**ACH** - ACH is the most efficient way to maximize payments for your practice, facility or health system by directly depositing electronic payments into your bank account. ACH payment delivery is CAQH CORE®- certified, which ensures compliance with ACA standards and HIPAA requirements. Once enrolled, your funds are automatically deposited into payee bank accounts, eliminating the steps of printing and mailing paper checks. **Although we can deposit the funds directly into your account, we have no access to recoup any payments from your account.**

to receive claims payments through the ACH program:

- Complete the online form in the SKYGEN Dental Hub: https://app.dentalhub.com/app/login

Allow 2-3 weeks for SKYGEN verification and for the ACH Program to be implemented after submitting the ACH form on-line via the Dental Hub. Once you are enrolled in the ACH Program, your Remittance Reports will be posted online and made available from the SKYGEN Dental Hub as soon as your claims are paid.

Once enrolled, please notify SKYGEN of any changes to bank accounts, including changes in Routing Number or Account Number, or if you switch to a different bank. Use the ACH Authorization Agreement form to submit your changes. Allow up to three weeks for changes to be implemented after we receive your change request. SKYGEN is not responsible for delays in payment if we are not properly notified, in writing, of banking changes.

# Electronic Remittance Reports

When you enroll in the SKYGEN EFT Program, your Remittance Reports will be made available automatically from the SKYGEN Dental Hub. For help registering for the Dental Hub or accessing your Remittance Reports send an email message to Provider Services to request electronic

remittances: providerservices@skygenusa.com.

# Health Insurance Portability and Accountability Act (HIPAA)

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.

CareSource Georgia and SKYGEN have implemented numerous operational policies and procedures to ensure we comply with all HIPAA Privacy Standards, and we intend to comply with all Administrative Simplification and Security Standards by their compliance dates. We also expect all providers in our networks to work cooperatively with us to ensure compliance with all HIPAA regulations.

The provider, CareSource Georgia and SKYGEN agree to conduct their respective activities in accordance with the applicable provisions of HIPAA and such implementing regulations.

When contacting Customer Services, providers will be asked to supply their Tax ID or NPI number. When calling regarding member inquiries, providers will be asked to supply specific member identification such as member ID, date of birth, name, and/or address.

As regulated by the Administrative Simplification Standards, you will note the benefit tables included in this provider manual reflect the most current coding standards (CDT-2025) recognized by the American Dental Association (ADA). Effective as of the date of this manual, CareSource Georgia and SKYGEN require providers to submit all claims with the proper CDT codes listed in this manual. In addition, all paper claims must be submitted on the current ADA claim form. To request copies of CareSource Georgia and SKYGEN HIPAA policies, call Customer Service at **1-800-508-2072** or send an email to providerservices@skygenusa.com.

## National Provider Identifier (NPI)

The Health Insurance Portability and Accountability Act (HIPAA) of 1996 required the adoption of a standard unique provider identifier for health care providers. An NPI number is required for all claims submitted to SKYGEN for payment. You must use your individual and billing NPI numbers. To apply for an NPI, do one of the following:

- Complete the application online at https://nppes.cms.hhs.gov/login
- Download and complete a paper copy from https://nppes.cms.hhs.gov/login
- Call **1-800-465-3203** to request an application.

# Utilization Management

## Community Practice Patterns

To ensure fair and appropriate reimbursement, SKYGEN has developed a philosophy of Utilization Management which recognizes the fact there exists, as in all health care services, a relationship between the dentist's treatment planning, treatment costs, and outcomes. The dynamics of these relationships, in any region, are reflected by community practice patterns of local dentists and their peers. With this in mind, SKYGEN Utilization Management is designed to ensure the fair and appropriate distribution of health care dollars as defined by the regionally based community practice patterns of local dentists and their peers.

All Utilization Management analysis, evaluations, and outcomes are related to these patterns. SKYGEN Utilization Management recognizes individual dentist variance within these patterns among a community of dentists and accounts for such variance. Specialty dentists are evaluated as a separate group and not with general dentists, since the types and nature of treatment may differ.

## Evaluation

SKYGEN Utilization Management evaluates claims submissions in such areas as:

- Diagnostic and preventive treatment
- Patient treatment planning and sequencing
- Types of treatment
- Treatment outcomes
- Treatment cost effectiveness

## Results

With the objective of ensuring fair and appropriate reimbursement to providers, SKYGEN's Enhanced Benefits Management department helps identify providers whose treatment patterns show significant deviation from the normal practice patterns of the community of their peers (typically less than five percent of all dentists). SKYGEN is contractually obligated to report suspected fraud, waste, abuse, or misuse by members and participating dental providers to CareSource Georgia.

## Non-Incentivization Policy

It is SKYGEN practice to ensure our contracted providers make treatment decisions based upon medical necessity for individual members. Providers are never offered, nor will they ever accept, any kind of financial incentive or any other encouragement to influence their treatment decisions. The SKYGEN Utilization Management reviewers base their decisions only on appropriateness of care, service, and existence of coverage. SKYGEN does not specifically reward practitioners or other individuals for issuing denials of coverage or care. If financial incentives exist for Utilization Management decision makers, they do not include or encourage decisions which result in underutilization.

# Fraud, Waste, and Abuse

SKYGEN conducts our business operations in compliance with ethical standards, contractual obligations, and all applicable federal and state statutes, regulations, and rules. We are committed to detecting, reporting, and preventing potential fraud, waste, and abuse, and we look to our providers to assist us. We expect our dental partners to share this same commitment, conduct their businesses similarly, and report suspected noncompliance, fraud, waste or abuse.

Fraud, waste, and abuse are defined as:

***Fraud*** is intentional deception or misrepresentation made by a person with knowledge the deception could result in some unauthorized benefit to themselves or some other person or entity. It includes any act which constitutes fraud under federal or state law.

***Waste*** is the unintentional, thoughtless, or careless expenditure, consumption, mismanagement, use, or squandering of federal or state resources. Waste also includes incurring unnecessary costs as a result of inefficient or ineffective practices, systems, or controls.

***Abuse*** is defined as practices that are inconsistent with sound fiscal, business, or medical practices, and that result in the unnecessary cost to the government health care program or in reimbursement for services medically unnecessary or that fail to meet professionally recognized standards for health care. Abuse includes intentional infliction of physical harm, injury caused by negligent acts, or omissions, unreasonable confinement, sexual abuse, or sexual assault. Abuse also includes beneficiary practices that result in unnecessary costs to the health care program.

***Provider fraud*** is any deception or misrepresentation committed intentionally, or through willful ignorance or reckless disregard, by a person or entity in order to receive benefits or funds to which they are not entitled. This may include deception by improper coding or other false statements by providers seeking reimbursement or false representations or other violations of federal health care program requirements, its associates, or contractors.

## Reporting suspected fraud, waste, or abuse

To report a suspected case of noncompliance, fraud, waste, or abuse, call the SKYGEN Fraud and Abuse hotline: **1-844-809-9449** or write to:

SKYGEN
Attention: Fraud and Abuse
P.O. BOX 372
Milwaukee, WI 53201

# Deficit Reduction Act: The False Claims Act

Section 6034 of the Deficit Reduction Act of 2005 signed into law in 2006 established the Medicaid Integrity Program in section 1936 of the Social Security Act. The legislation directed the Secretary of the United States Department of Health and Human Services (HHS) to establish a comprehensive plan to combat provider fraud, waste, and abuse in the Medicaid Program, beginning in 2006. The Comprehensive Medicaid Integrity Plan is issued for successive five-year periods.

Under the False Claims Act, those who knowingly submit or cause another person to submit false claims for payment of government funds are liable for up to three times the government's damages plus civil penalties of $5,500 to $11,000 for each false claim.

The False Claims Act allows private persons to bring a civil action against those who knowingly submit false claims. If there is a recovery in the case brought under the False Claims Act, the person bringing the suit may receive a percentage of the recovered funds.

For the party found responsible for the false claim, the government may exclude them from future participation in federal health care programs or impose additional obligations against the individual.

The False Claims Act is the most effective tool U.S. taxpayers have to recover the billions of dollars stolen through fraud every year. Billions of dollars in health care fraud have been exposed, largely through the efforts of whistleblowers acting under federal and state false claims acts.

For more information about the False Claims Act visit www.TAF.org.

# Whistleblower Protection

The False Claims Act (FCA) provides protection to qui tam relators who are discharged, demoted, suspended, threatened, harassed, or in any other manner discriminated against in the terms and conditions of their employment as a result of their furtherance of an action under the FCA. 31 U.S.C. § 3730(h). Remedies include reinstatement with comparable seniority as the qui tam relator would have had but for the discrimination, two times the amount of any back pay, interest on any back pay, and compensation for any special damages sustained as a result of the discrimination, including litigation costs and reasonable attorneys' fees. SKYGEN Fraud and Abuse Hotline: **1-844-809-9449**.

# Eligibility & Member Services

CareSource Georgia offers Dental services - Medicaid-coverage for children and adults enrolled in the program. CareSource Georgia includes the following plans:

**CareSource Georgia Families®, 0-20 and 21-999**

**CareSource Geogia Families® – Pathway 19-20 and 21-999**

**CareSource Peachcare for Kids® – 0-18**

**CareSource Planning for Healthy Babies – 18-44 (IPC only)**

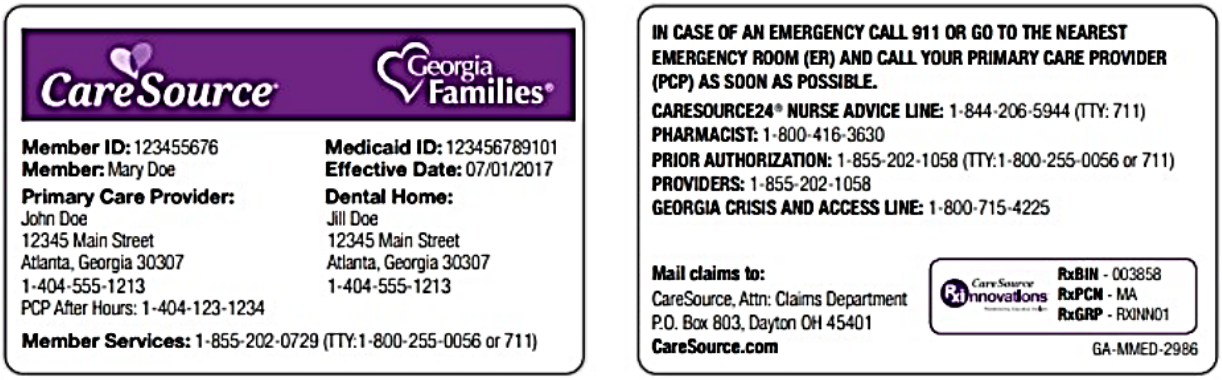
If your patients have questions about how to enroll in the CareSource Georgia program, or if they have questions about loss of eligibility ask them to call the Managed Care Enrollment Center – **1-866-305-5147**.

## Member ID Card

Members receive Member ID cards from CareSource Georgia. Participating providers are responsible for verifying that members are eligible when services are rendered and for determining whether recipients have other health insurance. Because it is possible for a member's eligibility status to change at any time without notice, presenting a Member ID card does not guarantee a member's eligibility, nor does it guarantee provider payment.

SKYGEN recommends each dental office make a photocopy of the member's identification card each time treatment is provided. Please be aware the identification card is not dated and does not need to be returned to SKYGEN should a member lose eligibility.

## Sample Member ID Card




## Verifying Member Eligibility

To verify member eligibility, you can:

- Log on to the SKYGEN Dental Hub: https://app.dentalhub.com/app/login, click on the "Eligibility" tab and fill out the Member Information.
- Call Interactive Voice Response (IVR) eligibility line: **1-800-508-2072**.
- Check member eligibility and benefits on the date of service.

The SKYGEN Dental Hub and IVR system are both available 24 hours a day, 7 days a week giving you quick access to information without requiring you to wait for an available Customer Service Representative during business hours.

## Verifying Eligibility via IVR

Use our Interactive Voice Response system to verify eligibility for an unlimited number of patients. Call **1-800-508-2072**. Follow the prompts to identify yourself and the patient whose eligibility you are verifying.

Our system analyzes the information entered and verifies the patient's eligibility. If the system cannot verify the member information, you will be transferred to a Customer Service Representative. You also have the option of transferring to a Customer Service Representative after completing eligibility checks, if you have other inquiries.

# Appointment Availability Standards

CareSource Georgia Dental Program has established appointment time requirements to ensure patients receive dental services within a time period appropriate to their health condition. We expect dental providers to meet these appointment standards in order to:

- Ensure patients receive the care they need to protect their health.
- Maintain member satisfaction.
- Reduce unnecessary use of alternative services such as emergency room visits.

SKYGEN will educate providers about appointment standards, monitor the adequacy of the process, and take corrective action if required.

**Access to Care & Appointment Guidelines**

| Network Access | General Dentist | Specialist |
|---|---|---|
| Urban | 1 within 30 miles or 30 minutes | 1 within 45 miles or 45 minutes |
| Rural | 1 within 45 miles or 45 minutes | 1 within 45 miles or 45 minutes |

| Type of Care | Should Be Seen |
|---|---|
| Emergency Needs | Within 24 hours (to evaluate, treat, or stabilize an emergency medical condition) |
| Urgent Needs | Within 48 hours (a non-emergent illness or injury with acute symptoms that require immediate care that impacts the ability to function but does not present imminent danger) |
| Routine Care Needs | Within 21 calendar days of initial contact |

| Appointment Time | Waiting Time |
|---|---|
| Scheduled Appointments | Waiting times shall not exceed 60 minutes. After 30 minutes, your patient must be given an update on waiting time with an option of waiting or rescheduling the appointment. |
| Work-In or Walk-In Appointments | Waiting times shall not exceed 90 minutes. After 45 minutes, your patient must be given an update on waiting time with an option of waiting or rescheduling the appointment. |

# Transportation Benefits

Members receive free rides to and from their health care visits. Call the number listed below for

information on the applicable county.

| Area | Company/Phone Number | Counties |
|---|---|---|
| **North** | **Verida**<br>Toll free: **1-866-388-9844** | Banks, Barrow, Bartow, Catoosa, Chattooga, Cherokee, Cobb, Dade, Dawson, Douglas, Fannin, Floyd, Forsyth, Franklin, Gilmer, Gordon, Habersham, Hall, Haralson, Jackson, Lumpkin, Morgan, Murray, Paulding, Pickens, Polk, Rabun, Stephens, Towns, Union, Walker, Walton, White and Whitfield |
| **Atlanta** | **Verida**<br>Toll free: **1-866-388-9844**<br>Local: **404-209-4000** | Fulton, DeKalb, and Gwinnett |
| **Central and Southwest** | **ModivCare**<br>Toll free: **1-888-224-7981** | Atkinson, Baker, Baldwin, Ben Hill, Berrien, Bibb, Bleckey, Brooks, Butts, Calhoun, Carroll, Chattahoochee, Clay, Clayton, Clinch, Coffee, Colquitt, Cook, Coweta, Crawford, Crisp, Decatur, Dodge, Dooly, Dougherty, Early, Echols, Fayette, Grady, Harris, Heard, Henry, Houston, Irwin, Jasper, Jones, Lamar, Lanier, Laurens, Lee, Lowndes, Macon, Marion, Meriwether, Miller, Mitchell, Monroe, Muscogee, Newton, Peach, Pike, Pulaski, Putnam, Quitman, Randolph, Rockdale, Schley, Seminole, Spalding, Stewart, Sumter, Talbot, Talfair, Taylor, Terrell, Thomas, Tift, Troup, Turner, Twiggs, Upson, Webster, Wilcox, Wilkinson and Wort. |
| **East** | **ModivCare**<br>Toll free: **1-888-224-7988**<br>For crisis stabilization Units and Psychiatric Residential Treatment Facilities, call **1-800-486-7642**, Ext. 461 or 436 | Appling, Bacon, Brantley, Bryan, Bulloch, Burke, Camden, Candler, Charlton, Chatham, Clarke, Columbia, Effingham, Elbert, Emanuel, Evans, Glascock, Glynn, Greene, Hancock, Hart, Jeff Davis, Jefferson, Jenkins, Johnson, Liberty, Lincoln, Long, Madison, McDuffie, McIntosh, Montgomery, Oconee, Oglethorpe, Pierce, Richmond, Screven, Taliaferro, Tattnall, Toombs, Treutlen, Ware, Warren, Washington, Wayne, Wheeler and Wilkes |

# Missed Appointments

Enrolled providers are not allowed to charge members for missed appointments. If your office mails letters to members who miss appointments, the following language may be helpful to include:

- “We missed you when you did not come for your dental appointment on Month/Date. Regular checkups are needed to keep your teeth healthy.”
- “Please call to reschedule another appointment. Call us in advance if you cannot keep the appointment. Missed appointments are very costly to us. Thank you for your help.”

CareSource Georgia Dental Program recommends contacting the member by phone or postcard prior to the appointment to remind the individual of the time and place of the appointment.

The Centers for Medicaid & Medicaid Services (CMS) interpret federal law to prohibit a provider from billing any CareSource Georgia member for a missed appointment. In addition, your missed appointment policy for CareSource Georgia Dental Program enrolled patients cannot be stricter than your private or commercial patients. If a CareSource Georgia Dental Program member exceeds your office policy for missed appointments and you choose to discontinue seeing the patient, ask them to contact CareSource Georgia Dental Program for a referral to a new dentist.

# Payment for Non-Covered Services

Enrolled participating providers shall hold members, CareSource Georgia and SKYGEN harmless for the payment of non-covered services except as provided in this paragraph. A provider may bill a member for non-covered services if the provider obtains an agreement from the member prior to rendering such service which indicates:

- The services to be provided.
- CareSource Georgia or SKYGEN will not pay for or be liable for these services.
- Members will be financially liable for such services.

Providers must inform members in advance and in writing when the member is responsible for non-covered services.

# Early Periodic Screening, Diagnostic, Treatment (EPSDT)

**EPSDT**, a benefit that includes comprehensive and preventive health care services for children and adolescents under age 21 who are enrolled in Medicaid. This program helps ensure that children and adolescents receive appropriate and timely preventive (dental, mental health, developmental), specialty services.

**Dental services required** in the **EPSDT** benefit include:

- Dental care needed for relief of pain, infection, restoration of teeth
- Prevention and maintenance of dental health (provided as early as age one)
- Emergency and therapeutic services for dental disease that, if left untreated, may become acute dental problems or cause irreversible damage to the teeth or supporting structures

Medically necessary oral health and dental services, including those identified during an oral screening or a dental exam, are covered for children:

**E**arly - Assessing and identifying problems early.
**P**eriodic - Checking children's health at periodic, age-appropriate intervals.
**S**creening - Providing physical, mental, developmental, dental, hearing, vision, and other screening tests to detect potential problems.
**D**iagnostic - Performing diagnostic tests to follow up when a risk is identified.
**T**reatment - Control, correct or reduce health problems found.

Each state is required to develop a dental periodicity schedule in consultation with recognized dental organizations involved in child health. The American Academy of Pediatrics and the American Academy of Pediatric Dentistry develop and update pediatric dental guidelines related to children’s access to dental services. The Pediatric Dental Periodicity Schedule provides preventive dental care and screening recommendations for Medicaid beneficiaries under 21 years of age for the following areas:

- Clinical Oral Examination (Includes Anticipatory Guidance, i.e.,
- information/counseling given to children and families to promote oral health)
- Prophylaxis/Topical Fluoride Treatment
- Radiographic Assessment
- Assessment for Pit and Fissure Sealants
- Caries Risk Assessment

The state of Georgia, has established oral health care guidelines in line with the EPSDT benefits.

# Prior Authorization & Documentation Requirements

## Prior Authorization for Treatment

CareSource Georgia has specific utilization criteria, as well as a prior authorization review process, to manage the utilization of services. Whether prior authorization is required for a particular service, and whether supporting documentation is also required, is defined in this provider manual in Benefit Plan Details & Authorization Requirements.

Non-emergency services requiring prior authorization should not be started until the authorization request is reviewed and approved by a SKYGEN dental consultant. Non-emergency treatment started prior to the determination of coverage will be performed at the financial risk of the dental office. If coverage is denied, the treating dentist will be financially responsible and may not balance bill the member, CareSource Georgia or SKYGEN.

Should a procedure need to be initiated to relieve pain and suffering in an emergency situation, you are to provide treatment to alleviate the patient's condition.

Submit requests for prior authorization online through the SKYGEN Dental Hub (https://app.dentalhub.com/app/login), electronically in a HIPAA-compliant data file. Any claims or authorizations submitted without the required documentation will be denied and must be resubmitted to obtain reimbursement.

SKYGEN will make a decision on a request for prior authorization within 3 business days from the date we receive the request, provided all information is complete.

SKYGEN will honor prior authorizations for 180 calendar days from the date they are determined. ***An authorization does not guarantee payment***. The member must be eligible for benefits at the time services are provided.

SKYGEN reviewers and licensed dental consultants approve or deny authorization requests based on whether:

- The item or service is medically necessary.
- A less expensive service would adequately meet the members' needs.
- The proposed item or service conforms to commonly accepted standards in the dental community.

## Procedures Requiring Prior Authorization

SKYGEN must make a decision on a request for prior authorization within 3 business days from the date SKYGEN receives this request, provided all information is complete. If you indicate or we determine that following this time frame could seriously jeopardize the member's life or health or ability to attain, maintain or regain maximum function, we will make an expedited authorization decision and provide notice of our decision within 24 hours.

If SKYGEN denies the approval for some or all of the services requested, SKYGEN will send the recipient a written notice of the reasons for the denial(s) and will tell the member he or she may appeal the decision. The requesting provider will also receive notice of the decision. SKYGEN has specific dental utilization criteria as well as a prior authorization and retrospective review process to manage the utilization of services. Consequently, SKYGEN's operational focus is on assuring compliance with its dental utilization criteria.

One method used on a limited basis to assure compliance is to require providers to supply specified documentation prior to authorizing payment for certain procedures. Services requiring

prior authorization should not be started prior to the determination of coverage (approval or denial of the prior authorization) for nonemergency services. Nonemergency treatment started prior to the determination of coverage will be performed at the financial risk of the dental office. If coverage is denied, the treating dentist will be financially responsible and may not balance bill the member, the state or any agents, and/or SKYGEN.

Prior authorizations will be honored for 365 days from the date they are issued. An approval does not guarantee payment. The member must be eligible at the time the services are provided. The provider should verify eligibility at the time of service. The basis for granting or denying approval shall be whether the item or service is medically necessary, whether a less expensive service would adequately meet the member's needs, and whether the proposed item or service conforms to commonly accepted standards in the dental community.

# Dental Services in Hospital/Ambulatory Surgery Center (ASC)

Dental services that are to be performed outside your office, either in an outpatient department of a hospital or at an ASC, must be approved by SKYGEN to ensure the services meet the medical necessity criteria for services rendered in an outpatient facility (hospital or ASC). Hospital/ASC facility approvals are completed by CareSource.

# Appealing an Authorization Decision

If you have questions about a prior authorization decision or wish to speak to the dental reviewer, call Provider Services: **1-800-508-2072.** If a denial is upheld through a peer-to-peer consultation, the provider can request a clinical appeal. See the Grievances & Appeals section in this manual for information.

If SKYGEN denies approval for any requested service, the member will receive written notice of the reasons for each denial and will be notified of how to appeal the decision. The requesting provider will also receive notice of the decision. To appeal an authorization decision, submit the appeal in writing along with any necessary documentation within 60 calendar days (an additional 3 calendar days for mailing time) of the original determination date to:

- CareSource Georgia Appeals
  P.O. Box 1251
  Milwaukee WI 53201

# Authorization Submission Procedures

SKYGEN accepts authorizations submitted in any of the following formats:

- SKYGEN Dental Hub, https://app.dentalhub.com/app/login
- Electronic submission via clearinghouse, Payer ID: **SCION**
- Paper submissions:
  CareSource GA: Authorizations
  P.O. BOX 474
  Milwaukee, WI 53201

## Submitting Authorizations via SKYGEN Dental Hub

Providers may submit authorizations along with any required treatment documentation directly to SKYGEN through our SKYGEN Dental Hub: https://app.dentalhub.com/app/login. Submitting authorizations via the Dental Hub has several significant advantages:

- The online dental form has built-in features that automatically verify member eligibility, pre-fill the authorization form with member information, and make data entry easy.
- The online authorization process steps you through clinical guidelines, when applicable, giving you a quick indication of how your authorization request will be evaluated and whether it's likely to be approved. (Successfully completing a clinical guideline does not guarantee payment).
- The online authorization process indicates whether supporting documentation is required and allows you to attach and send documents as part of the authorization request—***for no charge***.
- Dental reviewers and consultants receive your authorization requests and supporting documentation as soon as you submit them online which means faster decisions.
- As soon as an authorization is determined, its status is instantly updated online and available for review. You don't have to wait for a letter to find out whether your authorization request is approved.

If you have questions about submitting authorizations online, attaching electronic documents, or accessing the SKYGEN Dental Hub, call the Dental Hub Support Team: **1-855-609-5156.**

## Submitting Authorizations via Clearinghouses

Providers may submit electronic claims and authorizations to SKYGEN directly via the DentalXChange or Smart Data Solutions clearinghouses. If you use a different clearinghouse, your software vendor can provide you with information you may need to ensure electronic files are forwarded to SKYGEN.

The SKYGEN Payer ID is **SCION**. By using this unique Payer ID with electronic files, DentalXChange and Smart Data Solutions can ensure that claims and authorizations are submitted successfully to SKYGEN.

## Submitting Authorizations via 837D File

If you can't submit claims and authorizations electronically through the SKYGEN Dental Hub or a clearinghouse, SKYGEN will work with you individually to receive electronic files submitted using the HIPAA-Compliant 837D transaction set format. To inquire about this option, call Provider Services: **1-800-508-2072.**

# Attaching Electronic Documents

If you use the SKYGEN Dental Hub (https://app.dentalhub.com/app/login), you can quickly and easily send electronic documents as part of submitting a claim or authorization—***for no charge***. SKYGEN also accepts dental radiographs and other documents electronically via Fast Attach™ for authorization requests. For more information, visit https://vynedental.com/fastattach/ or call NEA (National Electronic Attachment, Inc.): **1-463-222-2190**.

Please note paper x-rays are preferred; original x-rays should be retained at the dental office and not submitted. To request copies of x-rays to be returned, providers must include a self-addressed stamped envelope with x-rays, otherwise, x-rays are shredded after scanning to an electronic image.

# Submitting Authorizations on Paper Forms

To ensure timely processing of submitted authorizations, the following information must be included on the paper 2019 ADA Dental Claim Form:

- Member Name, Member Date of Birth
- Provider Name, Provider Location, Provider NPI
- Billing Location
- Payee Tax Identification Number (TIN)

Use approved ADA dental codes, as published in the current CDT book or as defined in this manual, to identify all services. Include on the form: all quadrants, tooth numbers, and surfaces for dental codes that require identification (extractions, root canals, amalgams, and resin fillings). SKYGEN recognizes tooth letters A through T for primary teeth and tooth numbers 1 to 32 for permanent teeth. Designate supernumerary teeth with codes AS through TS or 51 through 82.

Designation of the tooth can be determined by using the nearest erupted tooth. If the tooth closest to the supernumerary tooth is 1, then chart the supernumerary tooth as 51. Likewise, if the nearest tooth is A, chart the supernumerary tooth AS. Missing, incorrect, or illegible information could result in the authorization being returned to the submitting provider's office, causing a delay in determination. Use the proper postage when mailing bulk documentation. Mail with postage due will be returned.

## Submitting Retrospective or Post Review

Post-treatment review (post approval) for designated services as outlined in this manual is allowed. Services that require prior approval but are rendered in an emergency are exempt from prior approval but MUST be submitted for post treatment review within thirty (30) calendar days from the date of service or discharge. This process for post treatment review is also used for non-emergency services requiring post-treatment authorization or where post-treatment approval is allowed.

Claims submitted for services that require post-treatment review need to be submitted with the appropriate documentation. The Dental Consultant/Clinical Reviewer reviews the documentation to ensure the services rendered meet the clinical criteria requirements. Once the clinical review is completed, the claim is either paid or denied, and notification will be sent to the provider via the provider's remittance statement.

# Claim Submission Procedures

SKYGEN accepts claims submitted in any of the following formats:

- SKYGEN Dental Hub, https://app.dentalhub.com/app/login
- Electronic submission via clearinghouse, Payer ID: **SCION**
- CareSource GA: Claims
  P.O. Box 1174
  Milwaukee, WI 53201

## ICD Code Requirement Reminders and Resources

SKYGEN will be enforcing the HIPAA submission requirements for the 2019 or current ADA dental claim form. If using the ICD codes, the provider must submit the qualifier in Box 34, enter the diagnosis code(s) in Box 34a and enter a diagnosis pointer in Box 29a for each oral and Maxillofacial Surgery and Anesthesia service line, and follow the instructions for completing the fields appropriately when submitting an ICD diagnosis code. If a valid ICD Code is submitted but a diagnosis pointer is missing, your requested service will be denied.

- Claims that include ICD codes which are NOT required by SKYGEN, but are invalid (e.g., the diagnosis code is not appropriate for the procedure code) will be denied. Therefore, it is important to include valid ICD codes for the CDT codes.
- Electronic claim submissions through the SKYGEN Dental SKYGEN Dental Hub and selected clearinghouses are accepted. Electronic versions conform to 2019 ADA Claim Form fields. The links to current electronic options are:
  - SKYGEN Dental SKYGEN Dental Hub: https://app.dentalhub.com/app/login
  - Smart Data Solutions: https://sdata.us/
  - DentalXChange: www.dentalxchange.com
  - Cognizant: www.cognizant.com

Please note that our representatives are not allowed to provide instructions on how to submit your claims with ICD requirements. We can provide you with information regarding resources available to your office.

## Submitting Claims via SKYGEN Dental Hub

Providers may submit claims directly to SKYGEN Dental through our SKYGEN Dental Hub: https://app.dentalhub.com/app/login. Submitting claims via the Dental Hub has several significant advantages:

- The online dental form has built-in features that automatically verify member eligibility, pre-fill the claim form with member information, and make data entry quick and easy.
- The online process allows you to attach and send electronic documents as part of submitting a claim—***for no charge***.
- Before submitting a claim—or before rendering services—you can generate an online claim estimate to find out how much you are likely to be paid or whether your claim will be denied—and the reasons why.
- Claims enter our benefits administration system faster which means you receive payment faster.
- As soon as a claim is paid, its status is instantly updated online, and a Remittance Report is available for review.

If you have questions about submitting claims online, attaching electronic documents, or accessing the SKYGEN Dental Hub, call the Dental Hub Support Team: **1-855-609-5156.**

## Submitting Claims via Clearinghouses

Providers may submit electronic claims and authorizations to SKYGEN directly via DentalXChange or Smart Data Solutions clearinghouses. If you use a different clearinghouse, your software vendor can provide you with information you may need to ensure electronic files are forwarded to SKYGEN. The SKYGEN Payer ID is **SCION**. By using this unique Payer ID with electronic files, DentalXChange, Smart Data Solutions can ensure that claims and authorizations are submitted successfully to SKYGEN.

# Submitting Claims on Paper Forms

To ensure timely processing of submitted claims, the following information must be included on the paper 2019 or 2024 ADA Dental Claim Form:

- Member Name, Member Date of Birth
- Provider Name, Provider Location, Provider NPI
- Billing Location
- Payee Tax Identification Number (TIN)

Use approved ADA dental codes, as published in the current CDT book or as defined in this manual, to identify all services. Include on the form: all quadrants, tooth numbers, and surfaces for dental codes that require identification (extractions, root canals, amalgams, and resin fillings). SKYGEN recognizes tooth letters A through T for primary teeth and tooth numbers 1 to 32 for permanent teeth. Designate supernumerary teeth with codes AS through TS or 51 through 82. Designation of the tooth can be determined by using the nearest erupted tooth. If the tooth closest to the supernumerary tooth is 1, then chart the supernumerary tooth as 51.

Likewise, if the nearest tooth is A, chart the supernumerary tooth as AS. Missing, incorrect, or illegible information could result in the claim being returned to the submitting provider's office, causing a delay in determination. Use the proper postage when mailing bulk documentation.

# Coordination of Benefits (COB)

When CareSource Georgia is the secondary insurance carrier, a copy of the primary carrier's Explanation of Benefits must be submitted with the claim. For electronic claim submissions, the payment made by the primary carrier must be indicated in the appropriate Coordination of Benefits (COB) field.

# Timely Filing Limits

SKYGEN must receive claims requesting payment within six (6) months from the date of service. Claims submitted more than six (6) months from the month of service will be denied for "untimely filing." If a claim is denied for untimely filing, you may not bill the member. If CareSource Georgia is not the primary carrier, the claim still must be received within six (6) months from process date on EOB.

# Orthodontic Continuation of Care (COC) and Requirements

Participants of CareSource Georgia are eligible to continue orthodontic treatment with a different provider if the original provider who initially banded them is unable to complete treatment. This is also an option for participants who began orthodontic treatment under a different insurance and have recently become eligible for CareSource Georgia.

In cases of continuation of care as it pertains to orthodontic periodic exams, please submit documentation and quantity medically necessary with D8670 for review prior to claim payment.

# Corrected Claim Process

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.

On the other hand, 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 services have no impact on member tooth history or service accumulators, and, as such, do not require reprocessing. A corrected claim should only be submitted if the original service(s) PAID is based on incorrect information.

Some examples of correction(s) that need to be made to a prior PAID claim are:

- Incorrect Provider NPI or location, Payee Tax ID, Incorrect Member, Procedure codes
- Services originally billed and paid at incorrect fees (including no fees)
- Services originally billed and paid without primary insurance

Providers can submit their corrected claims via the SKYGEN Dental Hub or through clearinghouse files. SKYGEN will continue to accept paper corrected claims but encourages providers to submit electronically going forward. Providers will be able to make corrections on original claims via the SKYGEN Dental Hub. Providers will have the ability to:

- Edit or correct ADA dental claim form fields
- Review attachments/documents associated with the original claim to determine if they should remain attached to the corrected claim
- Remove attachments/documents that either no longer apply to the corrected claim, or were originally attached in error

**Submitting Corrected Claims via the Dental Hub - Webinars and Quick Start Guide**

For more information on submitting corrected claims through the Dental Hub Providers, can you use this link https://www.dentalhub.com/webinars and click the **Quick Start Guide** icon for more information. This guide was designed to help our users get their business/practice registered and understand some of the Dental Hub's basic functionality.

## Submitting Corrected Claims via EDI

Corrected claims via Clearinghouse File will be accepted when a specific set of criteria is met to ensure the original claim can be identified. In order for a submission to be considered a corrected claim, it must include:

- Claim frequency code of 7 (Replacement) or 8 (Void/Cancel) in CLM05-3 element along with claim or encounter identifier in REF*F8 element.
- original claim in a paid status.
- original claim does not have previously resubmitted services or a corrected claim already processed.
- original claim does not have associated service adjustments or refunds.
- Corrected claim must have a data match to 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. The provider would then need to send another submission on the file that does meet the above requirements for consideration.

### Submitting Corrected Claims via Paper

All paper corrected claims must be submitted to the corrected claims P.O. Box for proper

processing and include the following:

- Current version of the ADA form and all required information.
- The ADA form must be clearly noted “Corrected Claim.”
- In the remarks field (Box 35) on the ADA form indicate the original paid encounter number and record all corrections you are requesting to be made. If information does not fit in Box 35, attach an outline of corrections to the claim form and submit it to:

  CareSource GA: Corrected Claims
  P.O. Box 541
  Milwaukee, WI 53201

# Resubmitting a Denied Claim

To resubmit a claim that has been denied with additional information, follow the standard Claim Submission Procedures section of this provider manual. Timely filing limitations apply when a claim is resubmitted for reprocessing. Corrected claims need to be submitted within six (6) months from the month of service, or three (3) months from the denial date, whichever is later.

# Receipt & Audit of Claims

To ensure timely, accurate payment to each participating provider, SKYGEN audits claims for completeness as they are received. This audit validates member eligibility, procedure codes, and provider identification information. When potential problems are identified, your office may be asked to help resolve the issue. For questions about claims submission or remittances, call Provider Services: **1-800-508-2072.**

# Claims Adjudication & Payment

The SKYGEN Dental benefits administration software system imports claim and authorization data, evaluates and edits the data for completeness and correctness, analyzes the data for clinical appropriateness and coding correctness, audits against plan and benefit limits, calculates the appropriate payment amounts, and generates payments and remittance summaries. The system also evaluates and automatically matches claims and services that require prior authorization and matches the claims and services to the appropriate member record for efficient and accurate claims processing.

As soon as the system prices and pays claims, checks and electronic payments are generated, and remittance summaries are posted and available for online review from the SKYGEN Dental Hub: (https://app.dentalhub.com/app/login). To appeal a reimbursement decision, submit the appeal in writing within 63 days of the decision date, along with any necessary documentation to:

CareSource Georgia Appeals
P.O. Box 1251
Milwaukee, WI 53201

# Grievances & Appeals

CareSource Georgia and SKYGEN are committed to providing high-quality dental services to all members. As part of that commitment, we work to ensure all members and providers have every opportunity to exercise their rights to a fair and timely resolution to any grievances and appeals. Our procedures for handling and resolving grievances (complaints) and appeals are designed to:

- Ensure fair, just, and speedy resolutions by working cooperatively with providers and supplying any documentation related to grievances and/or appeals, upon request.
- Treat providers and members with dignity and respect at all levels of the grievances and appeals resolution process.
- Inform providers and members of their full rights as they relate to grievance and appeal resolutions, including their rights of appeal at each step in the process.
- Resolve grievances and appeals in a satisfactory and acceptable manner within the CareSource Georgia and SKYGEN Dental protocol.
- Comply with all regulatory guidelines and policies with respect to grievances (complaints) and appeals.
- Efficiently monitor the resolution of grievances, to allow for tracking and identifying unacceptable patterns of care over time.

Differences sometimes arise between dental providers and insurers or their benefit administrators regarding prior authorization determinations and payment decisions. Since many of these issues result from misunderstanding of service coverage, processing policy, or payment levels, we encourage providers to contact us for explanations and education. For assistance, call Provider Services:
**1-855-202-1058.** A designated CareSource Georgia Appeals Specialist is dedicated to the expedient, satisfactory resolution of both provider and member grievances and appeals.

## Making a Grievance

CareSource Georgia takes an active role assisting providers and members who have grievances. If you have a grievance, you can also file a verbal grievance by calling CareSource Georgia at **1-855-202-1058** or send a written grievance to:

CareSource Georgia Grievance
P.O. Box 1251
Milwaukee, WI 53201

## Grievance Investigation & Resolution

CareSource Georgia investigates and resolves grievances within the following time frames:

- Standard Member or Provider Grievance: within 30 days ofreceipt.

## Appeals Investigation & Resolution

Appeals are available to any member or provider who disagrees with a decision to deny services or payment for services. Appeals can also be requested by representatives who are authorized to appeal on behalf of a member, such as a lawyer, parent or guardian, dental provider, etc. SKYGEN provides both the member and the provider with a copy of their appeal rights with each pre-or post-service denial.

# Submitting Provider Disputes

A dispute is a formal review of the processing of a claim by SKYGEN (excluding denials based on medical necessity) and is typically related to underpayment or overpayment of a claim. Claim disputes must be submitted in writing within three months of the payment date on the claim. At a minimum, the dispute submission must include:

- Sufficient information to identify the claim(s) in dispute.
- A statement of why you believe a claim adjustment is needed and the expected outcome of the claim adjustment
- Pertinent documentation to support the adjustment

Send written disputes to:

CareSource Georgia Claim Disputes
P.O. Box 1251
Milwaukee, WI 53201

# Submitting Provider Appeals

Providers who disagree with claim payment decisions may submit a written appeal within 30 calendar days (an additional 3 calendar days for mailing time) of the original denial date. If a reconsideration was requested, providers have 30 calendar days (an additional 3 calendar days for mailing time) from the date of the reconsideration resolution letter to file an appeal. Send written appeals to:

CareSource Georgia Appeals
P.O. Box 1251
Milwaukee, WI 53201

# Submitting Member Appeals

A member may appeal any decision which denies or reduces services. Appeals are reviewed under our administrative appeal procedure. As a provider, you may file an authorization appeal on a member's behalf, with their written consent. Include your name and your clinic address, member's name and Member ID, reasons you disagree with the decision, and additional documentation that supports your appeal, such as x- rays, treatment plans, medical records, etc. Appeals regarding authorization determinations must be filed within 60 calendar days (an additional 3 calendar days for mailing time) of the authorization denial date. Send written member appeals to:

CareSource Georgia Appeals
P.O. Box 1251
Milwaukee, WI 53201

# Expedited Appeals

Members and Providers may ask for an expedited (fast) appeal if waiting 30 calendar days could put the member's life or health in danger. to ask for a fast appeal, call CareSource Georgia toll free at **1-800-202-1058 (TTY 711)**. You don't have to request a fast appeal in writing. If we expedite the appeal, we'll let you know our decision within 72 hours of receiving the expedited request. If we don't feel the appeal needs to be expedited, we will contact you right away and send you a letter within two calendar days letting you know we'll review your appeal within 30 calendar days. If you don't agree with our decision not to expedite the appeal, a grievance (complaint) may be filed with CareSource Georgia.

# State Fair Hearings

You or an authorized representative may file a state fair hearing if you don't agree with our

appeal decision. You must file a state fair hearing within 120 calendar days of the date of the notice of the appeal decision.

# Clinical Criteria

## Medical Necessity

SKYGEN defines medical necessity as accepted health care services and supplies provided by health care entities appropriate to the evaluation and treatment of a disease, condition, illness, or injury and consistent with the applicable standard of care.

Dental care is medically necessary to prevent and eliminate orofacial disease, infection, and pain, to restore form and function to the dentition, and to correct facial disfiguration or dysfunction.

Medical necessity is the reason why a test, a procedure, or an instruction is performed. Medical necessity is different for each person and changes as the individual changes. The dental team must provide consistent, methodical documentation of medical necessity for coding. Please note: For children receiving EPSDT services, any limits on services may be exceeded when medically necessary.

## Emergency Treatment

Should a procedure need to be initiated to relieve pain and suffering in an emergency situation, you are to provide treatment to alleviate the patient's condition. To receive reimbursement for emergency treatment, submit all required documentation along with the claim for services rendered. SKYGEN uses the same clinical criteria (and requires the same supporting documentation) for claims submitted after emergency treatment.

## Clinical Criteria for Retro-Review and Prior Authorization of Treatment and Emergency Treatment

Some procedures require retrospective review (after treatment is performed) or prior authorization (before initiating treatment). When requesting these procedures, please note the documentation requirements when sending the information to SKYGEN. The criteria SKYGEN dental reviewers will look for in order to approve the request is listed below.

When submitting for prior authorization / retrospective review of these procedures, please note the documentation requirements when sending in the information to SKYGEN. If there is any question that a procedure which is subject to retro-review may not meet criteria and may not be paid, you have the option of submitting the procedure for prior authorization first.

SKYGEN criteria utilized for medical necessity determination, were developed from information collected from American Dental Association's Code Manuals, clinical articles and guidelines, as well as dental schools, practicing dentists, insurance companies, other dental related organizations, and local state or health plan requirements.

The criteria SKYGEN reviewers will look for in order to approve the request is listed below. Should the procedure need to be initiated under an emergency condition to relieve pain and suffering, you are to provide treatment to alleviate the patient's condition. However, to receive reimbursement for the treatment, SKYGEN will require the same criteria/documentation be provided (with the claim for payment) and the same criteria be met to receive payment for the treatment.

# Clinical Criteria Descriptions

| Code | Code Description | Required Documents | Clinical Criteria |
|---|---|---|---|
| D2740 | Crown - Porcelain/Ceramic | Periapical x-ray and treatment plan (completed RCT or treatment planned RCT necessary) | Root canal treated teeth: Clinically acceptable RCT, Minimum 50% bone support, No subcrestal caries. Non-root canal treated teeth: Anterior- 50% incisal angle/4+surfaces involved, Bicuspid - 1 cusp or 3+ surfaces involved, Molar- 2 cusps or 4+ surfaces involved. Minimum 50% bone support, no periodontal furcation, no subcrestal caries. Adult plan coverage is only for root canal treated teeth. |
| D2928 | Prefabricated porcelain/ceramic crown – permanent tooth | Pre-op bitewing & periapical x-ray & treatment plan, clinical notes as indicated | Medical necessity is not indicated: When a primary tooth is close to exfoliation, with more than half the root(s) resorbed, when a more conservative restoration is indicated, when solely provided for cosmetic purposes, excessive tooth crown loss resulting in the inability for mechanical retention, as a preventive measure for teeth with no evidence of pathology . |
| D2931 | Prefabricated Stainless Steel Crown - Permanent Tooth | Pre-op bitewing & periapical x-ray & treatment plan, clinical notes as indicated | Medical necessity is not indicated: When a primary tooth is close to exfoliation, with more than half the root(s) resorbed, when a more conservative restoration is indicated, when solely provided for cosmetic purposes, excessive tooth crown loss resulting in the inability for mechanical retention, as a preventive measure for teeth with no evidence of pathology . |
| D2932 | Prefabricated Resin Crown | Pre-op bitewing & periapical x-ray & treatment plan, clinical notes as indicated | Medical necessity is not indicated: When a primary tooth is close to exfoliation, with more than half the root(s) resorbed, when a more conservative restoration is indicated, when solely provided for cosmetic purposes, excessive tooth crown loss resulting in the inability for mechanical retention, as a preventive measure for teeth with no evidence of pathology . |
| D3310 | Endodontic Therapy, Anterior Tooth (Excluding Final Restoration) | Pre-op bitewing & periapical & treatment plan (if EMG post op images w/ claim) | Tooth must have adequate (50% bone or greater) periodontal support and adequate sound coronal structure for restoration. Medical necessity indications include presence of irreversible pulpitis; pulpal necrosis; apical periodontitis; or frank vital carious pulpal exposure. When the general oral condition indicates a poor and or uncertain periodontal, restorative, or endodontic outcome case may be denied due to the unfavorable prognosis of the involved tooth/teeth. Surgical endodontics may be indicated when: failed retreatment of endodontic therapy, when the apex of tooth cannot be accessed due to calcification or other anomaly, where visualization of the periradicular tissues and tooth root is required when perforation or root fracture is suspected. |
| D3320 | Endodontic Therapy Premolar Tooth (Excluding Final Restoration) | Pre-op bitewing & periapical & treatment plan (if EMG post op images w/ claim) | Tooth must have adequate (50% bone or greater) periodontal support and adequate sound coronal structure for restoration. Medical necessity indications include presence of irreversible pulpitis; pulpal necrosis; apical periodontitis; or frank vital carious pulpal exposure. When the general oral condition indicates a poor and or uncertain periodontal, restorative, or endodontic outcome, case may be denied due to the unfavorable prognosis of the involved tooth/teeth. Surgical endodontics may be indicated when: failed retreatment of endodontic therapy, when the apex of tooth cannot be accessed due to calcification or other anomaly, where visualization of the periradicular tissues and tooth root is required when perforation or root fracture is suspected. |
| D3330 | Endodontic Therapy, Molar tooth (Excluding Final Restoration) | Pre-op bitewing & periapical & treatment plan (if EMG post op images w/ claim) | Tooth must have adequate (50% bone or greater) periodontal support and adequate sound coronal structure for restoration. Medical necessity indications include presence of irreversible pulpitis; pulpal necrosis; apical periodontitis; or frank vital carious pulpal exposure. When the general oral condition indicates a poor and or uncertain periodontal, restorative, or endodontic outcome, case may be denied due to the unfavorable prognosis of the involved tooth/teeth. Surgical endodontics may be indicated when: failed retreatment of endodontic therapy, when the apex of tooth cannot be accessed due to calcification or other anomaly, where visualization of the periradicular tissues and tooth root is required when perforation or root fracture is suspected. |

| | | | |
|---|---|---|---|
| D3410 | Apicoectomy - Anterior | Pre-op bitewing & periapical & treatment plan (if EMG post op images w/ claim) | Tooth must have adequate (50% bone or greater) periodontal support and adequate sound coronal structure for restoration. Medical necessity indications include presence of irreversible pulpitis; pulpal necrosis; apical periodontitis; or frank vital carious pulpal exposure. When the general oral condition indicates a poor and or uncertain periodontal, restorative, or endodontic outcome, case may be denied due to the unfavorable prognosis of the involved tooth/teeth. Surgical endodontics may be indicated when: failed retreatment of endodontic therapy, when the apex of tooth cannot be accessed due to calcification or other anomaly, where visualization of the periradicular tissues and tooth root is required when perforation or root fracture is suspected. |
| D3426 | Apicoectomy - Each Additional Root) | Pre-op bitewing & periapical & treatment plan (if EMG post op images w/ claim) | Tooth must have adequate (50% bone or greater) periodontal support and adequate sound coronal structure for restoration. Medical necessity indications include presence of irreversible pulpitis; pulpal necrosis; apical periodontitis; or frank vital carious pulpal exposure. When the general oral condition indicates a poor and or uncertain periodontal, restorative, or endodontic outcome, case may be denied due to the unfavorable prognosis of the involved tooth/teeth. Surgical endodontics may be indicated when: failed retreatment of endodontic therapy, when the apex of tooth cannot be accessed due to calcification or other anomaly, where visualization of the periradicular tissues and tooth root is required when perforation or root fracture is suspected. |
| D4210 | Gingivectomy Or Gingivoplasty - Four Or More Contiguous Teeth | FMX, perio charting, perio diagnosis, and narrative, Photos where applicable | Elimination of suprabony pockets, exceeding 3mm, if the pocket wall is fibrous and firm and there is an adequate zone of keratinized tissue. Elimination of gingival enlargements/overgrowth. Elimination of suprabony periodontal abscesses. Exposure of soft tissue impacted teeth to aid in eruption. To reestablish gingival contour following an episode of acute necrotizing ulcerative gingivitis. To allow restorative access, including root surface caries. |
| D4240 | Gingival Flap Procedure, Including Root Planing - Four Or More Contiguous Teeth | FMX, perio charting, perio diagnosis, and narrative, Photos where applicable | In the presence of moderate to deep probing depths. Moderate/severe gingival enlargement or extensive areas of overgrowth. Loss of attachment. The need for increased access to root surface and/or alveolar bone when previous non-surgical attempts have been unsuccessful. The diagnosis of a cracked tooth, fractured root, or external root resorption when this cannot be accomplished by noninvasive methods. |
| D4241 | Gingival Flap Procedure, Including Root Planing - One To Three Contiguous Teeth | FMX, perio charting, perio diagnosis, and narrative, Photos where applicable | In the presence of moderate to deep probing depths. Moderate/severe gingival enlargement or extensive areas of overgrowth. Loss of attachment. The need for increased access to root surface and/or alveolar bone when previous non-surgical attempts have been unsuccessful. The diagnosis of a cracked tooth, fractured root, or external root resorption when this cannot be accomplished by noninvasive methods. |
| D4260 | Osseous Surgery (Including Flap And Closure) - Four Or More Teeth | FMX, perio charting, perio diagnosis, and narrative, Photos where applicable | May be indicated for diagnosis of Stage III or Stage IV periodontal disease and/or when less invasive therapy (i.e., non-surgical periodontal therapy, Flap procedures) has failed to eliminate disease. |
| D4270 | Pedicle Soft Tissue Graft Procedure | FMX, perio charting, perio diagnosis, and narrative, Photos where applicable | May be indicated for covering exposed tooth roots due to sensitivity or thickening existing gum tissue to halt further tissue loss; it is not reimbursable strictly for cosmetic reasons. |
| D4341 | Periodontal Scaling And Root Planing - Four Or More Teeth Per Quadrant | FMX, perio charting, perio diagnosis, narrative of med nec | Scaling and Root Planing is indicated for the treatment of the following: stage II-stage IV periodontitis with grade B or grade C progression (see American Academy of Periodontics (AAP) staging or periodontal abscess. https://www.perio.org/wp-content/uploads/2019/08/Staging-and-Grading-Periodontitis.pdf |
| D4342 | Periodontal Scaling And Root Planing - One To Three Teeth Per Quadrant | FMX, perio charting, perio diagnosis, narrative of med nec | Scaling and Root Planing is indicated for the treatment of the following: stage II-stage IV periodontitis with grade B or grade C progression (see American Academy of Periodontics (AAP) staging or periodontal abscess. https://www.perio.org/wp-content/uploads/2019/08/Staging-and-Grading-Periodontitis.pdf |
| D4910 | Periodontal Maintenance | FMX, perio charting, perio diagnosis, and narrative, Photos where applicable | To maintain the results of surgical and non-surgical periodontal treatment. As an extension of active periodontal therapy at selective intervals. Periodontal Maintenance is not indicated for the following: no history of scaling and root planing or surgical procedures; gingivitis. |

| | | | |
|---|---|---|---|
| D5110 | Complete Denture - Maxillary | FMX or panoramic x-rays | Removable Complete D5110, D5120, D5130, and D5140 or Partial Dentures D5211 and D5212 (including Immediate Complete and Partial Prostheses) are indicated for the definitive replacement of missing teeth lost due to disease, trauma, or injury. Treatment plans and clinical notes for dentures that indicate there has been extensive bone atrophy resulting in an inadequate edentulous ridge, poor neuro-muscular control; or unresolved soft tissue concerns (e.g., lack of vestibular depth, hypertrophy, hyperplasia, stomatitis may not be considered for approval. Include treatment plan, treatment notes, radiographic documentation, and images of study models as applicable with request. Be sure to include tooth numbers being replaced for partial dentures. |
| D5120 | Complete Denture - Mandibular | FMX or panoramic x-rays | Removable Complete D5110, D5120, D5130, and D5140 or Partial Dentures D5211 and D5212 (including Immediate Complete and Partial Prostheses) are indicated for the definitive replacement of missing teeth lost due to disease, trauma, or injury. Treatment plans and clinical notes for dentures that indicate there has been extensive bone atrophy resulting in an inadequate edentulous ridge, poor neuro-muscular control; or unresolved soft tissue concerns (e.g., lack of vestibular depth, hypertrophy, hyperplasia, stomatitis may not be considered for approval. Include treatment plan, treatment notes, radiographic documentation, and images of study models as applicable with request. Be sure to include tooth numbers being replaced for partial dentures. |
| D5130 | Immediate Denture - Maxillary | FMX or panoramic x-rays | Removable Complete D5110, D5120, D5130, and D5140 or Partial Dentures D5211 and D5212 (including Immediate Complete and Partial Prostheses) are indicated for the definitive replacement of missing teeth lost due to disease, trauma, or injury. Treatment plans and clinical notes for dentures that indicate there has been extensive bone atrophy resulting in an inadequate edentulous ridge, poor neuro-muscular control; or unresolved soft tissue concerns (e.g., lack of vestibular depth, hypertrophy, hyperplasia, stomatitis may not be considered for approval. Include treatment plan, treatment notes, radiographic documentation, and images of study models as applicable with request. Be sure to include tooth numbers being replaced for partial dentures. |
| D5140 | Immediate Denture - Mandibular | FMX or panoramic x-rays | Removable Complete D5110, D5120, D5130, and D5140 or Partial Dentures D5211 and D5212 (including Immediate Complete and Partial Prostheses) are indicated for the definitive replacement of missing teeth lost due to disease, trauma, or injury. Treatment plans and clinical notes for dentures that indicate there has been extensive bone atrophy resulting in an inadequate edentulous ridge, poor neuro-muscular control; or unresolved soft tissue concerns (e.g., lack of vestibular depth, hypertrophy, hyperplasia, stomatitis may not be considered for approval. Include treatment plan, treatment notes, radiographic documentation, and images of study models as applicable with request. Be sure to include tooth numbers being replaced for partial dentures. |
| D5211 | Maxillary Partial Denture - Resin Base | FMX or panoramic x-rays | Removable Complete D5110, D5120, D5130, and D5140 or Partial Dentures D5211 and D5212 (including Immediate Complete and Partial Prostheses) are indicated for the definitive replacement of missing teeth lost due to disease, trauma, or injury. Treatment plans and clinical notes for dentures that indicate there has been extensive bone atrophy resulting in an inadequate edentulous ridge, poor neuro-muscular control; or unresolved soft tissue concerns (e.g., lack of vestibular depth, hypertrophy, hyperplasia, stomatitis may not be considered for approval. Include treatment plan, treatment notes, radiographic documentation, and images of study models as applicable with request. Be sure to include tooth numbers being replaced for partial dentures. |
| D5212 | Mandibular Partial Denture - Resin Base | FMX or panoramic x-rays | Removable Complete D5110, D5120, D5130, and D5140 or Partial Dentures D5211 and D5212 (including Immediate Complete and Partial Prostheses) are indicated for the definitive replacement of missing teeth lost due to disease, trauma, or injury. Treatment plans and clinical notes for dentures that indicate there has been extensive bone atrophy resulting in an inadequate edentulous ridge, poor neuro-muscular control; or unresolved soft tissue concerns (e.g., lack of vestibular depth, hypertrophy, hyperplasia, stomatitis may not be considered for approval. Include treatment plan, treatment notes, radiographic documentation, and images of study models as applicable with request. Be sure to include tooth numbers being replaced for partial dentures. |
| D6240 | Pontic - Porcelain Fused To High Noble Metal | Physician letter, narrative, treatment plan, x-rays and prognosis | D6240 and D6750; have limited coverage available only for members whose medical or mental condition precludes the use of removable prosthodontics and must be documented by physician, included with submission notes, along with treatment plan, radiographs, clinical notes, and prognosis. |

| | | | |
|---|---|---|---|
| D6750 | Retainer Crown - Porcelain Fused To High Noble Metal | Physician letter, narrative, treatment plan, x-rays and prognosis | D6240 and D6750; have limited coverage available only for members whose medical or mental condition precludes the use of removable prosthodontics and must be documented by physician, included with submission notes, along with treatment plan, radiographs, clinical notes, and prognosis. |
| D7210 | Extraction, Erupted Tooth | Pre-op x-rays | The fracture of a tooth or roots during a non-surgical extraction procedure (post approval allowed only in these instances). Erupted teeth with unusual root morphology (dilacerations, cementosis). Erupted teeth with developmental abnormalities that would make non-surgical extraction unsafe or cause harm. When fused to an adjacent tooth. In the presence of periapical lesions. For maxillary posterior teeth whose roots extend into the maxillary sinus. When tooth has been crowned or been treated endodontically. |
| D7220 | Removal Of Impacted Tooth - Soft Tissue | Pre-op x-rays | Occlusal surface of tooth covered by soft tissue; requires mucoperiosteal flap elevation. |
| D7230 | Removal Of Impacted Tooth - Partially Bony | Pre-op x-rays | Part of crown covered by bone; requires mucoperiosteal flap elevation and bone removal. |
| D7240 | Removal Of Impacted Tooth - Completely Bony | Pre-op x-rays | Most or all of crown covered by bone; requires mucoperiosteal flap elevation and bone removal. |
| D7250 | Removal Of Residual Tooth (Cutting Procedure) | Pre-op x-rays | This is a cutting procedure, which involves cutting soft tissue and/or hard tissue (bone). If the crown of the tooth is not present and the removal of the root is performed, no (cutting) is involved (i.e., elevator and/or forceps removal), the appropriate ADA code should be used (i.e., D7140 - extraction, erupted tooth, or exposed root). |
| D7280 | Exposure of an Unerupted Tooth | Pre-op x-rays | Surgical access of unerupted tooth D7280 Documentation should support indications of when a normally developing permanent tooth is unable to erupt into a functional position, or for labially impacted teeth if there will be 2-3 mm of gingival cuff present after eruption. D7283 Placement of device to facilitate eruption of impacted tooth is not a covered benefit under the state program, as the approval of D7280 should be used in combination with orthodontic cases already approved or in treatment. |
| D7284 | excisional biopsy of minor salivary glands | Narrative of medical necessity | Narrative of medical necessity, other supporting info as indicated to support medical necessity. |
| D7310 | Alveoloplasty In Conjunction With Extractions - Four Or More Teeth | Pre-op x-rays | Indicated for bone recontouring and smoothing as part of the tooth extraction process prior to fixed or removable prosthetic construction, when removal or reshaping of irregular alveolar bone is necessary to prepare for radiation therapy or transplant surgery, when it is necessary to remove alveolar bone arising from a pathologic condition. |
| D7311 | Alveoloplasty In Conjunction With Extractions - One To Three Teeth | Pre-op x-rays | Indicated for bone recontouring and smoothing as part of the tooth extraction process prior to fixed or removable prosthetic construction, when removal or reshaping of irregular alveolar bone is necessary to prepare for radiation therapy or transplant surgery, when it is necessary to remove alveolar bone arising from a pathologic condition. |
| D7320 | Alveoloplasty Not In Conjunction With Extractions - Four Or More Teeth | Pre-op x-rays | Indicated for bone recontouring and smoothing as a standalone procedure prior to fixed or removable prosthetic construction, when removal or reshaping of irregular alveolar bone is necessary to prepare for radiation therapy or transplant surgery, when it is necessary to remove alveolar bone arising from a pathologic condition. |
| D7321 | Alveoloplasty Not In Conjunction With Extractions - One To Three Teeth | Pre-op x-rays | Indicated for bone recontouring and smoothing as a standalone procedure prior to fixed or removable prosthetic construction, when removal or reshaping of irregular alveolar bone is necessary to prepare for radiation therapy or transplant surgery, when it is necessary to remove alveolar bone arising from a pathologic condition. |
| D7471 | Removal Of Lateral Exostosis (Maxilla Or Mandible) | X-rays or photos and narrative | If a partial or complete denture cannot be adapted successfully. When causing soft tissue trauma with existing removable appliances. Unusually large protuberances that are prone to recurrent traumatic injury. When there is a functional disturbance, including, but not limited to mastication, swallowing and speech. |
| D7961 | buccal / labial frenectomy (frenulectomy) | Narrative of medical necessity and diagnostic quality photos | When the frenum attachment causes gingival defects and/or loss of alveolar bone leading to a present or future detriment of the involved dento-alveolar complex. When the position attachment of the Frenum is interfering with proper oral hygiene. Prior to the construction of a removable denture replacing teeth in the area of aberrant frenal attachment. When there is a functional disturbance, including, but not limited to mastication, swallowing, and speech. For Ankyloglossia or papillary penetrating attachment of maxillary labial Frenum in newborns when there is interference with feeding. |

| | | | |
|---|---|---|---|
| D7962 | lingual frenectomy (frenulectomy) | Narrative of medical necessity and diagnostic quality photos | When the frenum attachment causes gingival defects and/or loss of alveolar bone leading to a present or future detriment of the involved dento-alveolar complex. When the position attachment of the Frenum is interfering with proper oral hygiene. Prior to the construction of a removable denture replacing teeth in the area of aberrant frenal attachment. When there is a functional disturbance, including, but not limited to mastication, swallowing, and speech. For Ankyloglossia or papillary penetrating attachment of maxillary labial Frenum in newborns when there is interference with feeding. |
| D7970 | Excision Of Hyperplastic Tissue - Per Arch | Narrative of medical necessity and recent diagnostic images | May be indicated when the presence of excess tissue interferes with the fit of a partial or complete denture |
| D7971 | Excision Of Pericoronal Gingiva | Narrative of medical necessity and recent diagnostic images | For recurrent infections of the operculum around impacted or partially erupted lower third molars. When an erupted maxillary third molar is traumatizing soft tissue around opposing tooth. When the presence interferes with the fit of a partial or complete denture. |
| D7997 | Appliance Removal (Not By Dentist Who Placed Appliance) | Narrative describing type of attachment and the medical necessity | Covered for surgical arch bar. |
| D8020 | Limited Orthodontic Treatment Of The Transitional Dentition | Pan or fmx, ceph, diagnostic quality photos, HLD scoresheet, narr. of med. nec. | See D8080 |
| D8030 | Limited Orthodontic Treatment Of The Adolescent Dentition | Pan or fmx, ceph, diagnostic quality photos, HLD scoresheet, narr. of med. nec. | See D8080 |
| D8080 | Comprehensive Orthodontic Treatment Of The Adolescent Dentition | Pan or fmx, ceph, diagnostic quality photos, HLD scoresheet, narr. of med. nec. | Medically Necessary Orthodontic Services (General Criteria), banding (D8080) and periodic visits (D8670) require prior approval. D8670 is auto approved upon an approved or in treatment case of D8080 (for any eligible remaining D8670 units). The Handicapping Labio-Lingual Deviation (HLD) Index is a quantitative method for measuring malocclusion and identifying dento-facial handicaps. The HLD Index is intended to measure the degree of handicap caused by these components, rather than to diagnose malocclusion. Comprehensive orthodontic services will be authorized for the correction of severe functionally handicapping malocclusions on a case-by-case basis. As defined by the AAO services to alleviate, correct, or resolve a handicapping malocclusion (including craniofacial abnormalities and traumatic or pathologic anatomical deviations) that cause pain or suffering, physical deformity, significant malfunction, aggravates a condition, or results in further injury or infirmity may be considered medically necessary.<br><br>Cleft Lip/Palate deformities and other significant craniofacial anomalies, deep impinging overbite that shows palatal impingement of the majority of lower incisors, severe traumatic deviations (e.g., accidental loss of premaxilla, gross pathology), true anterior open bite (not including one or two teeth slightly out of occlusion or where the incisors have not fully erupted), anterior or posterior crossbite (Involves three or more teeth in crossbite or in cases where gingival stripping from the crossbite is demonstrated), impacted incisors or canines that will not erupt into the arches without orthodontic or surgical intervention (does not include cases where incisors or canines are going to erupt ectopically), overjet greater than 9 mm with incompetent lips, reverse overjet greater than 3.5mm, malocclusions requiring a combination orthodontic and orthognathic surgery for correction. |
| D8670 | Periodic Orthodontic Treatment Visit | Pan or fmx, ceph, diagnostic quality photos, HLD scoresheet, narr. of med. nec. | Provider should request procedure code D8080 for the banding, orthodontic appliance, and procedure code D8670, twelve (12) units , for the monthly maintenance visits. For continuation of care, see COC guidelines in Provider Manual. |
| D9222 | Administration of deep sedation/general anesthesia - first 15 min increment | Anes Scorecard, Narrative, X-rays, treat plan; Post- | Anes Scorecard, Narrative, X-rays, treat plan; Post-Anes/Sed records if than 120 minutes |

| | | | |
|---|---|---|---|
| | | Anes/Sed records if than 120 minutes | |
| D9223 | Administration of deep sedation/general anesthesia – each subsequent 15 min increment | Anes Scorecard, Narrative, X-rays, treat plan; Post-Anes/Sed records if than 120 minutes | Anes Scorecard, Narrative, X-rays, treat plan; Post-Anes/Sed records if than 120 minutes |
| D9230 | Administration of nitrous oxide | Narrative of medical necessity | Narrative of medical necessity |
| D9239 | Administration of intravenous moderate (conscious) sedation/analgesia- first 15 min increment | Anes Scorecard, Narrative, X-rays, treat plan; Post-Anes/Sed records if than 120mn | Anes Scorecard, Narrative, X-rays, treat plan; Post-Anes/Sed records if than 120mn |
| D9243 | Administration of intravenous moderate (conscious) sedation/analgesia- each subsequent 15 min increment | Anes Scorecard, Narrative, X-rays, treat plan; Post-Anes/Sed records if than 120mn | Anes Scorecard, Narrative, X-rays, treat plan; Post-Anes/Sed records if than 120mn |
| D9248 | Non-intravenous conscious sedation | Narrative of medical necessity | Narrative of medical necessity |
| D9420 | Hospital Or Ambulatory Surgical Center Call | Hospital Adm & Outpatient Proc (Form #: GMCF form PA81/100), X-rays, Treatment plan | Requests for approval for hospitalization or ASC are limited to those cases which cannot be managed in the dental office setting due to the existence of one or more of the following conditions or situations: members that are medically compromised or those with special needs, (specific diagnosis or problem(s) should be stated), members with physical, cognitive, or developmental disabilities, (Document specific disability or special need), or extremely young member. Complex or extensive dental rehabilitation procedure(s) performed on a member who requires monitored anesthesia (e.g., general, intravenous sedation, monitored anesthesia care) and use of an operating room. |
| D9610 | Therapeutic Parenteral Drug, Single Administration | Narrative including type of drug, dosage and method of delivery | Description of drugs (antibiotics, steroids, anti-inflammation, non-opioid or other therapeutic medication) and parenteral administration |
| D9630 | Drugs or Medicaments - dispensed for home use | Narrative including type of drug, dosage and method of delivery | Description of oral antibiotics, oral analgesics, topical fluoride or other drugs / medicaments for home use, Does not include writing prescriptions |
| D9920 | Behavior Management, By Report | Narrative of medical necessity | Documentation (treatment history) supports indication of non-cooperative patient. |

# Covered Benefits

## Covered Benefits and Plan Eligibility:

CareSource Georgia offers Dental services - Medicaid-coverage for children and adults enrolled in the program. CareSource Georgia includes the following plans:

**CareSource Georgia Families, 0-20 and 21-999**

**CareSource Geogia Families – Pathway 19-20 and 21-999**

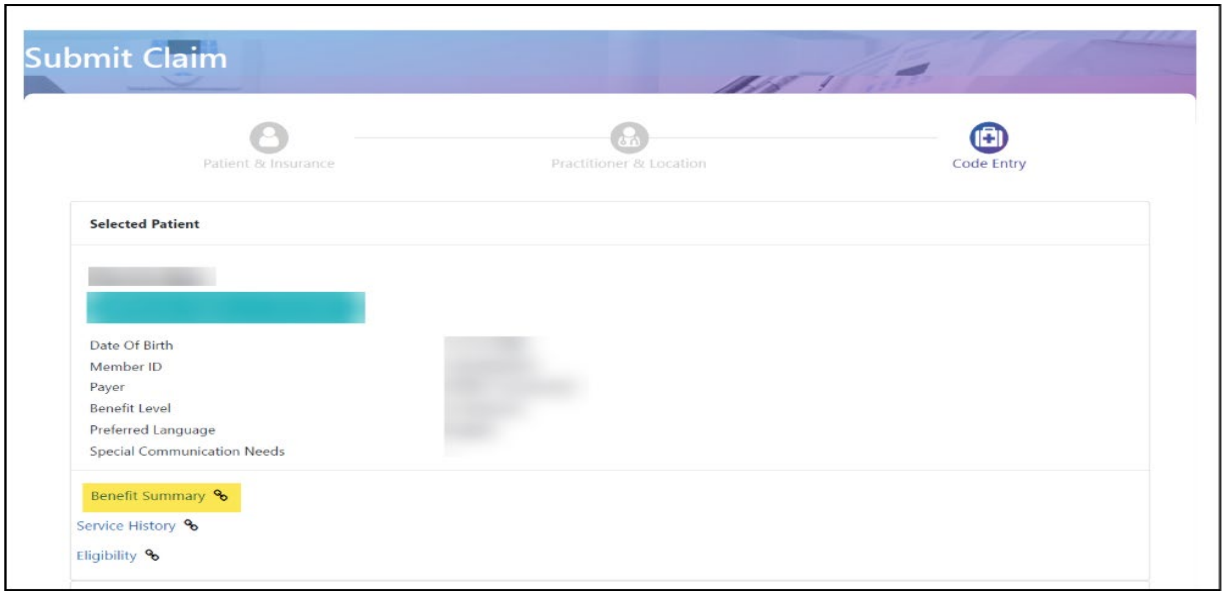
**CareSource Peach Care for Kids – 0-18**

**CareSource Planning for Healthy Babies – 18-44**

## CareSource Georgia Medicaid Authorization Requirements and Benefit Details

Providers can view the Authorization Requirements and Benefit Detail information related to the claim or authorization in the Dental Hub.

- When a provider is in the Dental Hub making a claim or authorization, they have the ability to see the Authorization Requirements and Benefit Detail information related to the claim or authorization in the benefit summary. See below:



**ADA Codes In Network** Benefit Period: **01/01/2025 - 12/31/2025**

| Code | Description | Subcodes | Ages | Frequency | Copay | Coinsurance |
|---|---|---|---|---|---|---|
| D0113 | Periodic exam | *Procedure not covered* | | | | |
| D0120 | Periodic Oral Exam | | | 1 every 6 Months | | |
| D0140 [1] | Limited Oral Evaluation - Problem Focused | | | 1 per Day | | |
| D0140 | Limited Oral Evaluation - Problem Focused | | | 2 per Day | | |
| D0145 | Oral Evaluation Of A Patient Under Three Years Of Age And Counseling With Primary Caregiver | | 0 to 2 | 10 per Lifetime | | |