CareSource Dual Advantage™
CareSource Dual Advantage™ Plus

Dental Provider Manual

Manual Effective: January 1, 2026

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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: **1-833-230-2176**, 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: Log on to SKYGEN Dental Hub: 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. Submit claims through these formats: • SKYGEN Dental Hub: https://app.dentalhub.com/app/login • Electronic submission via clearinghouse –Payer ID: SCION • CareSource Dual Advantage/CareSource Dual Advantage Plus Claims P.O. BOX 1174 Milwaukee, WI 53201
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. • SKYGEN Dental Hub: https://app.dentalhub.com/app/login • Electronic submission via clearinghouse –Payer ID: SCION • CareSource Dual Advantage/CareSource Dual Advantage Plus P.O. BOX 1174 Milwaukee, WI 53201 Claims originally filed timely with a third-party carrier, but were recouped, denied or paid insufficiently, must be billed to Medicare 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.

Quick Reference Information

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. 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 the Georgia Department of Community Health (DCH) a need for additional info and how extension is in the member's best interest. Prior authorizations will be honored for 365 days from date they are determined. Submit authorizations in one of the following formats: • SKYGEN Dental Hub: https://app.dentalhub.com/app/login • Electronic submission clearinghouse, Payer ID: SCION • CareSource Dual Advantage/CareSource Dual Advantage Plus Authorizations P.O. Box 474 Milwaukee, WI 53201
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: • CareSource Dual Advantage/CareSource Dual Advantage Plus Appeals P.O. Box 1251 Milwaukee, Wi 53201 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 Deposit) Enrollment	The EFT Authorization Agreement form is found online in the SKYGEN Dental Hub: https://app.dentalhub.com/app/login

Welcome

Welcome to the CareSource Dual Advantage™ (HMO D-SNP) and CareSource Dual Advantage™ Plus (HMO D-SNP) 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 has chosen SKYGEN to administer dental benefits for members enrolled in the CareSource Dual Advantage and CareSource Dual Advantage Plus 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 **1-833-230-2176**.

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 **1-833-230-2176.** If information in this manual differs from your Participating Agreement, the Participating Agreement takes precedence and shall control.

Member Rights & Responsibilities

Member Rights

CareSource 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
- 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.
- Voice a complaint against CareSource/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 Dual Advantage and CareSource Dual Advantage Plus 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 and SKYGEN have established the following core concepts in our approach to a positive provider experience:

- Access to flexible participation options in the 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 Dual Advantage and CareSource Dual Advantage Plus Dental Plan and SKYGEN.
- File an appeal or complaint about the procedures of CareSource 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 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 Dual Advantage/CareSource Dual Advantage Plus/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 Dual Advantage/CareSource Dual Advantage Plus 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 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

Positive Provider Experience

Committed dentists are essential to the success of CareSource Dual Advantage and CareSource Dual Advantage Plus. The CareSource Dual Advantage and CareSource Dual Advantage Plus 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, 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 the CareSource Dual Advantage and CareSource Dual Advantage Plus plans.

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 members 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 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 Dual Advantage and CareSource Dual Advantage Plus 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 Dual Advantage and CareSource Dual Advantage Plus 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 Dual Advantage and CareSource Dual Advantage Plus 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://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 online 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 Dual Advantage/CareSource Dual Advantage Plus 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 Dual Advantage/CareSource Dual Advantage Plus 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-2026) recognized by the American Dental Association (ADA). Effective as of the date of this manual, CareSource Dual Advantage/CareSource Dual Advantage Plus 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 Dual Advantage/CareSource Dual Advantage Plus and SKYGEN HIPAA policies, call Customer Services 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.
- Download and complete a paper copy from https://nppes.cms.hhs.gov.
- 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 Dual Advantage and CareSource Dual Advantage Plus.

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 Dual Advantage and CareSource Dual Advantage Plus offer Dental services –
Dual Advantage coverage for adults enrolled in the program. CareSource includes the following plans:

CareSource Dual Advantage™ (HMO D-SNP)

CareSource Dual Advantage™ Plus (HMO-D-SNP)

If your patients have questions about how to enroll in the CareSource Dual Advantage/CareSource Dual Advantage Plus programs, or if they have questions about loss of eligibility ask them to call the Managed Care Enrollment Center – **1-833-230-2176**.

Member ID Card

Members receive Member ID cards from CareSource Dual Advantage and CareSource Dual Advantage Plus. 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 CareSource should a member lose eligibility.

Sample Member ID Card

CareSource Dual Advantage

CareSource Dual Advantage Plus

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: **1-833-230-2176**.
- 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 **1-833-230-2176**. 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 Dual Advantage and CareSource Dual Advantage Plus Dental Program have 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 no cost 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** 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** Toll free: **1-866-388-9844** Local: **404-209-4000**	Fulton, DeKalb, and Gwinnett
Central and Southwest	**ModivCare** 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** Toll free: **1-888-224-7988** 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 Dual Advantage and CareSource Dual Advantage Plus Dental Programs recommend 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) interprets federal law to prohibit a provider from billing any CareSource Dual Advantage and CareSource Dual Advantage Plus member for a missed appointment. In addition, your missed appointment policy for CareSource Dual Advantage/CareSource Dual Advantage Plus Dental Program enrolled patients cannot be stricter than your private or commercial patients. If a CareSource Dual Advantage/CareSource Dual Advantage Plus Dental Program member exceeds your office policy for missed appointments and you choose to discontinue seeing the patient, ask them to contact CareSource Dental Program for a referral to a new dentist.

Payment for Non-Covered Services

Enrolled participating providers shall hold members, CareSource Dual Advantage/CareSource Dual Advantage Plus 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 Dual Advantage/CareSource Dual Advantage Plus 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.

Prior Authorization & Documentation Requirements

Prior Authorization for Treatment

CareSource Dual Advantage and CareSource Dual Advantage Plus have 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 Dual Advantage, CareSource Dual Advantage Plus 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/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**.** 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 CareSource Dual Advantage or CareSource Dual Advantage Plus 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
  Attn: Appeals
  P.O. Box 1947
  Dayton, OH 45401-1947

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 Dual Advantage/CareSource Dual Advantage Plus: 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: **1-855-434-9237**

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 www.nea-fast.com or call NEA (National Electronic Attachment, Inc.): **1-800-782-5150**.

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 Dual Advantage/CareSource Dual Advantage Plus: 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://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 Dual Advantage or CareSource Dual Advantage Plus 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 180 days 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 Dual Advantage or CareSource Dual Advantage Plus is not the primary carrier, the claim still must be received within six (6) months from process date on EOB.

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 Dual Advantage/CareSource Dual Advantage Plus: 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 6 months of the date of service.

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: **1-833-230-2176.**

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 Dual Advantage/CareSource Dual Advantage Plus: Appeals
P.O. Box 1251
Milwaukee, WI 53201

Grievances & Appeals

CareSource Dual Advantage, CareSource Dual Advantage Plus 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 Dual Advantage, CareSource Dual Advantage Plus 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: **1-833-230-2176**. A designated CareSource Dual Advantage or CareSource Dual Advantage Plus Appeals Specialist is dedicated to the expedient, satisfactory resolution of both provider and member grievances and appeals.

Making a Grievance

CareSource Dual Advantage and CareSource Dual Advantage Plus take 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 Dual Advantage/CareSource Dual Advantage Plus at 1-855-221-5656 or send a written grievance to:

CareSource Dual Advantage/CareSource Dual Advantage Plus
Grievance
P.O. Box 1251
Milwaukee, WI 53201

Grievance Investigation & Resolution

CareSource Dual Advantage/CareSource Dual Advantage Plus investigates and resolves grievances within the following time frames:

- Standard Member or Provider Grievance: within 30 days of receipt.

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 Dual Advantage/CareSource Dual Advantage Plus
Claim Disputes
P.O. Box 1251
Milwaukee, WI53201

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 Dual Advantage/CareSource Dual Advantage Plus
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. 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 5 calendar days for mailing time) of the authorization denial date. Send written member appeals to:

CareSource Dual Advantage/CareSource Dual Advantage Plus Appeals
P.O. Box 1251
Milwaukee, WI 53201

Expedited Appeals

Members, the member's representative, or any physician or staff acting on behalf of the physician 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 toll-free at **1-833-230-2020 (TTY: 1-833-711-4711 or 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.

Teledentistry

Under OCGA § 43-11-54(a), the following definitions apply:

“Authorizing dentist” means a dentist licensed by and in good standing with the board and practicing in the State of Georgia.

“Dental hygienist” means a licensed dental hygienist in good standing with the board who meets the requirements to perform the specific dental hygiene functions permitted under general supervision under Code Section 43-11-74.

“Digital scan” means a computer-generated replica of the hard and soft tissues of the oral cavity created with digital technology and enhanced digital photography.

“Referred dentist” means a dentist licensed by and in good standing with the board practicing in this state to provide in-person dental treatment to patients receiving dental care through a teledentistry interaction under this Code section.

“Store and forward technologies” means technologies that allow for the electronic transmission of dental and health information, including images, photographs, documents, and health histories, through a secure communication system

Conditions for Practice: Licensed dentists must notify the board before providing teledentistry services and maintain a physical office in Georgia. They must also establish a referral relationship with a local dentist for in-person treatments.

Authorized Actions: Authorizing dentists can permit dental hygienists to perform specific functions, prescribe non-controlled medications, and use technology to transmit patient information. However, certain services like orthodontics and the delivery of dental appliances are excluded.

Patient Interactions: Teledentistry services should adhere to standards of care, including maintaining patient records and obtaining informed consent. Initial consultations may occur via teledentistry, but an in-person examination is required before certain treatments.

Regulatory Compliance: The document mandates compliance with privacy laws and emphasizes that dentists are not required to practice teledentistry or authorize hygienists to do so.

Insurance Provisions: Amendments to insurance regulations ensure that dental insurers cannot require dentists to accept payments for non-covered services and must provide coverage for teledentistry services starting January 1, 2026.

House Bill 567 (HB 567)
Professions and businesses; authorize and regulate teledentistry by licensed dentists
Georgia General Assembly, 2025–2026 Session
Effective Date: **January 1, 2026**

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.

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
D6010	Endosteal Implant	Full Mouth Series of X-rays	Documentation shows healthy bone and periodontium
D6011	Surgical access to an implant body (second stage implant surgery)	Full Mouth Series of X-rays	Documentation shows healthy bone and periodontium
D6013	Surgical placement of mini implant	Full Mouth Series of X-rays	Documentation shows healthy bone and periodontium
D6040	Eposteal Implant	Full Mouth Series of X-rays	Documentation shows fully integrated surgical implant with good crown / root ratio, Healthy bone and periodontium surrounding surgical implant.
D6050	Transosteal Implant, Including Hardware	Full Mouth Series of X-rays	Documentation shows healthy bone and periodontium
D6055	Connecting Bar – implant or abutment supported	Full Mouth Series of X-rays	Documentation shows fully integrated surgical implant with good crown / root ratio, Healthy bone and periodontium surrounding surgical implant.
D6056	Prefabricated Abutment	Full Mouth Series of X-rays	Documentation shows fully integrated surgical implant with good crown / root ratio, Healthy bone and periodontium surrounding surgical implant.

D6057	Custom Abutment	Full Mouth Series of X-rays	Documentation shows fully integrated surgical implant with good crown / root ratio, Healthy bone and periodontium surrounding surgical implant.
D6058	Abutment supported porcelain ceramic crown	Full Mouth Series of X-rays	Documentation shows fully integrated surgical implant with good crown / root ratio, Healthy bone and periodontium surrounding surgical implant.
D6059	Abutment supported porcelain fused to high noble metal	Full Mouth Series of X-rays	Documentation shows fully integrated surgical implant with good crown / root ratio, Healthy bone and periodontium surrounding surgical implant.
D6060	Abutment supported porcelain fused to predominately base metal crown	Full Mouth Series of X-rays	Documentation shows fully integrated surgical implant with good crown / root ratio, Healthy bone and periodontium surrounding surgical implant.
D6061	Abutment supported porcelain fused to noble metal crown	Full Mouth Series of X-rays	Documentation shows fully integrated surgical implant with good crown / root ratio, Healthy bone and periodontium surrounding surgical implant.
D6062	Abutment supported cast high noble metal crown	Full Mouth Series of X-rays	Documentation shows fully integrated surgical implant with good crown / root ratio, Healthy bone and periodontium surrounding surgical implant.
D6063	Abutment supported cast predominately base metal crown	Full Mouth Series of X-rays	Documentation shows fully integrated surgical implant with good crown / root ratio, Healthy bone and periodontium surrounding surgical implant.
D6064	Abutment supported cast noble metal crown	Full Mouth Series of X-rays	Documentation shows fully integrated surgical implant with good crown / root ratio, Healthy bone and periodontium surrounding surgical implant.
D6065	Implant supported porcelain/ceramic crown	Full Mouth Series of X-rays	Documentation shows fully integrated surgical implant with good crown / root ratio, Healthy bone and periodontium surrounding surgical implant.
D6066	Implant supported crown fused to high noble alloys	Full Mouth Series of X-rays	Documentation shows fully integrated surgical implant with good crown / root ratio, Healthy bone and periodontium surrounding surgical implant.
D6067	Implant supported crown, high noble alloys	Full Mouth Series of X-rays	Documentation shows fully integrated surgical implant with good crown / root ratio, Healthy bone and periodontium surrounding surgical implant.

D6068	Abutment supported retainer for porcelain/ceramic fixed partial denture	Full Mouth Series of X-rays	Documentation shows fully integrated surgical implant with good crown / root ratio, Healthy bone and periodontium surrounding surgical implant.
D6069	Abutment supported retainer for porcelain fused to high noble metal fixed partial denture	Full Mouth Series of X-rays	Documentation shows fully integrated surgical implant with good crown / root ratio, Healthy bone and periodontium surrounding surgical implant.
D6070	Abutment supported retainer for porcelain fused to predominately base metal fixed partial denture	Full Mouth Series of X-rays	Documentation shows fully integrated surgical implant with good crown / root ratio, Healthy bone and periodontium surrounding surgical implant.
D6071	Abutment supported retainer for porcelain fused to noble metal fixed partial denture	Full Mouth Series of X-rays	Documentation shows fully integrated surgical implant with good crown / root ratio, Healthy bone and periodontium surrounding surgical implant.
D6072	Abutment supported retainer for cast high noble metal fixed partial denture	Full Mouth Series of X-rays	Documentation shows fully integrated surgical implant with good crown / root ratio, Healthy bone and periodontium surrounding surgical implant.
D6073	Abutment supported retainer for predominately base metal fixed partial denture	Full Mouth Series of X-rays	Documentation shows fully integrated surgical implant with good crown / root ratio, Healthy bone and periodontium surrounding surgical implant.
D6074	Abutment supported retainer for cast noble metal fixed partial denture	Full Mouth Series of X-rays	Documentation shows fully integrated surgical implant with good crown / root ratio, Healthy bone and periodontium surrounding surgical implant.
D6075	Implant supported retainer for ceramic fixed partial denture	Full Mouth Series of X-rays	Documentation shows fully integrated surgical implant with good crown / root ratio, Healthy bone and periodontium surrounding surgical implant.
D6076	Implant supported retainer for porcelain FPD - porcelain fused to high noble alloys	Full Mouth Series of X-rays	Documentation shows fully integrated surgical implant with good crown / root ratio, Healthy bone and periodontium surrounding surgical implant.
D6077	Implant supported retainer for metal FPD - high noble alloys	Full Mouth Series of X-rays	Documentation shows fully integrated surgical implant with good crown / root ratio, Healthy bone and periodontium surrounding surgical implant.

D6085	Interim implant crown	Full Mouth Series of X-rays	Documentation describes medical necessity.
D6090	Repair Implant Prosthesis	Full Mouth Series of X-rays	Documentation describes medical necessity.
D6094	Recement implant/abutment supported fixed partial denture and titanium alloys	Full Mouth Series of X-rays	Documentation shows fully integrated surgical implant with good crown / root ratio, Healthy bone and periodontium surrounding surgical implant.
D6096	Remove broken implant retaining screw	Full Mouth Series of X-rays	Documentation describes medical necessity.
D6098	Implant supported retainer - porcelain fused to predominantly base alloys	Full Mouth Series of X-rays	Documentation shows fully integrated surgical implant with good crown / root ratio, Healthy bone and periodontium surrounding surgical implant.
D6106	TISSUE REGEN RESORBABLE	Full Mouth Series of X-rays	Documentation supports need in conjunction with bone replacement or to correct deformities resulting from inadequate faciolingual bone during implant placement.
D6107	TISSUE REGEN NON-RESORBABLE	Full Mouth Series of X-rays	Documentation supports need in conjunction with bone replacement or to correct deformities resulting from inadequate faciolingual bone during implant placement.
D6110	Implant/abutment supported removable denture for edentulous arch-maxillary	Full Mouth Series of X-rays	Documentation shows fully integrated surgical implant with good crown / root ratio, Healthy bone and periodontium surrounding surgical implant.
D6111	Implant/abutment supported removable denture for edentulous arch-mandibular	Full Mouth Series of X-rays	Documentation shows fully integrated surgical implant with good crown / root ratio, Healthy bone and periodontium surrounding surgical implant.
D6112	Implant/abutment supported removable denture for partially edentulous arch-maxillary	Full Mouth Series of X-rays	Documentation shows fully integrated surgical implant with good crown / root ratio, Healthy bone and periodontium surrounding surgical implant.
D6113	Implant/abutment supported removable denture for partially edentulous arch-mandibular	Full Mouth Series of X-rays	Documentation shows fully integrated surgical implant with good crown / root ratio, Healthy bone and periodontium surrounding surgical implant.
D6114	Implant/abutment supported fixed denture for edentulous arch-maxillary	Full Mouth Series of X-rays	Documentation shows fully integrated surgical implant with good crown / root ratio, Healthy bone and periodontium surrounding surgical implant.
D6115	Implant/abutment supported fixed denture for edentulous arch-mandibular	Full Mouth Series of X-rays	Documentation shows fully integrated surgical implant with good crown / root ratio, Healthy bone and periodontium surrounding surgical implant.
D6116	Implant/abutment supported fixed denture for	Full Mouth Series of X-rays	Documentation shows fully integrated surgical implant with good crown / root ratio, Healthy bone and periodontium surrounding surgical implant.

	partially edentulous arch-maxillary		
D6117	Implant/abutment supported fixed denture for partially edentulous arch-mandibular	Full Mouth Series of X-rays	Documentation shows fully integrated surgical implant with good crown / root ratio, Healthy bone and periodontium surrounding surgical implant.
D6118	Implant/abutment supported interim fixed denture for edentulous arch – mandibular	Full Mouth Series of X-rays	Documentation shows fully integrated surgical implant with good crown / root ratio, Healthy bone and periodontium surrounding surgical implant.
D6119	Implant/abutment supported interim fixed denture for edentulous arch – maxillary	Full Mouth Series of X-rays	Documentation shows fully integrated surgical implant with good crown / root ratio, Healthy bone and periodontium surrounding surgical implant.
D7252	Partial extraction for immediate implant placement	Pre-op x-rays	Documentation describes medical necessity

Covered Benefits

Dental services – Dual Advantage-covered

In general, preventive dental services (such as cleaning, routine dental exams, and dental x-rays) are not covered by original Medicaid.

Covered Benefits and Plan Eligibility:

CareSource Dual Advantage/CareSource Dual Advantage Plus offers Dental services - Medicaid-coverage for adults enrolled in the program. CareSource includes the following plans:

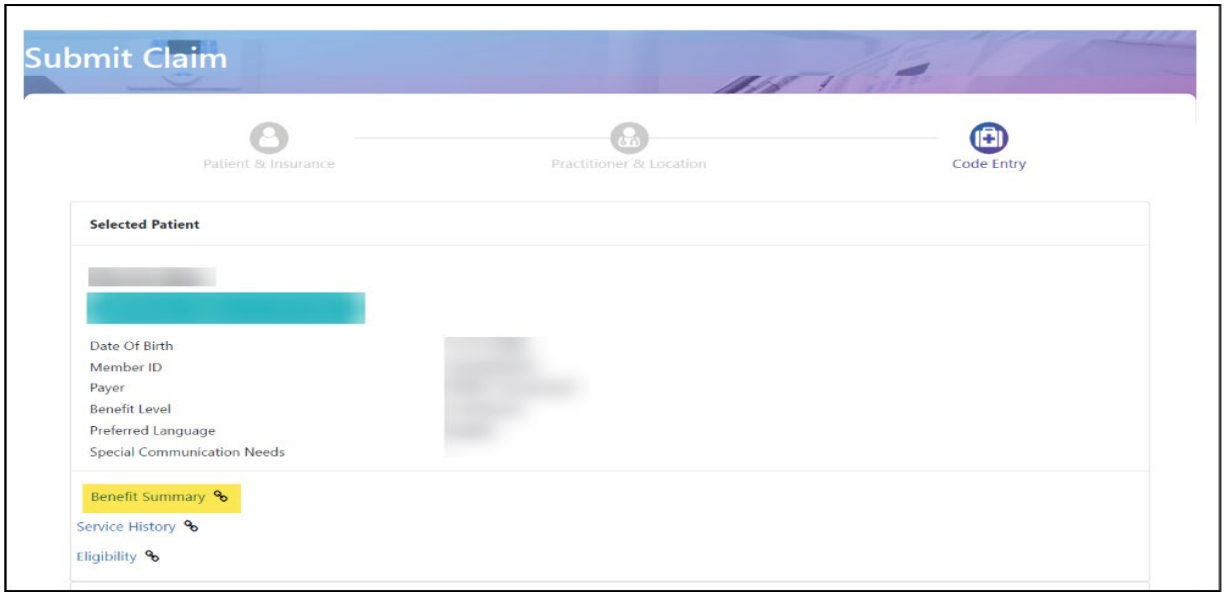
CareSource Dual Advantage™ (HMO D-SNP)

CareSource Dual Advantage™ Plus (HMO-D-SNP)

CareSource Dual Advantage/CareSource Dual Advantage Plus Medicare 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		

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