AmeriHealth Caritas VIP Care

# AmeriHealth Caritas VIP Care
# Highly Integrated Dual Eligible Special Needs Plan (HIDE-SNP)
# Provider Manual

**Program Effective: January 1, 2026**

# Michigan Provider Manual

Program administered by:

# Contents

# Welcome

Welcome to the SKYGEN provider network. SKYGEN is a nationwide leader in managed benefits administration. We are committed to providing our members the best possible care, keeping them healthy, stable, and independent, it's our reason for being here. We have partnered with AmeriHealth Caritas VIP Care to administer dental benefits for members enrolled in the programs. We are pleased to welcome you to our team.

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 what benefits are offered to members.

When you need answers, log on to the SKYGEN Dental Hub: https://app.dentalhub.com/app/login

SKYGEN, LLC 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 for AmeriHealth Caritas VIP Care . 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 844- 275-8755. If information in this manual differs from your Participating Agreement, the Participating Agreement takes precedence and shall control. This document contains confidential and proprietary information and may not be disclosed to others without written permission from SKYGEN LLC © 2025 SKYGEN LLC All rights reserved.*

# 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**: 844- 275-8755 **Email**: providerservices@skygenusa.com

| Quick Contacts | |
|---|---|
| **Corrected Claims mailing address** | Submit Corrected Claims through these formats:<br>• SKYGEN Dental Hub: https://app.dentalhub.com/app/login<br>• Electronic submission via clearinghouse –Payer ID: SCION<br>• AmeriHealth Caritas VIP Care :<br>Corrected Claims<br>P.O. Box 541<br>Milwaukee WI 53201. |
| **Member Appeals, Complaints and Grievances address** | AmeriHealth Caritas VIP Care Attn:<br>Appeals and Grievances<br>P.O. Box 80109<br>London, KY 40742-0109 |
| **Credentialing Team** | Send credentialing and recredentialing applications and documents to SKYGEN by:<br>Email: credentialing@skygenusa.com<br>https://providercap.skygenusasystems.com/CAP<br>Call: 855-812-9211 |
| **Electronic Funds Transfer** | Fax: 262-721-0722<br>Email: providerservices@skygenusa.com |
| **Electronic Outreach Team** | 855-434-9239<br>Email: providerportal@sciondental.com |
| **AmeriHealth Caritas VIP Care Fraud & Abuse Hotline** | 866-833-9718 |
| **Provider Services** | Email: providerservices@skygenusa.com |
| **SKYGEN Dental Hub** | https://app.dentalhub.com/app/login |

# Quick Reference to Common Questions

| | |
|---|---|
| **Member Eligibility** | To verify member eligibility, you can either:<br>• Login to SKYGEN's Dental Hub: https://app.dentalhub.com/app/login<br>• Call Interactive Voice Response (IVR) eligibility hotline: **844-275-8755** |
| **Authorizations Information** | Prior authorization determinations made within (7) calendar days from the date SKYGEN receives the request. Prior authorizations will be honored for 180 calendar days from the date they are determined. Expedite authorization determinations must be made within (72) calendar hours.<br>Authorization submissions formats:<br>• Electronic authorizations via SKYGEN's Dental Hub: https://app.dentalhub.com/app/login<br>• Electronic submission via clearinghouse, Payer ID: **SCION**<br>• AmeriHealth Caritas VIP Care:<br>Authorizations PO Box 654<br>Milwaukee, WI 53201 |
| **Claims Submission** | The timely filing requirement is 365 calendar days. Submit claims in one of the following formats:<br>• SKYGEN Dental Hub: https://app.dentalhub.com/app/login<br>• Electronic submission via clearinghouse, Payer ID: **SCION**<br>• AmeriHealth Caritas VIP Care:<br>Claims PO Box 651<br>Milwaukee, WI 53201 |
| **Provider Complaints** | To file a complaint, either:<br>• AmeriHealth Caritas VIP Care: Provider Complaints<br>PO Box 1243<br>Milwaukee, WI 53201<br>• Call: Provider Services: **844-275-8755** |
| **Provider Claim Appeals** | Claim Appeals must be filed within 180 days following the date the denial letter was mailed. SKYGEN issues a decision within 30 days if an extension was not requested and granted.<br>To request reconsideration of a claim denial:<br>• AmeriHealth Caritas VIP Care: Claim Appeals PO Box 1243<br>Milwaukee, WI 53201 |

# Member Rights & Responsibilities

Members participating in the AmeriHealth Caritas VIP Care (HIDE-SNP) Plan have the following rights and responsibilities.

## Member Rights

AmeriHealth Caritas VIP Care is 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 grievance** against the AmeriHealth Caritas VIP Care , 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, updated information** about AmeriHealth Caritas VIP Care Dental Program, the services provided, the 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, 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

SKYGEN has established the following core concepts in our approach to a positive provider experience:

- **Access** to flexible participation options in provider networks.
- **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 SKYGEN.
- **File an appeal or grievance** about the procedures of SKYGEN.
- **Supply accurate, relevant, and factual information** to a member in conjunction with an appeal or grievance filed by the member.
- **Object to policies, procedures, or decisions** made by SKYGEN.
- **Be informed of the status** of their credentialing or recredentialing application, upon request.

## Provider Responsibilities

Participating providers have the following responsibilities:

- If a recommended treatment plan is not covered (not approved by 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.
- A provider wishing to terminate participation with the SKYGEN Plan must follow the termination guidelines stipulated in the provider contract.
- A provider may not bill both medical codes and dental codes for the same procedure.
- 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).

## 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 every government-sponsored dental program. Our 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 AmeriHealth Caritas VIP Care, 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 government-sponsored dental programs.

# Flexible Participation Options

SKYGEN invites all licensed dentists, regardless of their past commitment to government-sponsored dental programs, to participate in our 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.
- Be excluded from directories and accept appointments for only new patients directed to their office from AmeriHealth Caritas VIP Care /SKYGEN.
- Treat only emergencies or special needs cases on an individual basis.
- Access online contracting and credentialing applications from a self-service web portal.

To make it as fast and easy as possible to join our network, SKYGEN streamlines the contracting and credentialing process by offering online web portals and accepting electronic documents.

# Provider Clinical Chart Notes

Providers are expected to maintain comprehensive Clinical Chart notes. The patients' record, which includes Clinical Chart notes, is essential to the provision of quality oral health care.

- The recording of patients' medical and dental history, present illness, clinical examination, diagnosis, completed treatment, overall prognosis and patient-homecare communications are fundamental to patient care.
- The record serves to determine the patients' baseline findings and treatment plan.
- In addition to being a legal record, it is a comprehensive accounting of what transpired during the dental visit, may be used in defense of malpractice allegations, and serves as the basis for insurance claims and forensic purposes.

Adequate documentation of registration information, which requires entry of these items:

- Patient first and last name, Date of Birth, Gender
- Address, Telephone number.
- Name and telephone number of the person to contact in case of emergency.

Per the West Virginia Department of Health, the chart notes for each member should include the following:

- Registration data including a complete health history.
- Initial examination data
- Periodontal and Occlusal status
- Treatment plan/alternative treatment plan.
- Tooth charting noting the presence or absence of teeth, existing restorations, areas of decay, fractured teeth, periodontal charting as applicable, and any other documentation that is pertinent.
- Radiographs that are identified by patient name and date.
- All informed consent forms must be signed and dated by parent and/or legal guardian and provider in their preferred language.
- If interpreter is used, this must be noted in the record at every visit.
- Name of member and their birth date on each chart note page.
- Chart notes for every DOS to include diagnosis, progress notes, preventative services, treatment rendered, and medical/dental consultations.
- Medical necessity of the procedures completed for that DOS should be documented.
- Tooth numbers and surfaces of teeth receiving treatment.
- Name of provider (or initials) of the clinician providing the treatment, as well as that of the RDH
- Anesthesia administered, location and the amount given.
- If nitrous oxide is used: the amount, duration, % oxygen flush, and statement that the patient tolerated the procedure well (status) and any complications.
- If abbreviations are used, they must be widely accepted and used universally in the office.
- The documentation in the chart notes for each DOS should match the claims submitted for those procedures.

The design of the record must provide the capability or periodic update, without the loss of documentation of the previous status, of the following information:

- Health history
- Medical alert
- Examination/ Recall data
- Periodontal status
- Treatment plan

The design of the record must ensure that all permanent components are attached or secured within the record and must be readily identified to the patient (i.e., patient name and identification number on each page). The organization of the record system must require that the individual records be assigned to each patient.

An adequate health history that requires documentation of these items:

- Current medical treatment
- Significant past illnesses
- Current medications
- Drug allergies
- Hematologic disorders
- Respiratory disorders
- Endocrine disorders
- Communicable diseases
- Neurologic disorders
- Signature and date by patient
- Signature and date by reviewing dentist.
- History of alcohol and/or tobacco usage including smokeless tobacco
- History of controlled substance usage or abuse including medical marijuana

An adequate update of health history at subsequent recall examinations that requires documentation of these items:

- Significant changes in health status.
- Current medical treatment.
- Current medications.
- Dental problems/concerns.
- Signature and date by reviewing dentist.

A conspicuously placed medical alert inside the chart jacket that documents highly significant terms for health history. These items are:

- Health problems, which contraindicate certain types of dental treatment.
- Health problems that require precautions or pre-medication prior to dental treatment.
- Current medications that may contraindicate the use of certain types of drugs or dental treatment.
- Drug sensitivities.
- Infectious diseases that may endanger personnel or other patients.

Adequate documentation of the initial and subsequent clinical examination that is dated and requires descriptions of findings in these items:

- Blood pressure (recommended)
- Head/neck examination
- Soft tissue examination
- Periodontal assessment
- Occlusal classification
- Dentition charting

Radiographs that are identified by patient name

- Dated
- Designated by patient’s left and right side
- Mounted (if intraoral films)
- An indication of the patient’s clinical problems/diagnosis.

Adequate documentation of the treatment plan (including any alternate treatment options) that specifically describes all the services planned for the patient by entry of these items:

- Procedure
- Localization (area of mouth, tooth number, surface)

An adequate documentation of the periodontal status, if necessary, which is dated and requires charting of the location and severity of these items:

- Periodontal pocket depth
- Furcation involvement
- Mobility
- Recession
- Adequacy of attached gingiva
- Missing teeth

An adequate documentation of the patient's oral hygiene status and preventative efforts which requires entry of these items:

- Gingival status
- Amount of plaque
- Amount of calculus
- Education provided to the patient
- Patient receptiveness/compliance
- Recall interval
- Date

An adequate documentation of medical and dental consultations within and outside the practice, which requires entry of these items:

- Provider to whom consultation is directed.
- Information/services requested.
- Consultant's response
- Date of service/procedure

Compliance:

- The patient record has one explicitly defined format that is currently in use.
- There is consistent use of each component of the patient record by all staff.
- The components of the record that are required for complete documentation of each patient's status and care are present.
- Entries in the records are legible.
- Entries of symbols and abbreviations in the records are uniform, easily interpreted and are commonly understood in the practice.

All clinicians treating members should be credentialed and have an active license in the state where the services are being rendered

# Cultural Competency

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

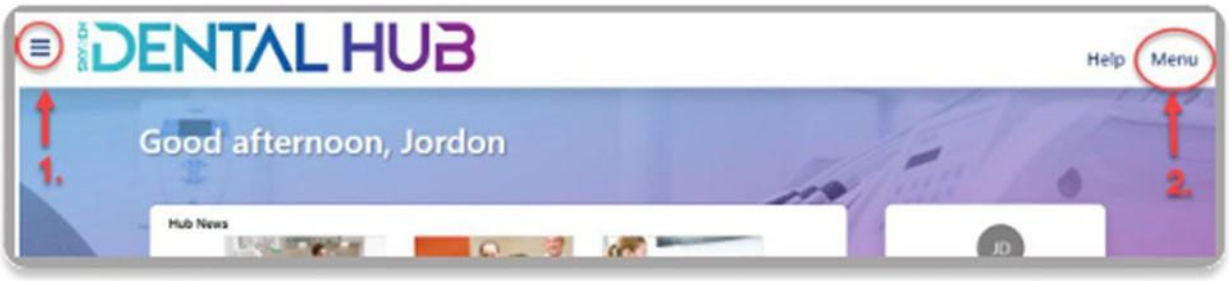
- Assessing and documenting cultural and/or language barriers to member care.
- Seeking information from community resources to assist in servicing the needs of culturally and ethnically diverse members and families.
- Displaying pictures, posters, and other materials to reflect the cultures and ethnic 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 different cultures.
- Seeking bilingual staff or trained personnel to serve as interpreters, when possible.
- Understanding that a limited English proficiency in no way reflects intellect.

**Cultural Competency Training**

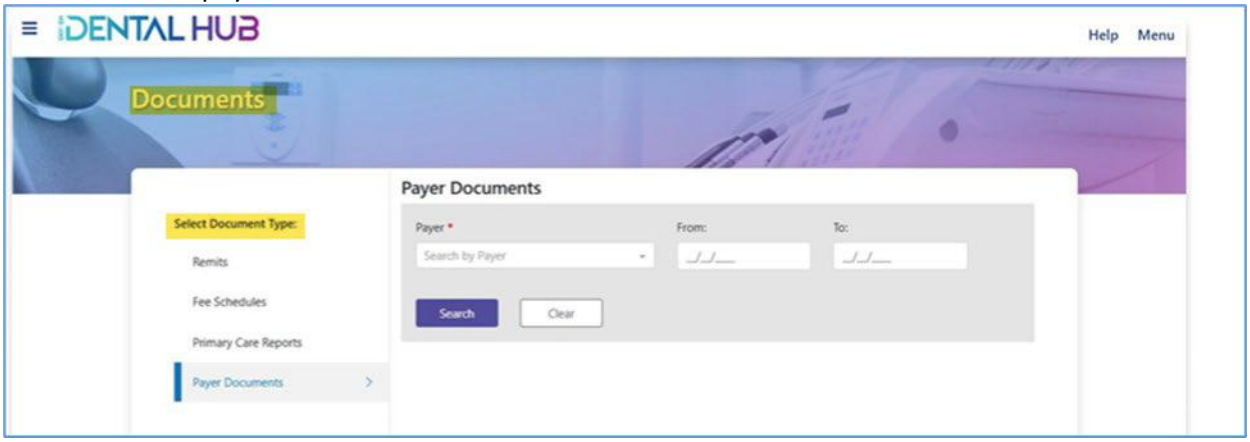
CMS guidelines require all providers servicing Medicare patients complete a cultural competency training each year. Providers need to review the training documents for Cultural Competency and Fraud Waste and Abuse. This can be accessed in the providers Dental Hub account in the "Documents" menu drop-down.

**How to Access Payor Documents**

In the Dental Hub providers should go to: **Navigate to Main Menu > Practice Management > Documents > Payer Documents**




Please note the payer is - Elevance-WellPoint WV




- After viewing the training document we require verification of completion. Providers will need to click on the attestation link within the training module to complete the necessary information. We ask that providers submit the requested information on the attestation within 30 days of receipt.

# Provider Credentialing

SKYGEN has an open recruitment strategy that encourages all providers to participate, all dentists seeking acceptance into the network must undergo a qualification process, which includes a background check, licensing verification, and primary source verification of professional credentials.

As required by law, any dentist (DDS or DMD) who is interested in participating with SKYGEN is invited to apply and submit a credentialing application for review by SKYGEN's Credentialing Committee. We do not differentiate or discriminate in the treatment of providers seeking credentialing on the basis of race, ethnicity, gender, age, national origin, or religion. Providers must be credentialed before participating in the SKYGEN network. Providers accepted into the network are recredentialed at least every 36 months.

## Credentialing Process

The SKYGEN credentialing process follows NCQA (National Committee for Quality Assurance) credentialing guidelines for dentistry. All credentialing applications must satisfy NCQA and/or URAC standards of credentialing as they apply to dental services. SKYGEN has the sole right to determine which dentists it accepts and continues to allow as participating providers in the SKYGEN network.

In reviewing an application, the Credentialing Committee may request further information from the applicant. The Credentialing Committee may postpone a decision pending the outcome of an investigation of the applicant by a hospital, licensing board, government agency, institution, or any other organization, or the Committee may recommend other actions it deems appropriate. SKYGEN notifies AmeriHealth Caritas VIP Care of all disciplinary actions that involve participating providers.

Any acceptance of an applicant is conditioned upon the applicant's execution of a participation agreement with the SKYGEN network. If you have questions about the credentialing process, call the SKYGEN Credentialing team: **855-812- 9211**.

## Submitting a Credentialing Application

To submit your credentialing application and required documents, email: credentialing@skygenusa.com.

## Recredentialing Process

Recredentialing is required at least every 36 months, per NCQA guidelines. Six months before you are due for recredentialing, SKYGEN will notify you of your upcoming recredentialing due date. Our notification letter will include instructions for how to complete the recredentialing process. If you have questions about recredentialing or need assistance, call the SKYGEN Credentialing team: **855- 812-9211**

## Appealing a Credentialing Decision

The SKYGEN Credentialing Committee has the discretion and authority to accept an application without restrictions. However, if the Credentialing Committee determines an application should be accepted with restriction or declined, the Committee recommends the appropriate action to the Executive Subcommittee for approval and offers the applicant an opportunity to request a reconsideration review or appeal the recommendation. If the applicant accepts the opportunity for a reconsideration review, the Credentialing Committee reviews all original documents, as well as any additional information submitted for the reconsideration review. If an applicant appeals the Credentialing Committee's recommendation, a Peer Review Committee completes the review. SKYGEN retains ultimate responsibility for the credentialing process and final credentialing decisions.

To appeal a decision, send a written request for a reconsideration review within 30 days of receiving an adverse recommendation to:

SKYGEN Attention: Credentialing
N92 W14612 Anthony Ave
Menomonee Falls, WI 53051

# 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 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 any 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 will 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

# Electronic Payments

## Automated Clearing House (ACH)

SKYGEN partners with Zelis to offer AmeriHealth Caritas VIP Care 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 download 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 on SKYGEN's 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 SKYGEN 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 ACH Program, your Remittance Reports will be made available automatically from the SKYGEN Dental Hub. For help registering for the portal or accessing your Remittance Reports send an email message to the Provider Portal Team.

Email: providerportal@skygenusa.com

Call: **855-434-9239**

# Eligibility & Member Services

AmeriHealth Caritas VIP Care offers dental coverage for members enrolled in the AmeriHealth Caritas VIP Care Programs. AmeriHealth Caritas VIP Care determines member eligibility.

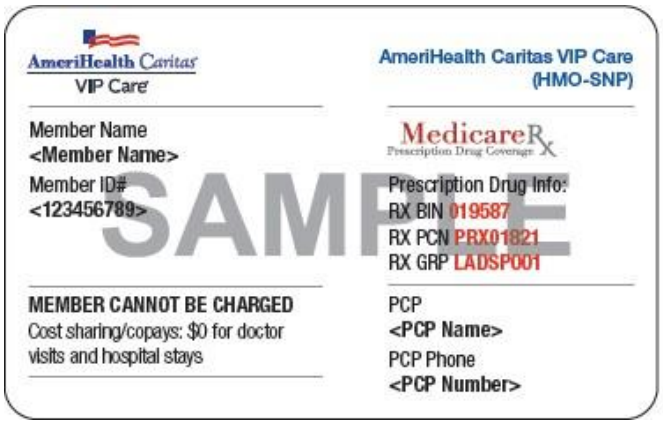
If your patients have questions about how to enroll in an AmeriHealth Caritas VIP Care Dental Program, or if they have questions about loss of eligibility, refer them to their local health department, or ask them to call Member Services: **888-667-0318.**

## Member ID Card

Members receive AmeriHealth Caritas VIP Care Member ID cards from AmeriHealth Caritas. 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. Note Presenting a Member ID card does not guarantee that a person is currently eligible for benefits in the AmeriHealth Caritas VIP Care Dental Program.

**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: 855- 434-9239
- Check member eligibility and benefits on the date of service.

The Provider Web Portal 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 (IVR) system to verify eligibility for an unlimited number of patients. Call **844-275-8755**. 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

SKYGEN 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 for a number of important reasons, including:

- 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.

Dentists are expected to meet the following minimum standards for appointment availability:

- **Routine appointments** - Routine dental care must be scheduled within 21 business days.
- **Preventive services** – Within six weeks of request.
- **Initial appointment** – Within eight weeks of request.
- **Urgent Care** - Urgent care must be available within 48 hours.
- **Emergency services** - Emergency services must be scheduled immediately 24 hours/day seven days per week.

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

# Summary: Appointment Availability Standards

| Appointment Type | Appointment Required… |
|---|---|
| Preventative services | Within six weeks of request |
| Initial appointment | Within eight weeks of request |
| Emergency services | Within 24 hours |
| Urgent services | Within 48 hours |
| Routine follow-up visits | Within 21 days |

# Retrospective Review, Prior Authorization & Documentation Requirements

## Prior Authorization for Treatment

SKYGENs 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, AmeriHealth Caritas VIP Care 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 7 calendar 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 member's needs.
- The proposed item or service conforms to commonly accepted standards in the dental community.

## Retrospective Review

Services that require retrospective review are outlined in the exhibit section at the end of this manual. Claims that require retrospective review need to be submitted with the appropriate documentation. Retro reviews are determined within 30 calendar days. Types of documentation required, not limited to, are:

- Radiographs (Pre-op, post-op or opposing arch x-rays as indicated in the exhibits)
- Narrative of medical necessity
- Perio charting

Any claims for retrospective review submitted without the required documents will be denied and must be resubmitted for reimbursement. The SKYGEN dental consultant reviews the documentation to ensure the services rendered meet the clinical criteria requirements as outlined in this manual. Once the clinical review is completed, the claim is either paid or denied within 30 calendar days for clean claims and notification will be sent to the provider via the provider remittance statement.

# Procedures Requiring Prior Authorization

SKYGEN must make a decision on a request for prior authorization within 7 calendar 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 three calendar days.

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 of Kansas or any agents, and/or SKYGEN.

Prior authorizations will be honored for 180 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 Surgery Services

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).

# 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:
- AmeriHealth Caritas VIP Care:
  Authorizations PO Box 654
  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 web portal 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 quick and 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 you receive decisions faster.
- 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 Electronic Outreach Team: **855-609-5156**

## Submitting Authorizations via Clearinghouses

Providers may submit electronic claims and authorizations to SKYGEN directly via the Optum and DentalXChange 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.

## 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.): **800-782-5150**.

# Submitting Authorizations on Paper Forms

To ensure timely processing of submitted authorizations, the following information must be included on the paper 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. 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

# 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**
- Paper 2012 ADA Dental Claim Form, available from the American Dental Association

## Submitting Claims via Provider SKYGEN Dental Hub

Providers may submit claims directly to SKYGEN through our Dental Hub: https://app.dentalhub.com/app/login. Submitting claims via the web portal 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 Provider Web Portal, call the Electronic Outreach Team: **855-434-9239**.

## Submitting Claims via Clearinghouses

Providers may submit electronic claims to SKYGEN directly via either the Optum or DentalXChange 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. SKYGEN Payer ID is **SCION**. By using this unique Payer ID with electronic files, Emdeon and DentalXChange can ensure that claims are submitted successfully to SKYGEN.

For more information about Emdeon and DentalXChange, visit their websites: https://business.optum.com/en/ and www.dentalxchange.com.

## 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—***for no charge***. SKYGEN, in conjunction with NEA (National Electronic Attachment, Inc.), also allows enrolled providers to submit documents electronically via FastAttach™. This program allows secure transmissions of radiographs, periodontics charts, intraoral pictures, narratives, and Explanation of Benefits (EOBs). FastAttach™ is compatible with most claims clearinghouses and practice management systems. For more information, visit http://www.nea-fast.com or call NEA at **800-782-5150**.

# Submitting Claims on Paper Forms

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

- Member Name
- Member Plan, Medicare, or Medicaid ID Number
- Member Date of Birth
- Provider Name
- Provider Location
- Billing Location
- Provider NPI
- Payee Tax Identification Number (TIN)
- Date of Service for each service line

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 payment. Use the proper postage when mailing bulk documentation. Mail with postage due will be returned. Mail paper claims to:

SKYGEN Administrative Service of AmeriHealth Caritas VIP Care : Claims
PO Box 651
Milwaukee, WI 53201

# Coordination of Benefits (COB)

The AmeriHealth Caritas VIP Care /SKYGEN is the payer of last resort. When a participant arrives for an appointment, always ask if they have other dental insurance coverage. When AmeriHealth Caritas VIP Care /SKYGEN is the secondary insurance carrier, submit a copy of the primary carrier's Explanation of Benefits (EOB) with the claim. For electronic claim submissions, indicate the payment made by the primary carrier in the appropriate Coordination of Benefits (COB) field.

When a primary carrier's payment meets or exceeds a provider's contracted rate or fee schedule, AmeriHealth Caritas VIP Care /SKYGEN will consider the claim paid in full and no further payment will be made on the claim.

# Timely Filing Limits

SKYGEN must receive claims requesting payment within 365 days from the date of service. Claims submitted more than 365 days from the date of service will be denied for "untimely filing." If a claim is denied for untimely filing, you may not bill the member. If AmeriHealth Caritas VIP Care /SKYGEN is the secondary carrier, the timely filing limit begins with the date of payment or denial from the primary carrier.

# 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.

Miscalculations in payments made by the insurer shall be corrected and paid within thirty (30) calendar days upon the insurer's receipt of documentation from the provider verifying the error.

*An insurer shall not be required to correct a payment error to a provider if the provider's request for a payment correction is filed more than twenty-four (24) months after the date that the provider received payment for the claim from the insurer.

*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.

What scenarios are subject to the Corrected Claim Process? A corrected claim should only be submitted if the original service(s) PAID 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.

### 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 PO 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:

AmeriHealth Caritas VIP Care Corrected Claims
PO BOX 541
Milwaukee, WI 53201

# Claims Adjudication & Payment

The SKYGEN benefits administration software system imports claim 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 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 on the SKYGEN Dental Hub.

To appeal a reimbursement decision, submit the appeal in writing within 180 days of the decision date, along with any necessary documentation to:

AmeriHealth Caritas VIP Care Claim Appeals
PO Box 1243
Milwaukee, WI 53201

# Making an Appeal or a Grievance

If the member has an appeal or a grievance, the member can write to:

| **Grievances** | **Appeals** |
|---|---|
| AmeriHealth Caritas VIP Care Attn:<br>Grievances<br>P.O. Box 7140<br>London, KY 40742-7140 | AmeriHealth Caritas VIP Care Attn:<br>Appeals<br>P.O. Box 80109<br>London, KY 40742-0109 |

If the Provider has a grievance, they can write

AmeriHealth Caritas VIP Care
Claim Appeals
PO Box 1243
Milwaukee, WI 53201

# Health Insurance Portability and Accountability Act (HIPAA)

As a healthcare 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.

SKYGEN has 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.

Together, you (the provider) and SKYGEN agree to conduct our respective activities in accordance with the applicable provisions of HIPAA and such implementing regulations.

When you contact Provider Services, you will be asked to supply your Tax ID or NPI number. When you call regarding member inquiries, you will be asked to supply specific member identification such as Member ID or Social Security Number, date of birth, name, and/or address.

As regulated by the Administrative Simplification Standards, the benefit tables included in this provider manual reflect the most current CDT coding standards recognized by the American Dental Association (ADA). Effective as of the date of this manual, AmeriHealth Caritas VIP Care /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 SKYGEN HIPAA policies, call Provider Services or send an email to providerservices@skygenusa.com. To report a potential security issue, call our Hotline: 877-378-5292.

## National Provider Identifier (NPI)

The Health Insurance Portability and Accountability Act (HIPAA) of 1996 required the adoption of a standard unique provider identifier for healthcare providers.

An NPI number is required for all claims submitted to SKYGEN for payment. All providers must register as an individual practitioner and get an individual NPI.

If you own and operate a group practice, you must also register as a group and obtain a group or organizational NPI.

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 **800-465-3203** to request an application.

# Utilization Management

## Community Practice Patterns

To ensure fair and appropriate reimbursement, SKYGEN Utilization Management philosophy recognizes the relationships between the dentist's treatment planning, treatment costs, and outcomes. The dynamics of these relationships are typically influenced by community practice patterns. With this in mind, our Utilization Management guidelines are designed to ensure healthcare dollars are distributed fairly and appropriately, 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 community practice patterns. SKYGEN Utilization Management recognizes individual dentist variance within these patterns among a community of dentists and accounts for such variance. To ensure fair comparisons within peer groups, our Utilization Management evaluates specialty dentists as a separate group (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 Utilization Management helps identify providers whose treatment patterns show significant deviation from the normal practice patterns of the community of their peers (typically less than 5 percent of all dentists). SKYGEN is contractually obligated to report suspected fraud, waste, abuse, or misuse by members and participating dental providers to AmeriHealth Caritas VIP Care .

## Non-Incentivization Policy

It is SKYGEN practice to ensure our contracted providers make treatment decisions based on medical necessity for individual members. Providers are never offered, nor shall they ever accept, any kind of financial incentives or any other encouragement to influence their treatment decisions.

The SKYGEN Utilization Management team bases their decisions on only 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 & 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.

## Definitions

Fraud, waste, and abuse are defined as:

**Fraud**. 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**. Waste is the unintentional, thoughtless, or careless expenditures, 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**. 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 healthcare 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 healthcare program.

**Provider Fraud**. 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 healthcare program requirements, its associates, or contractors.

## Reporting suspected fraud, waste, or abuse

To report a suspected case of noncompliance, fraud, waste, or abuse contact:

**AmeriHealth Caritas VIP Care**

- Call: Toll-free Fraud Tip Line at 866-833-9718
- Email: fraudtip@amerihealthcaritas.com
- Write to:
  Special Investigations Unit, AmeriHealth Caritas 200
  Stevens Drive
  Philadelphia, PA 19113

# 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 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 healthcare 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 healthcare 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.

## Fraud and Abuse Hotlines

SKYGEN Fraud and Abuse Hotline: **844-809-9449**

Agency for Health Care Administration: **888-419-3456**

# Clinical Criteria for Procedures Requiring Prior Authorization

## Crowns (D2710, D2721, D2722, D2740, D2750, D2751, D2752, D2753, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2794, D2931)

Required documentation – Periapical radiograph showing the root and crown of the natural tooth. Non-abutment teeth: Current periapical x-rays of the tooth/teeth to be crowned. All criteria below must be met:

- Tooth to be crowned must have an opposing tooth in occlusion or be an abutment tooth for a partial denture.
- Minimum 50% bone support.
- The patient must be free of active / advanced periodontal disease.
- No subosseous and / or furcation carious involvement.
- No periodontal furcation lesion or a furcation involvement.
- Clinically acceptable RCT if present and all the criteria below must be met:
    - The tooth is filled within two millimeters of the radiographic apex.
    - The root canal is not filled beyond the radiographic apex.
    - The root canal filling is adequately condensed and/or filled.
    - Healthy periapical tissue (healing PARL or no PARL).
- And 1 of the criteria below must be met:
    - Anterior teeth must have pathological destruction to the tooth by caries or trauma and involve four (4) or more surfaces and at least 50% of the incisal edge.
    - Premolar teeth must have pathological destruction to the tooth by caries or trauma and must involve three (3) or more surfaces and at least one (1) cusp.
    - Molar teeth must have pathological destruction to the tooth by caries or trauma and must involve four (4) or more surfaces and two (2) or more cusps.

## Core Buildups, Posts and cores (D2950, D2952, D2954)

Required documentation – Periapical radiograph showing the root and crown of the natural tooth. All criteria below must be met:

- Minimum 50% bone support.
- The patient must be free of active / advanced periodontal disease.
- No subosseous and / or furcation carious involvement.
- No periodontal furcation lesion or a furcation involvement.
- Clinically acceptable RCT (if present all the criteria below must be met):
    - The tooth is filled within two millimeters of the radiographic apex.
    - The root canal is not filled beyond the radiographic apex.
    - The root canal filling is adequately condensed and/or filled.
    - Healthy periapical tissue (healing PARL or no PARL).

## Root canal therapy (D3310, D3320, D3330, D3346, D3347, D3348)

Required documentation – Periapical radiograph showing the crown and entire root of the tooth. All criteria below must be met:

- Minimum 50% bone support.
- The patient must be free of active / advanced periodontal disease.
- No subosseous and / or furcation carious involvement.
- No periodontal furcation lesion and / or a furcation involvement.
- Closed apex.
- Tooth must be crucial to arch/occlusion (3rd molars not covered).

And 1 of the criteria below must be met if absence of decay or large restoration on the x-ray:

- Evidence of apical pathology/fistula.
- Narrative describing symptoms of irreversible pulpitis.

## Apicoectomy (D3410, D3421, D3425, D3426, 3430)

Required documentation – Periapical radiograph showing the crown and entire root of the tooth. All criteria below must be met:

- Minimum 50% bone support
- The patient must be free of active / advanced periodontal disease
- No subosseous and / or furcation carious involvement
- No periodontal furcation lesion and / or a furcation involvement
- Completed root canal
- Tooth must be crucial to arch/occlusion
- And 1 of the criteria below must be met if absence of decay or large restoration on the x-ray
    - Evidence of apical pathology/fistula
    - Narrative describing symptoms of irreversible pulpitis

## Gingivectomy or Gingivoplasty (D4210, D4211)

Required documentation – Pre-operative x-ray, periodontal charting, narrative of medical necessity and photo (optional). 1 of the criteria below must be: met:

- Hyperplasia or hypertrophy from drug therapy, hormonal disturbances or congenital defects
- Generalized 5 mm or more pocketing indicated on the periodontal charting

## Periodontal scaling and root planning (D4341 and D4342)

Required documentation – Periodontal charting and current diagnostic radiographs of the quadrant(s) to be treated. All criteria below must be met:

- 5 mm or more pocketing on 2 or more sites indicated on the involved teeth.
- Presence of root surface calculus and/or noticeable loss of bone support on x-rays.

## Full mouth debridement (D4355)

Limited to one treatment per 365 days. Required documentation - pre-op x-rays. All criteria below must be met:

- No history of periodontal treatment in past 12 months.
- Extensive coronal calculus on 50% of teeth.

## Full dentures (D5110, 05120, D5810, D5811)

Required documentation - panoramic radiographic image (D0330) or intraoral complete series. of radiographic images (D0210). 1 of the criteria below must be met:

- If present, existing denture greater than 5 years old and not serviceable per narrative
- Remaining teeth do not have adequate bone support or are not restorable

## Immediate dentures (D5130, 05140)

Required documentation - panoramic radiographic image (D0330) or intraoral complete series. of radiographic images (D0210). All criteria below must be met:

- Remaining teeth do not have adequate bone support or are not restorable

## Partial dentures (05211, D5212, D5213, D5214, D5221, D5222, D5223, D5224, D5225, D5226, D5820, D5821)

Partial dentures limited to one per arch, regardless of procedure code, every four years. Required documentation - panoramic radiographic image (D0330) or intraoral complete series. of radiographic images (D0210). All criteria below must be met:

- Remaining teeth have greater than 50% bone support and are restorable
- If present existing denture greater than 5 years old and not serviceable per narrative

In addition,1 of the criteria below must be met:

- Replacing one or more anterior teeth
- Replacing one or more posterior teeth unilaterally (excluding 3rd molars)
- Replacing three or more teeth bilaterally (excluding 3rd molars)

## Surgical Placement of Mini-implant (D6013)

All criteria below must be met:

- History of mandibular complete removable denture (D5120) or approved treatment plan for mandibular complete removable denture
- History of inability to retain mandibular complete removable denture or radiographic evidence of ridge resorption to the extent that retention of mandibular complete denture is not possible

## Implant/Abutment supported removable denture for edentulous arch - mandibular (D6111)

Existing denture greater than 5 years o1d and not serviceable per narrative. All criteria below must be met:

- Presence of mandibular implants or approval of mandibular implants
- Implants must have favorable long term prognosis

## Impacted teeth (D7220, D7230, D7240, D7241)

Documentation required – Pre-operative radiographs (excluding bitewings) and narrative of medical necessity

- Documentation describes pain, swelling, etc. around tooth (symptomatic)
- The prophylactic removal of asymptomatic teeth or teeth exhibiting no overt clinical pathology is not a covered benefit.
- X-ray matches type of impaction code described
- Documentation of clinical evidence indication impaction, although asymptomatic may not be disease free

## Surgical removal of residual tooth roots (D7250)

Documentation required – Pre-operative radiographs (excluding bitewings) and narrative of medical necessity. All criteria below must be met:

- Tooth root is completely covered by bony tissue on x-ray.
- Documentation describes pain, swelling, etc. around tooth (must be symptomatic or impinging upon adjacent tooth).

## Other surgical procedures (D7260, D7261, D727050)

Documentation required – Pre-operative radiographs (excluding bitewings) and narrative of medical necessity.

## Alveoloplasty with extractions (D7310)

Documentation required – Narrative of medical necessity. All criteria below must be met:

- For bone recontouring and smoothing as part of the tooth extraction process.
- For debulking procedures for pathologic conditions of the bone.

## Alveoloplasty without extractions (D7320)

Documentation required – Narrative of medical necessity. All criteria below must be met:

- For bone recontouring and smoothing as a standalone procedure prior to removable prosthetic construction.
- For debulking procedures for pathologic conditions of the bone.

## Removal of lateral exostosis (D7471)

Documentation required – Narrative of medical necessity. Criteria:

- If a partial or complete denture cannot be adapted successfully.
- When causing soft tissue trauma with existing removable appliances.
- For 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.

## Removal of tori (D7472, D7473)

Documentation required – Narrative of medical necessity. Criteria:

- If a partial or complete denture cannot be adapted successfully.
- When causing soft tissue trauma with existing removable appliances.
- For 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.

## Reduction of osseous tuberosity (D7485)

Documentation required - Narrative of medical necessity.

## Incision and drainage of abscess (D7510)

Documentation required - Narrative of medical necessity.

## Other repair procedures (D7961, D7962, D7970, D7971, D7972)

Documentation required – Narrative of medical necessity.

## General anesthesia / IV sedation (Dental Office Setting) - (D9222, D9223, D9239, D9243, D9224, D9225)

Documentation required – Narrative of Medical Necessity, Anesthesia Log (retrospective review). 1 of the criteria below must be met:

- Extractions of impacted or unerupted cuspids or wisdom teeth or surgical exposure of unerupted cuspids
- 2 or more extractions in 2 or more quadrants
- 4 or more extractions in 1 quadrant
- Excision of lesions greater than 1.25 cm
- Surgical recovery from the maxillary antrum
- Documentation of failed local anesthesia
- Documentation of situational anxiety
- Documentation and narrative of medical necessity supported by submitted medical records (cardiac, cerebral palsy, epilepsy, MR or other condition that would render patient noncompliant)
- Documentation of existing clinical condition or circumstance making the use of general anesthesia/IV sedation a reasonable inclusion as a Medically Necessary part of the therapeutic regimen.

Note that D9222/D9239 may be prior authorized as described above and D9223/D9243 may be retro authorized (with anesthesia log required).

## Non-intravenous conscious sedation (Dental Office Setting) (D9244, D9245, D9246, D9247)

Documentation required – Narrative of medical necessity. 1 of the criteria below must be met:

- Extractions of impacted or unerupted cuspids or wisdom teeth or surgical exposure of unerupted cuspids
- 2 or more extractions in 2 or more quadrants
- 4 or more extractions in 1 quadrant
- Excision of lesions greater than 1.25 cm
- Surgical recovery from the maxillary antrum
- Documentation of failed local anesthesia
- Documentation of situational anxiety
- Documentation and narrative of medical necessity supported by submitted medical records (cardiac, cerebral palsy, epilepsy, MR or other condition that would render patient noncompliant)
- Documentation of existing clinical condition or circumstance making the use of non-intravenous conscious sedation a reasonable inclusion as a Medically Necessary part of the therapeutic regimen.

## Treatment of complications (post-surgical) – (D9930)

Documentation required – Narrative of Medical Necessity

## Occlusal guards – (D9944, D9945, D9946)

Documentation required – Narrative of Medical Necessity

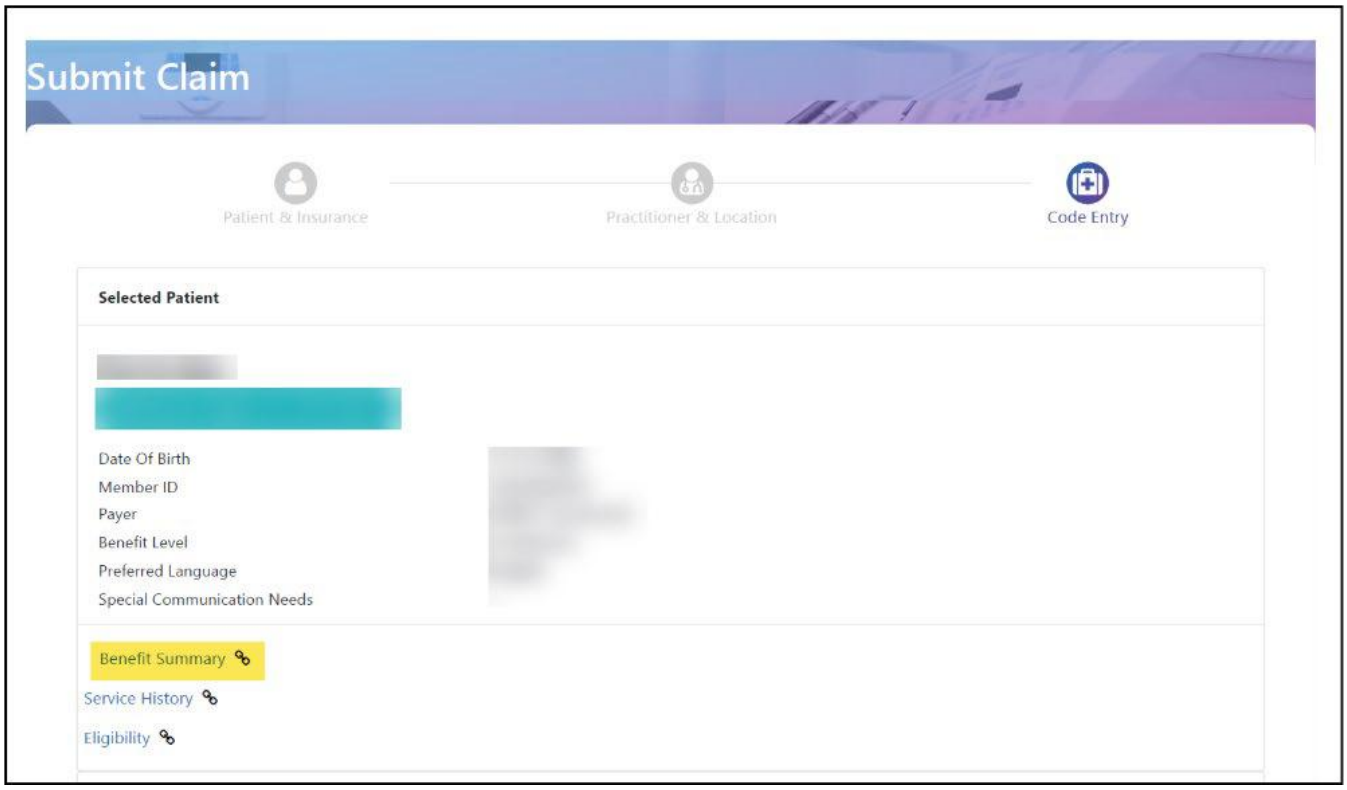
## Unspecified Procedure (D2999, D3999, D4999, D5899, D7999, D999)

Documentation required – Description of procedure and Narrative of Medical Necessity

# AmeriHealth Caritas VIP Care  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 | 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 | | |