Maryland Healthy Smiles Dental Program (MHSDP) Adult Dental Pilot
Frequently Asked Questions - Providers

Q: Who is the eligible population for this Pilot?
A: Adults ages 21-64 years old who are eligible for both Medicaid and Medicare, and who are not enrolled in an MCO.

Q: What if an eligible member of the Pilot becomes pregnant?
A: If a member of the Pilot becomes pregnant, she is eligible to receive services under the MHSDP benefit plan for pregnant women. Once the member gives birth, she will once more receive dental benefits under the Pilot program if she remains eligible.

Q: How will providers know about the Pilot's covered services and annual maximum benefit allowance?
A: (1) The Department sent Dental Transmittal No. 49 to all Medicaid enrolled dentists on May 1, 2019;
(2) SKYGEN USA has posted the provider training focused on the Pilot and how it works on the Provider Web Portal; and
(3) The MHSDP Provider Manual is being updated to include detailed information about the Pilot.

Q: What are the Program's rates for services covered by the Pilot?
A: The rates for services are on the Adult Dental Pilot Program Fee Schedule which will be included in the Provider Manual, Version 7 and posted on the Department's website and SKYGEN USA's Provider Web Portal. Reimbursement rates for the Pilot are consistent with the current Maryland Medicaid Dental Fee Schedule.

Q: Do providers need to get preauthorization for services rendered to members of the Pilot?
A: No preauthorization is needed for reimbursement of covered services.

Q: Which providers will be part of this network?
A: All general dentists and oral surgeons participating in the MHSDP are part of the Adult Dental Pilot's network. No additional enrollment or contracting activities will be required for the Pilot. General dentists and oral surgeons are encouraged to complete an adult dental survey, which can be found on SKYGEN USA's Provider Web Portal, indicating if they are willing to provide services to members eligible for the Adult Dental Pilot Program. Providers can also call Provider Services at 844-275-8753 to inform SKYGEN USA that they are willing to provide services to eligible members of the Pilot program. Providers can also specify how many members they are willing and able to treat.

Q: Do providers have to complete the adult dental survey on SKYGEN USA's Provider Web Portal in order to participate in the Adult Dental Pilot Program provider network?

A: No, providers do not have to complete the survey in order to treat members of the Adult Dental Pilot Program; however, providers must complete the survey or call SKYGEN USA's Provider Services' team at 844-275-8753 to receive dental home assignments for eligible members of the pilot.

Q: Will any additional credentialing or enrollment activities be required?

A: No additional credentialing or enrollment activities are required to participate in the Adult Dental Pilot Program provider network.

Q: Will providers need to do anything differently for the Pilot?

A: Yes, providers will need to do the following:

(1) When scheduling the appointment, the provider should verify the member's eligibility on SKYGEN USA's Provider Web Portal or by calling the Provider Services' team at 844-275-8753 and selecting **Option 1**;
(2) On the date of service, providers should call Provider Services' team at 844-275-8753 Monday thru Friday 7a.m. to 6 p.m. EST and select **Option 5** to verify that the member remains eligible for the Pilot and to confirm funds available in the member's annual benefit allowance; and
(3) Review and sign the member's global treatment plan outlining recommendations and costs for services.

Q: How will providers know that a member is eligible for the Adult Dental Pilot Program?

A: Providers must contact SKYGEN USA's Provider Services' team at 844-275-8753 and select **Option 1** to check the IVR to ensure that the member is eligible for services. Members eligible for the Adult Dental Pilot Program will be identified with the following message: **"Maryland Medicaid Medicare – Limited Dental $800 Maximum"**.

Q: What is a global treatment plan?

A: A global treatment plan is a document that details the dental services recommended by the provider and the costs for those services. The provider and member must review the recommended course of treatment and both parties must sign this form prior to services being rendered at each visit.

Q: Does a global treatment plan need to be submitted with every claim?

A: No, the global treatment does not need to be submitted with claims. Providers should give a copy of the signed plan to the member at each visit and keep a copy in the member's chart.

Q: Which claims are going to be paid first? First claims filed or first services performed?

A: Claims will be reimbursed in the order they are submitted to SKYGEN USA. Valid claims will be paid up to the $800 maximum benefit allowance for each member annually. For example, if there is only $25 remaining and the claim equals $50, then $25 will be reimbursed by Medicaid and the provider is able to charge the member for the remaining balance at the Medicaid rate, as long as the member signs a Non-Covered Service Agreement.

Q: How will claims be reimbursed for services rendered at a Federally Qualified Health Center (FQHC)?

A: FQHCs will be paid their cost-based rate for dental services rendered to eligible members of the Pilot. In instances where there is $1 or more remaining in a member's benefit allowance and at least one CDT code identified on the claim that is covered by the Pilot, the FQHC will be reimbursed its entire cost-based rate for the visit.

Q: What happens if a dentist performs service(s) and then finds out that the member's annual maximum benefit allowance has been reached? How will the claim be paid? Will the Department cover the financial overage?

A: Claims shall only be approved and reimbursed up to the $800 maximum benefit allowance. If a member signs a Non-Covered Service Agreement before additional services are rendered, the member will be responsible for the overage. If a Non-Covered Service Agreement is NOT signed, the provider will be responsible for the balance. MDH will not be responsible for any amounts not paid, beyond the annual maximum.

Q: When should a member sign a Non-Covered Services Agreement?

A: A Non-Covered Services Agreement should be completed and signed when the member has agreed to pay for a service out-of-pocket, after the provider has confirmed that the services to be rendered:

1) Exceed the member's $800 maximum benefit allowance; or
2) Are not included in the Pilot's benefit package.

Example: The member needs a four-surface restoration (D2335) which is reimbursed at $151 by Medicaid, but the member only has $100 remaining in their benefit allowance for the calendar year. The member should be given the opportunity to sign the Non-Covered Services Agreement agreeing to pay the remaining $51 out-of-pocket, if they would like for the service to be rendered.

Q: How will a dentist know what fee may be charged to a member after the maximum benefit allowance has been reached?

A: Once the member's maximum benefit allowance has been reached, the member can choose to pay out-of-pocket for additional services. Providers may not charge the member in excess of the Medicaid fee for any services covered under the Adult Dental Pilot's benefit plan. If the service needed is not a covered service under the Pilot, the dentist may charge the member up to their usual and customary charge for that service. Additional details can be found in SKYGEN USA's Provider Manual.

Q: Do providers need to request preauthorization and obtain a denial in order to charge members for service rendered?

A: Preauthorization is not required to charge the member for services rendered after their maximum benefit allowance is reached; however, the provider is required to have a signed Non-Covered Services Agreement on file in the member's chart.

Q: What if the member has a legal guardian or authorized representative?

A: Legal guardians and authorized representatives ae responsible for making arrangements to be available to discuss treatment and/or sign documents at each appointment, prior to dental services being rendered to the member.

Q: How will providers know when a new member has been assigned to them as a dental home?

A: Providers can visit SKYGEN USA's Provider Web Portal to view a roster of members assigned to them at any time, by following these steps after logging into the portal: (1) Click on *Report* at the top of the toolbar; (2) Click *Primary Care Assignments*; (3) Keep default at "All" for location and provider; and (4) Click *Print Report* to export to PDF or Excel.