



DEPARTMENT OF ECONOMIC SECURITY

Your Partner For A Stronger Arizona



Division of Aging and Adult Services
Arizona Refugee Resettlement Program
Refugee Medical Assistance Program (RMA)

Provider Manual

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Purpose of the Program

Arizona's Refugee Medical Assistance Program (RMA) is a federally funded program that provides payment for medical and dental care rendered to eligible refugees who have resettled in Arizona. RMA is not a health insurance program; rather, it is a temporary, time-limited benefit provided by the U.S. Department of Health and Human Services, Office of Refugee Resettlement, for those meeting eligibility requirements as determined in 45CFR §400.

RMA provides for the preventive, emergency, and health maintenance medical and dental services listed in the RMA guidelines for members. Medical and dental services that are immediate and crucial to stabilize the patient and allow him/her to function without major risk to his/her health will be covered. Elective services are not covered.

Any health care agency receiving federal assistance (AHCCCS, Medicare or RMA reimbursement) is required under Title VI, Civil Rights Act of 1964, 42 U.S.C. to provide interpretation and/or translation services as necessary for refugees requiring assistance due to Limited English Proficiency (LEP). ***It is the provider's responsibility to ensure refugee language needs are met.***

Arizona's Refugee Medical Assistance Program is administered by the Arizona Refugee Resettlement Program (RRP) within the Department of Economic Security in the Division of Aging and Adult Services. RRP is responsible for processing RMA applications, issuing RMA coverage cards to clients, and processing and paying claims.

RMA business hours are Monday through Friday from 8:00 AM to 5:00 PM excluding State and Federal holidays and State mandated furlough days. After hours, phone or email messages may be left to notify RMA of emergencies.

Eligibility

Refugees must meet specific eligibility requirements as determined by federal regulations to be eligible to receive services under this program. A refugee is a person who is outside their home country and unable or unwilling to return due to persecution or a well-founded fear of persecution based on their race, religion, nationality, membership in a social group or political opinion. The current eligible beneficiaries for RMA services are as follows:

A refugee or other eligible beneficiary pursuant to the Refugee Act of 1980, as amended, who is within the first eight months from their day of arrival into the United States. Eligible beneficiaries include the following:

- Refugees admitted under INA § 207
- Asylees granted asylum under INS § 208
- Cuban and Haitian Entrants as defined under 45 CFR § 401.2
- Certain Amerasians
- Adult Victims of Trafficking certified by the U.S. Department of Health and Human Services

(DHHS) and Minor Victims of Trafficking

- Special Immigrant Visa holders from Iraq and Afghanistan
- Children whose parents or parent (if a single headed household) are eligible beneficiaries and if that child is not eligible for Medicaid or any other federally funded health care coverage.
- Others as indicated by the Arizona Refugee Resettlement Program (RRP)

Per Federal Regulation 45 Subpart G, refugees may be eligible for RMA benefits up to eight (8) months from date of United States (U.S.) entry or grant of qualifying status as shown on the I-94 Departure Record or other documentation issued by the Department of Homeland Security. Due to the Coronavirus Disease 2019 pandemic (COVID-19) the Federal Office of Refugee Resettlement has extended the RMA eligibility and coverage period. For the current eligibility policy please reach out to the RRP office at (602) 542-6644. Refugees are encouraged to apply for RMA through their resettlement agency prior to services being provided. Refugees are issued an RMA health care coverage card within seven days of being enrolled in RMA. This health care coverage card includes RMA coverage start and end dates, pharmacy information, benefit ID number, and the address where claims need to be sent for processing and payment.

In addition to refugees, Unaccompanied Refugee Minors (URM) with Special Juvenile Immigrant Status (SJIS) are eligible for RMA coverage from the date of grant of qualifying status up until their 21st birthdays as long as they remain residents of the state of Arizona. To determine if a member is eligible for RMA coverage as an Unaccompanied Refugee Minor with SJIS, please contact the RMA office.

Provider Responsibility

RMA members may choose to obtain covered services from any public or private agency or health care institution in Arizona that is appropriately licensed or certified to deliver needed medical or optical services or is designated as a qualified vendor through the Arizona State Procurement System. A W-9 form is provided on the General Accounting Office website under the “Publications” and “Forms” tabs (<https://gao.az.gov/>). For emergencies, members may seek care from any licensed medical provider or facility. Any service provided outside of Arizona is limited to emergency medical care received en-route to Arizona during their initial resettlement period. Members travelling outside of Arizona for recreation or employment or those out-migrating to another state are not covered by RMA except in an emergency. It is the responsibility of the provider to verify that the person requesting services is eligible prior to rendering services. This can be done by verifying coverage on the RMA coverage card or calling the RMA office at (602) 542-6644.

Covered services for medical and dental care will be reimbursed by RMA based on the current State of Arizona AHCCCS fee schedules. **By delivering a service, the provider agrees to accept the reimbursement allowed in the AHCCCS fee schedule.** The current AHCCCS Physician Fee Schedule can be found here:

<https://www.azahcccs.gov/PlansProviders/RatesAndBilling/FFS/Physicianrates/FFSCodes.aspx?schedule=2019JanuaryPhysicianRates>

There are no client fees, co-payments, deductibles, or cost-shares associated with RMA coverage. Providers may not bill RMA members for the difference between AHCCCS rates and the providers' customary fees, may not collect co-pays, cost-shares, or deductibles from RMA members, and may not attempt to collect fees for services denied by RMA. In some cases, AHCCCS plans may require a co-payment for members. RMA cannot be used to cover such co-payments.

Please note that RMA is not affiliated with or a part of AHCCCS and is not a health insurance program. RMA is a temporary health benefit designed to assist refugees and other eligible beneficiaries who lose AHCCCS coverage due to increased income from employment within the first 8 month of arrival to the U.S. or grant of eligible status. Refugees resettling in Arizona who are eligible for AHCCCS benefits should be enrolled in AHCCCS with help provided by their Resettlement Agencies and should not be enrolled in RMA.

Providers' rights and obligations – By providing covered services to the eligible client, the provider is accorded all the rights and is bound by the obligations stated in this manual.

Authorized providers:

A **medical provider** must be licensed in accordance with A.R.S., Chapter 13 or 17, Title 32, and/or be a fellow of the appropriate American Specialty College or a member of an Osteopathic Specialty College.

A **pharmacist** must be licensed per A.R.S., Chapter 18, Title 32. All drugs shall be handled and labeled as prescribed by federal and state laws.

A **dentist and/or oral surgeon** must be licensed per ARS, Chapter 11, Title 32.

A **hospital** must be licensed by the Arizona Department of Health Services and may be accredited by the Joint Commission on Accreditation of Hospitals.

A **behavioral health** provider must be licensed by the appropriate State board.

Claims Submitted by Service Providers

Form	Used for
CMS 1500 form	Medical claims, including doctor, X-ray, laboratory services, and Optical services.
UB04 claim form	Hospital in-patient and out-patient claims
ADA Dental claim form	Dental services

For claims to be accepted they must include all of the following:

- Benefit ID number (e.g. RefXXXXXX)
- Member's name
- Member's date of birth
- Diagnosis code(s)
- Date of service
- Procedure code(s)
- Units, if applicable
- Charged amount
- Provider's Federal Employer Identification Number (EIN) or social security number (SSN)
- Provider name
- Provider address (where service provided)
- Patient account number
- Provider billing address, including city, state, and zip code
- Provider telephone number, including area code
- Prior-authorization number, if applicable

Claims must be submitted and received by RMA within 180 days of the date of service.

Claims received after 180 days will not be paid. Claims will normally be reviewed, processed, denied, or adjudicated and approved for payment by the RMA office within 30 days of the date of receipt of a clean, complete, and accurate claim. Payment will normally be rendered within ten business days of the claim adjudication date.

Payment will be remitted to the provider billing address as shown on the claim form by physical check. If a check is not received within 45 days of claim submission, please contact our office at (602) 542-6644.

Claims must be submitted with single dates of service (except for inpatient hospital claims) and contain complete and accurate information. Claims that are incomplete, illegible, inaccurate, or that contain multiple service dates will be returned to the provider.

Inpatient, hospital, and emergency department claims must be submitted with supporting documentation such as discharge instructions or progress notes, and a copy of any prior authorizations received by RMA. Please note that if the member is enrolled in AHCCCS or any other health insurance plan, RMA will deny the claim and require the primary plan be billed. At this time, RMA is unable to accept or process electronic claims; all claims should be mailed to the RMA office at:

RMA
Mail Drop 6287
PO Box 6123
Phoenix AZ 85005

Policy Guidelines for Covered / Non-Covered Services

General

Each service that is not routine must be prior-authorized following RMA procedures (see the Medical Prior-authorization and Dental Pretreatment Estimates Authorization sections of this manual). Routine services are defined as basic diagnostic evaluations and follow-up care provided in a physician's office associated with a non-surgical procedure, and that are considered immediate and crucial need. Any procedure or service provided to RMA eligible beneficiaries must demonstrate medical necessity.

Services must be rendered within the RMA eligibility period to be covered by RMA.

Motor vehicle accident claims will be paid only with a copy of the police report, the name and telephone number of the responsible party, and the insurance carrier(s). If an attorney is retained, his/her name and telephone number are required. RMA will instruct the member to obtain this information.

Covered Services

Preventive Health Services

Domestic Medical Examination for Newly Arriving Refugees (DME) – Newly arrived refugees will receive a Centers for Disease Control and Prevention (CDC) - recommended preventive health examination within 30 to 60 days of arrival to the United States. Preventive Health services are provided only through the Maricopa County Department of Public Health in Maricopa County (MCDPH) or the Banner University Medical Center in Pima County and will not be covered if performed by other providers unless authorized by RMA. DME services include the following:

- History and physical examination
 - Nutrition and growth
 - Pregnancy test
 - Immunizations
- Mental health screening
- General laboratory testing
 - Complete blood count
 - Urinalysis
 - Glucose and serum chemistries (optional)
 - Infant metabolic screening for newborns
- Disease-specific laboratory testing
 - Tuberculosis
 - Lead testing
 - Malaria
 - Sexually transmitted diseases

- HIV
- Syphilis
- Chlamydia
- Gonorrhea

Public Health Concerns

Services and treatment for tuberculosis, Hansen's disease, and sexually transmitted diseases will only be covered when provided by the appropriate county Public Health Department. In some cases, treatment by other providers may be covered at the request of the health department and with prior authorization.

Office Visit and Physical Examination

The following examinations and tests are covered and do not require prior authorization:

- A complete physical examination
- Routine women's health examinations to include history and physical examination, pelvic and breast examination, papanicolaou smear, and laboratory tests
- Routine office visits
- Mental health, physical development, and dental screenings
- Vision and hearing tests

Immunizations

Immunizations for children under the age of 21 years who are eligible for vaccines through the Vaccines For Children (VFC) program will not be paid for by RMA. RMA will only reimburse for vaccines that are required for immigration by the CDC. Procedure codes 90471 and 90472, pertaining to administration fees for immunizations, are not covered and will not be reimbursed. One dose of each immunization per date of service will be covered. RMA does not currently cover the following vaccines:

- Zostavax (Zoster)
- Pneumovax (Pneumococcal)
- Gardasil (HPV) will only be covered for members between 18 and 26 years, as per CDC recommendations, and only if provided through a primary care provider (PCP) office.

Pharmacy

OptumRx is RMA's pharmacy benefits manager. Any pharmacy in Arizona able to accept RMA can be used. Prescriptions for more than a 30-day supply must be prior authorized. RMA will cover a diabetic glucometer one time only, and diabetic supplies such as insulin, lancets, syringes, and test-strips are covered when accompanied by a prescription and with authorization. Generic prescriptions should be used in place of name brands whenever possible. Medications used in the treatment of active or latent tuberculosis are not covered. Except for prenatal vitamins used during pregnancy and head-lice treatments, over-the-counter drugs are not covered, even if accompanied by a prescription.

Clinical Laboratory Services

Screening laboratory tests such as complete blood count, cholesterol, urinalysis, pregnancy test, routine metabolic panels and liver / kidney panels are covered without prior authorization if the services provided are ordered by a physician, dentist or podiatrist within the scope of his/her practice and are medically necessary. All labs submitted for payment will be reviewed based upon the ICD-9 diagnosis codes. Additional documentation may be requested by the RMA office prior to payment being rendered.

Radiology Services

Basic, routine radiology services, such as chest or abdominal x-rays, extremity x-rays, and screening mammograms are covered without prior authorization. CT scans, Magnetic Resonance Imaging (MRI) exams, ultrasounds, echocardiograms, PET scans, nuclear medicine studies, and/or any non-routine procedures are covered only with prior authorization and must be medically necessary. Dexiscans are not covered. RMA reserves the right to request medical justification for any radiology services requested prior to payment. All non-routine radiological studies must be prior authorized before scheduling.

Hospital Emergency Room Services

Patients directly admitted to the hospital through the emergency room will be covered if the refugee is eligible for RMA on the date of service. All emergency room claims must be accompanied by a discharge summary or other medical justification.

Urgent Care Services

Urgent care services are covered for acute illnesses and / or conditions that cannot wait for a scheduled appointment. All urgent care claims must be submitted with supporting documentation to show medical necessity.

Hospital In-Patient Services

Hospital in-patient services are covered when the hospital admission is deemed medically necessary and is ordered by the patient's physician. Claims for in-patient hospital service will not be processed for reimbursement until a discharge summary has been received by the RMA office. All claims must be detailed and fully itemized. Services and supplies such as guest meals and accommodations, televisions, telephone, admission kit, and personal care items are not covered unless directly related to the care of the patient. Private rooms are not covered unless required to isolate a contagious disease. Hospitalization for tuberculosis is not covered. Skilled nursing facility or long-term care services must be prior-authorized. Emergency Medical Hospitalization < 72 hours do not require prior authorization.

Maternity/OB Services

Prenatal care does not require pre-authorization.

Surgery

All non-emergency surgical procedures must be prior-authorized before scheduling, and procedures performed without prior-authorization will be denied payment. The provider will be paid for surgical procedures based on the AHCCCS fee schedule. If a procedure is modified

after prior authorization, it will be reviewed to determine reimbursement. Assistant surgeon services will be reimbursed if the surgery has been prior-authorized. Anesthesiology services will be paid for prior-authorized procedures.

Emergency surgeries will be covered. The hospital must contact the RMA as soon as possible and no later than the following business day to verify eligibility and to give notification of the emergency procedures. Non–Surgical Procedures, e.g., PICC Line/Central Line removal or placement, PEG removal, Blood Transfusions do not require pre-authorization.

Ambulatory (Outpatient) Surgical Procedures

All ambulatory surgical procedures must be prior authorized, and authorization must be obtained prior to the procedure being scheduled. Claims for reimbursement for ambulatory surgery services must be accompanied by a discharge summary to be considered for payment.

Abortion

Abortion services are covered only when the life of the mother is in danger or the pregnancy is the result of rape or incest and when the procedure is in accordance with the federal laws governing funding of abortions. The provider must first receive prior authorization from RMA unless there is a medical emergency.

Circumcision

The CDC has determined that there is no medical basis for circumcision, therefore circumcisions are not covered.

Family Planning Services

Family planning services performed under the supervision of a licensed health care provider in his/her office or in a family planning agency are covered. Contraceptive methods requiring a prescription, such as depo-provera, oral contraceptives, diaphragms, intra-uterine devices, and vaginal rings are covered. Over the counter birth control methods such as condoms and contraceptive foams, gels and suppositories will not be covered. Infertility treatments are not covered. Reproductive sterilization procedures, such as vasectomy and tubal ligation, are not covered.

Specialty Medical Services

Specialty medical services such as orthopedics, cardiology, neurology, etc., are covered when referred by a primary care provider due to medical necessity. Prior authorization is not required for the initial office visit by the specialist, however any treatments or procedures performed by the specialty clinic must be prior authorized.

Behavioral Health Services

Counseling and psychiatric clinical services and medications are covered by RMA. Inpatient services are covered with prior authorization. Emergency Admission to Behavioral Health Level 1 Inpatient facility requires RMA notification within 72 hours from admission and concurrent review every seven days.

Physical Therapy Services

Physical therapy services are covered with prior-authorization. Physical therapy is not covered for the following: pulled muscles or backs, palliative therapy such as application of heat or ice, massage, routine calisthenics, assistance in any activity, or use of a simple device not requiring the skill of a qualified physical therapist.

Occupational Therapy Services

Occupational therapy services are covered with prior-authorization.

Podiatry Services

Treatment for foot conditions such as fungal or other infections of the feet or toenails will be covered when prior authorized and provided by a licensed podiatrist. Routine foot care, such as trimming of toenails and other hygiene or other preventive maintenance is not covered.

Home Health Services

Home health services are covered when provided by a home health agency certified under Title XVIII of the Social Security Act (Medicare). Home health services are also covered when provided by a registered nurse or a licensed practical nurse in an area that does not have a certified Title XVIII home health agency. Home health services are limited to eligible adult members who are homebound and must be prior-authorized. "Homebound" means the person is essentially confined to place of residence due to illness, injury, or a condition and, if ambulatory or otherwise mobile, is unable to be absent from the place of residence except on an infrequent basis for short periods, e.g. for short walks prescribed for therapeutic exercise.

Durable Medical Equipment

Medical equipment including wheelchairs, nebulizers, orthopedic braces, prosthetics, and orthotics must be prior-authorized. Prosthetic or orthotic devices will only be covered if needed for conditions caused by illness, injury, or birth defects.

Chemotherapy Services

Medical services and supplies related to chemotherapy and/or cancer care must be prior-authorized.

Hearing Aids

Hearing aids including cochlear implants are covered if immediate and crucial need is established. They must be prior-authorized and provided by a licensed hearing aid dispenser.

Emergency Transportation

Transportation by means of ambulance, air-ambulance or wheelchair equipped vehicles will be reimbursed only when certified by the attending physician as an emergency. All claims for transportation services not considered an emergency will be denied. Routine transportation services such as bus, light-rail, taxicab, or shuttle service are not covered.

Medical Cosmetic Services

Cosmetic services are generally not covered. This includes acne treatment and medication,

except in extreme cases or when appearance limits employability. Any cosmetic service determined to be medically necessary must be prior authorized.

Allergy/Immunology Testing

Allergy and immunology testing is only covered when immediate medical need can be demonstrated, and prior authorization obtained.

Organ Transplants

Organ transplants are covered in accordance with current AHCCCS and Medicaid policy and when prior authorized.

Research Studies

Out-patient services provided in connection with research and / or training are not covered.

Eye Care Services

Eye care services are covered on a limited basis. Covered services include eye examinations to detect the presence or absence of ocular abnormality or visual disability, glaucoma screening, and pupil dilation. Eyeglasses are covered and may be prescribed, if needed, by an ophthalmologist, optometrist, or dispensing optician. Members are limited to one (1) eye examination and one (1) pair of eyeglasses during their RMA eligibility period. Eyeglasses will be reimbursed based on the AHCCCS approved reimbursement rate for frames and lenses. Contact lenses are covered only if, for medical reasons, the client cannot tolerate eyeglasses and requires prior authorization. RMA reimbursement cannot be adjusted to cover the additional cost of polycarbonate or other special lenses, tinted or scratch resistant coatings, special or designer frames or other enhancements. If the patient requests features in addition to those covered by RMA, the patient will be responsible for payment for the additions. The additional costs and the responsibility for payment must be explained in a language clearly understood by the patient.

Ophthalmology Services

Ophthalmology services are covered when the client is referred to an ophthalmologist office by a primary care provider or an optometry office, and prior authorization is not required for an initial office visit. Treatments or procedures performed by the ophthalmologist office must be prior authorized. LASIK procedures are not covered.

Dental Services

RMA provides limited dental services to members age 20 and older, and members under the age of 20 who are not covered by an AHCCCS dental plan.

RMA covers the following dental services provided by a licensed dental provider for members who are 21 years or older:

1. Emergency dental services up to \$1,000 per member per contract year. The emergency dental services are as specified in this manual.
2. Medical and surgical services furnished by a dentist only to the extent such services may

be performed under state law either by a physician or by a dentist and such services would be considered a physical service.

RMA dental services are reimbursed based on an AHCCCS approved fee schedule. RMA members are authorized for emergency dental services up to \$1000 per member per contract year for the duration of their eligibility period. Members are permitted to receive services from one (1) dental office for the duration of their eligibility period. Members are generally not permitted to change dental providers during eligibility except under extenuating circumstances, and all changes must be approved by the RMA Dental Consultant or a refugee health representative at the Arizona Refugee Resettlement Program. Claims submitted for members who have already seen another dental office will not be paid. It is the dental provider's responsibility to establish eligibility and to verify if the member is already established with another dental office.

Adult routine dental services are not covered for members 21 years of age or older. RMA covers medical and surgical services related to dental (oral) care only. Covered dental services for members 21 years of age and older must be related to the treatment of a medical condition such as acute pain, infection, or fracture of the jaw with the exception of RMA eligible clients in the Refugee Unaccompanied Minor Program, who may receive cleanings two (2) times per year for as long as they remain covered by the program.

Prior authorization must be obtained for all services except examinations, radiographs, and cleanings. Mounted full mouth X-ray (FMX) films are to be included with all submitted dental pre-treatment estimates (PTEs). All FMX digital X-rays must be able to be clearly interpreted and be submitted on glossy paper. Dental offices are also required to annotate all missing teeth on the PTE. PTEs received without required, mounted radiographs or other required documentation will be returned to the provider without being reviewed by the RMA dentist consultant. All approved services are issued a prior authorization number, which must accompany all claims in order to be considered for payment.

Emergency dental and dental services for members < 21 years old do not require prior authorization.

Emergency service is limited to simple extractions and palliative treatment and must be authorized by telephone. If the emergency occurs after normal office hours, leave a message at 602-542-6644, or outside Maricopa County at 866-228-1662 and RMA will return your call no later than the following business day. Remember to include the client's name, member identification number, tooth number, your telephone number and fax number. If the situation meets RMA emergency criteria, you will be issued an emergency authorization that will either be faxed to your office or provided over the phone. A copy of the emergency authorization must be included when submitting for payment.

The following routine services, when provided by a licensed dentist, are covered without prior authorization:

- X-ray procedures necessary for diagnosis of dental abnormalities are covered. RMA covers the following dental x-ray options: Either one Panorex X-ray and bitewing x-rays (4 films) or complete intraoral series, but not both. Supplemental bitewings or periapical x-rays, unless requested by the RMAP dental consultant, will not be reimbursed. All dental X-rays must be mounted or, in the case of digital x-rays, submitted on glossy paper.
- Panorex x-rays are covered only once during the client's RMAP eligibility period.
- Treatment of injuries to the teeth or supporting structures or treatment necessary to control bleeding.

All other dental services allowable under RMA require prior authorization and must be submitted as a pre-treatment estimate (PTE) by the requesting provider and accompanied by supporting x-rays as noted above. All PTEs will be reviewed by the RMA dental consultant for appropriateness and "immediate and crucial need." RMA reserves the right to request a second opinion on any PTE as deemed necessary by the dental consultant. Providers may be requested to submit post-procedure x-rays on any work completed at the discretion of the dental consultant prior to payment being remitted.

Please note that RMA does not allow reimbursement for treatment of incipient decay or stain and wear. All decay must be clearly visible on supporting x-rays.

The PTE, including all supporting X-rays, and any other dental documentation, should be mailed to:

RMA
Mail Drop 6287
PO Box 6123
Phoenix AZ 85005

RMA eligibility cannot, under any circumstances, be extended to accommodate treatment plans that cannot be completed by the termination date of coverage. Treatment plans or claims for services provided that extend beyond the members' eligibility period will be denied. It is the provider's responsibility to determine client eligibility for services provided.

A complete and current list of covered services and the dental reimbursement fee schedule is included at the end of this provider manual. Additional information regarding RMA dental services is available by calling 602-542-6644 or 866-228-1662 outside of Maricopa County.

Denied Claims

RMA may deny claims for reimbursement for a variety of reasons, which may include the following:

- Claims submitted more than 180 days after the date of service without documentation of proof of timely filing.
- Submission of claim for services provided without prior authorization, as required.
- Claim form incomplete or improperly filled out.

- Services provided outside of the RMA eligibility period or client is not an RMA beneficiary.
- Client was determined to be eligible for an AHCCCS plan or another insurance carrier on date of service.
- Claim is for a service not covered by RMA.
- Additional information, such as emergency department records, discharge summary, or medical justification, is required.

All denied and returned claims will be accompanied by a denial letter explaining the reason for the denial. Further information may be obtained on any denied claim or service by contacting the RMA office.

Medical Prior-Authorization Procedure

Any non-routine medical service must be prior authorized by RMA. If submitted without prior authorization, claims for such services will be denied. A copy of our prior authorization form may be obtained by contacting the RMA office at (602) 542-6644 or for individuals calling from out of state, contact +1-866-228-1662.

All completed prior authorization requests must be accompanied by full supporting documentation of immediate and crucial need for each procedure. Routine prior authorization requests may be sent in a secure email to blyle@azdes.gov and all requests will be reviewed by the RMA physician contractor within two (2) business days of receipt. In the event the RMA medical contractor is not available, urgent and/or emergency authorizations may be approved by the Refugee Health Coordinator at (480) 276-5211 during normal business hours. After hour emergencies do not require prior authorization, however claims must be submitted with supporting documentation of emergent need. RMA may ask for additional information or a second opinion on any request for prior authorization. The provider will be contacted by RMA staff if this is required.

If the request is approved, a prior authorization number will be issued and covers only the authorized procedure(s), including facility and/or anesthesiology fees. Approved or denied prior authorizations will be faxed to the provider. Prior authorized procedures must be completed within 90 days of approval, unless the patient's RMA coverage expires sooner, in which case the procedure must be completed before expiration of coverage. If the procedure(s) are not completed within this period and the prior authorization expires, the procedure(s) will not be covered without RMA approval of a new request. All claims for prior authorized services must cite the RMA prior authorization number. A copy of the RMA authorization should also be attached to the submitted claim.

Second Opinions

The RMA medical contractor may require a second opinion on any request for prior authorization of treatment. The member and his/her sponsoring resettlement agency will be informed of the determination that a second opinion is necessary. The member then has thirty (30) days to see a different provider for an evaluation.

Upon receipt of the second treatment plan, RMA will determine which treatment will be more beneficial to the client within the limits of immediate and crucial need. The member, resettlement agency, and approved provider will be informed of the decision.

Appeal Process

A provider has the right to appeal a claim for reimbursement that has been denied by RMA within six (6) months of the original date of service. A letter of appeal should explain why, in the provider's opinion, the denied service falls within RMA's designated limits of immediate and crucial need, without which the member would be unable to function without major risk to health. If the denied service is associated with services prior-authorized by RMA, a copy of the prior authorization form must be attached. All appeals will be reviewed by the Deputy State Refugee Coordinator within ten business days of receipt. Appeals may be sent by mail or email to:

RMA
Mail Drop 6287
PO Box 6123
Phoenix AZ 85005
blyle@azdes.gov

Dental Pre-Treatment Estimate (PTE) Procedure

All dental procedures, other than initial consultation and routine care, must be prior-authorized. If further treatment is determined to be necessary, the provider must submit a pre-treatment estimate (PTE) for prior authorization. Applicable mounted full mouth x-rays should be included with all PTE requests via email.

The RMA dental consultant will review the PTE for approval or denial within three (3) working days of receipt. If clarification or further documentation, such as additional x-rays, is required, the PTE will be returned to the provider for completion. Urgent or emergency requests may be reviewed by a health representative at the Arizona Refugee Resettlement Program. Approved PTE's will be returned to the provider along with all original X-rays and the RMA authorization form.

All approved dental work must be completed within the patient's RMA eligibility period. It is the provider's responsibility to ensure that the treatment is concluded before coverage expires. Claims for procedures performed after the expiration of coverage will be denied.

A copy of the approved PTE must accompany all claims for reimbursement for authorized treatments. RMA reserves the right to request post-procedure x-rays to support completed treatments prior to payment.

Second Opinions

The RMA dental consultant may request a second opinion on any dental PTE, and such requests will be made directly to the refugee and his/her resettlement agency.

The RMA medical consultant may require a second opinion on any request for prior-authorization of treatment. The refugee and his/her sponsoring resettlement agency will be informed of the determination that a second opinion is necessary. The refugee then has thirty (30) days to see a different provider for an evaluation.

Upon receipt of the second treatment plan, RMA will determine which treatment will be more beneficial to the client within the limits of immediate and crucial need. The refugee resettlement agency, and approved provider will be informed of the decision.

Appeal Process

A provider has the right to appeal a claim for reimbursement that has been denied by RMA within six (6) months of the original date of service. A letter of appeal should explain why, in the provider's opinion, the denied service falls within RMA's designated limits of immediate and crucial need, without which the member would be unable to function without major risk to health. If the denied service is associated with services prior-authorized by RMA, a copy of the prior authorization form must be attached. All appeals will be reviewed by the Deputy State Refugee Coordinator of Arizona Refugee Resettlement Program within 10 business days of receipt. Appeals may be sent by mail or emailed to:

RMA Appeals
P.O. Box 6123, Mail Drop 6287
Phoenix, AZ 85005
blyle@azdes.gov

Provider Enrollment Process

RMA is not a health insurance program, not a public benefit. Providers participating in RMA must register and follow the application and Arizona procurement as found on Procure AZ. Provider offices must complete and submit an AZ Substitute W-9 and Vendor Authorization Form and submit copies of facility and provider licenses, as applicable, to receive payment for services rendered through RMA. Licenses and Substitute W-9 may be submitted by email to blyle@azdes.gov. RMA staff may request an on-site visit to the participating facility prior to approving enrollment.

RMAP Dental Fee Schedule*

*Note: Any CDT not appearing in this fee schedule is not a covered service and will not be reimbursed. This fee schedule is effective as of October 1, 2020.

CDT Code	Description	Maximum Fee
DIAGNOSTIC		
Clinical, Oral Evaluation		
0150	Comprehensive Oral Evaluation	46.28
Radiography**		
0210	Intraoral, complete series (with bitewings)	72.29
0220	Intraoral, single, first	14.88
0230	Intraoral, each additional	12.23
0270	Bitewing, single film	12.38
0272	Bitewings, two films	23.90
0274	Bitewings, four films	34.28
0330	Panorex film	61.90
** RMAP covers the following dental x-ray options: Either one Panorex X-ray and bitewing x-rays (4 films) or complete intraoral series, but not both. Supplemental bitewings or periapical x-rays, unless requested by the RMAP dental consultant, will not be reimbursed.		
PREVENTIVE		
Dental Prophylaxis		
1110	Adult dental prophylaxis	54.36
1120	Child prophylaxis (up to age 13 years)	44.44
1351	Sealant, per tooth***	29.70
*** Fluoride treatments and sealants are only covered for clients age 18 years and younger on permanent teeth that have erupted in the previous 12 months based on standard eruption schedules. Sealants must be prior-authorized.		
Dental services to children under age 20 years is limited to those who are not eligible for dental services under an AHCCCS plan.		
Space Maintainers		
1510	Fixed, unilateral	169.83
1520	Removable, unilateral	154.06
RESTORATIVE		
Amalgam Restorations		
2140	Amalgam, one surface, permanent/primary	71.62
2150	Amalgam, two surfaces, permanent/primary	88.10
2160	Amalgam, three surfaces, permanent/primary	102.10
2161	Amalgam, four or more surfaces, permanent/primary	122.06

Resin Restorations

2330	Resin, one surface, anterior	84.08
2331	Resin, two surfaces, anterior	105.33
2332	Resin, three or more surfaces, anterior	126.80
2391	Resin, one surface, posterior	80.90
2392	Resin, two surfaces, posterior	97.72
2393	Resin, three or more surfaces, posterior	118.15

Crowns, Single Restoration Only (Minors through age 18 years)

2920	Re-cement crown	47.00
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Other Restorative Services

2950	Core build-up with pin	131.38
2954	Prefab post and core, in addition to crown	142.78

ENDODONTICS/PULP THERAPY

Root Canal Therapy is covered on all teeth except third (3rd) molars in minors through the age of 20 who are not covered by AHCCCS. Root Canal Therapy includes treatment plan, clinical procedures, necessary X-rays and follow up.

Adult (age 21 and older) root canals are limited to the six (6) anterior teeth upper and lower. No exceptions allowed.

A completed final X-ray for root canal treatment must show post in place in order for payment to be made.

Endodontics

3220	Therapeutic pulpotomy	90.37
3310	Root canal, anterior (adult and minor)	372.58
3320	Root canal, bicuspid (minor only)	442.47
3330	Root canal, molar (minor only)	546.14
3346	Retreatment, anterior (adult and minor)	454.94
3347	Retreatment, bicuspid (minor only)	494.36
3348	Retreatment, molar (minor only)	587.18

Periodontics

4355****	Full mouth debridement	81.43
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**** Criteria for full mouth debridement: posterior radiograph or digital photos must show posterior calculus in at least two (2) quadrants.

Prosthodontics*

5110	Complete upper	792.33
5120	Complete lower	796.21

5130	Immediate upper	867.26
5140	Immediate lower	865.93
5211	Upper partial-resin base	667.72
5212	Lower partial-resin base	668.27
5410	Adjust complete denture, upper	41.38
5411	Adjust complete denture, lower	41.38
5421	Adjust partial denture, upper	41.38
5422	Adjust partial denture, lower	41.38
5520	Replace missing/broken teeth, complete denture, per tooth (up to two teeth)	87.14
5630	Repair or replace broken clasp	89.95
5640	Replace broken tooth, per tooth (up to three teeth)	86.18
5650	Add tooth to existing partial denture (up to three teeth)	101.81
5660	Add clasp to existing partial denture (up to two clasps)	127.50
5820	Interim partial denture (maxillary)	351.50
5821	Interim partial denture (mandibular)	351.50

* If partial dentures are recommended, they must be deemed essential for function. As a standard, it may be considered that eight (8) posterior teeth in occlusion (four [4] maxillary and four [4] mandibular teeth in functional contact with each other) will be considered adequate for functional purposes. You may ask for both an upper and lower partial denture, but if one establishes the eight (8) tooth requirement the other unit may be denied. Please Note: a more flexible program to allow partial dentures is intended, as a result of the new adult endodontic protocol. A denture may be denied for replacement if it is not broken beyond repair. Age may not be considered as a factor for replacement.

ORAL SURGERY**

** All extractions will be considered a Code 7140 (see CDT) if upon X-ray review the tooth does not appear to require a flap for removal. Code 7210 (see CDT) will be allowed if the obvious need is shown on the X-ray for cutting and a flap. All other surgical extractions will apply as noted below. All extractions submitted for payment must be accompanied by a post-extraction x-ray.

As noted previously, only a routine extraction (Code 7140) will be allowed as a telephone authorized emergency procedure.

Extractions

7111	Extraction, coronal remnants	60.19
7140	Extraction, erupted tooth or exposed root	87.59

Surgical Extractions

7210	Surgical removal of erupted tooth	133.09
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7220	Removal of impacted tooth, soft tissue	157.55
7230	Removal of impacted tooth, partially bony	199.33
7240	Removal of impacted tooth, completely bony	233.39
7241	Removal of impacted tooth, completely bony with unusual factors	299.88
7250	Surgical removal of residual tooth roots	136.44

EMERGENCY AND PALLIATIVE TREATMENT***

Emergency Treatment

9110	Palliative emergency treatment of dental pain	61.62
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*** Palliative treatment performed in connection with a root canal is included in the allowed fee.

UNACCOMPANIED REFUGEE MINORS RMA SERVICES

Unaccompanied Refugee Minors (URM) are children age 20 years and younger who are certified by the federal Office of Refugee Resettlement as eligible for URM services and are under the care, custody, and control of Catholic Charities Community Services URM Program. Some URM children are eligible for RMA benefits until their 21st birthdays. This will be reflected in their RMA benefits card. RMA eligible children will be identified as such by their guardian when seeking dental care and are eligible for dental services beyond the usual eight (8) month RMA eligibility period. For specific information regarding the URM program and covered services, please contact the RMA office.

Crowns

2930	Prefab stainless steel crown, primary	139.38
2931	Prefab stainless steel crown, permanent	152.45
2932	Prefab resin crown	137.51

Orthodontics*

8070	Comprehensive treatment of transitional dentition	2655.95
8080	Comprehensive treatment of adolescent dentition	2864.43
8090	Comprehensive treatment of adult dentition	2966.44
8660	Initial orthodontic records, casts, treatment plans, consultation	46.58

* Only RMA members who are in the Unaccompanied Refugee Minors Program are eligible for orthodontic services. CDT 8660 will only be reimbursed if orthodontic work is not done. If the patient receives comprehensive orthodontic treatment, this cost will be included as part of the package.

Additional information regarding the fee schedule can be obtained by calling 602-542-6644, or outside Maricopa County 866-228-1662.

In accordance with the Families First Act the following changes have been made until further notice:

RMA will cover COVID-19 testing and treatment for all RMA-covered individuals. Prior Authorizations are not required for these services.

RMA will permit providers located out of state to offer emergency and non-emergency care to RMA enrollees.

Requirements that Physicians and other healthcare professionals be licensed in AZ has been waived, to the extent consistent with state law.

Equal Opportunity Employer/Program • Auxiliary aids and services are available upon request to individuals with disabilities.

This document is available in alternative formats by contacting (602) 542-6644.

For individuals calling from out of state, contact +1-866-228-1662 USA Toll Free.