310-D1 EMERGENCY DENTAL SERVICES FOR MEMBERS 21 YEARS OF AGE AND OLDER

EFFECTIVE DATE: July 19, 2023
REFERENCES: A.R.S. § 32-1207 and 32-1231; AMPM 310-D1

PURPOSE

This policy establishes requirements for the provision of medically necessary dental services for Members of the Division of Developmental Disabilities (Division) who are age 21 and older.

DEFINITIONS

1. "Dental Emergency" means an acute disorder of oral health resulting in severe pain or infection due to pathology or trauma.
2. "Dental Provider" means an individual licensed under A.R.S. Title 32, Chapter 11, whose scope of practice allows the individual to:
    a. Independently engage in the practice of dentistry as defined in A.R.S. §32-1202,
    b. A dentist as defined in A.R.S. §32-1201,
    c. A dental therapist as defined in A.R.S. §32-1201,
    d. A dental hygienist as defined in A.R.S. §32-1201,

e. An affiliated practice dental hygienist as defined in A.R.S. §32-1201.

3. "Informed Consent" means a process by which the provider advises the Responsible Person of the diagnosis, proposed treatment and alternate treatment methods with associated risks and benefits of each, as well as the associated risks and benefits of not receiving treatment.
4. "Member" means the same as "Client" as defined in A.R.S. § 36-551.
5. "Physician Service" means medical assessment, treatments, and surgical services provided by licensed allopathic or osteopathic physicians within the scope of practice.
6. "Responsible Person" means the parent or guardian of a minor with a developmental disability, the guardian of an adult with a developmental disability, or an adult with a developmental disability who is a member or an applicant for whom no guardian has been appointed.
7. "Simple Restoration" means silver amalgam or composite resin fillings, stainless steel crowns or preformed crowns.

POLICY

A. GENERAL COVERED DENTAL SERVICES

1. The Division shall require the following dental services are covered and provided by a licensed Dental Provider for Members who are 21 years of age or older:
    a. Emergency dental services up to $1,000 per Member per contract year (October 1st to September 30th) as specified in A.R.S. § 36-2907.
    b. Medical and surgical services furnished by a Dental Provider when:
        i. The services may be performed under state law either by a physician or by a Dental Provider, and
        ii. The services would be considered a Physician Service if furnished by a physician.
2. The Division shall ensure emergency services relate to treatment of the following medical conditions:
    a. Acute pain,
    b. Infection, or
    c. Fracture of the jaw.

3. The Division shall ensure the following emergency services, which are not subject to the $1,000 adult emergency dental limit, are covered:
    a. Limited problem focused examination of the oral cavity,
    b. Required radiographs,
    c. Complex oral surgical procedures such as treatment of maxillofacial fractures,
    d. Administration of an appropriate anesthesia, and
    e. Prescription of pain medication and antibiotics.
4. The Division shall not cover the diagnosis and treatment of Temporomandibular Joint Dysfunction (TMJ) except for reduction of trauma. This item is not subject to the $1,000 adult emergency dental limit.
5. The Division shall ensure the following limited dental services, which are not subject to the $1,000 adult emergency dental limit, are covered for Members needing medically necessary dental services as a prerequisite to Division-covered organ or tissue transplantation:

a. Elimination of oral infections and the treatment of oral disease, which include:

i. Dental cleanings,

ii. Treatment of periodontal disease,

iii. Medically necessary extractions, and

iv. Provision of Simple Restorations.

6. The Division shall ensure services outlined in subsection (5) of this section are covered only after a transplant evaluation determines that the Member is an appropriate candidate for organ or tissue transplantation.

7. The Division shall ensure prophylactic extraction of teeth are covered in preparation for radiation treatment of cancer of the jaw, neck or head. This item is not subject to the $1,000 adult emergency dental limit.

8. The Division shall ensure cleanings for Members who are in an inpatient hospital setting and experiencing the following are covered:

a. Placed on a ventilator, or

b. Physically unable to perform oral hygiene.

B. EMERGENCY DENTAL SERVICES COVERAGE FOR PERSONS AGE 21 AND OLDER

1. The Division shall ensure medically necessary emergency dental care and extractions are covered for persons aged 21 years and older who meet the criteria for a Dental Emergency.
2. The Division shall ensure the following services and procedures are covered as emergency dental services:
    a. Emergency oral diagnostic examination;
    b. Radiographs and laboratory services, limited to the symptomatic teeth;
    c. Composite resin due to recent tooth fracture for anterior teeth;
    d. Prefabricated crowns, to eliminate pain due to recent tooth fracture only;
    e. Recementation of clinically sound inlays, onlays, crowns, and fixed bridges;
    f. Pulp cap, direct or indirect plus filling;
    g. Root canals and vital pulpotomies when indicated for the treatment of acute infection or to eliminate pain;

h. Apicoectomy performed as a separate procedure, for treatment of acute infection or to eliminate pain, with favorable prognosis;

i. Immediate and palliative procedures, including extractions if medically necessary, for relief of pain associated with an oral or maxillofacial condition;

j. Tooth reimplantation of accidentally avulsed or displaced anterior tooth, with favorable prognosis;

k. Temporary restoration which provides palliative/sedative care limited to the tooth receiving emergency treatment;

l. Initial treatment for acute infection, including:

   i. Periapical and periodontal infections, and

   ii. Abscesses by appropriate methods.

m. Preoperative procedures and anesthesia appropriate for optimal patient management; and

n. Cast crowns limited to the restoration of root canal treated teeth only.

3. The Division shall ensure follow-up procedures needed to stabilize teeth due the emergency services are covered, and subject to the $1,000 limit.

C. ADULT EMERGENCY DENTAL SERVICES LIMITATIONS FOR PERSONS AGE 21 YEARS AND OLDER

1. The Division shall not cover the following adult dental services:
    a. Maxillofacial dental services provided by a Dental Provider, except to the extent prescribed for the reduction of trauma, including reconstruction of regions of the maxilla and mandible;
    b. Diagnosis and treatment of temporomandibular joint dysfunction, except for the reduction of trauma;
    c. Routine restorative procedures and routine root canal therapy;
    d. Treatment for the prevention of pulpal death and imminent tooth loss, except for:
        1. Non-cast fillings,
        2. Crowns constructed from pre-formed stainless steel,
        3. Pulp caps, and

4. Root canals and vital pulpotomies when indicated for the treatment of acute infection or to eliminate pain.

e. Fixed bridgework to replace missing teeth; and

f. Dentures.

D. DIVISION AND FFS PROGRAM RESPONSIBILITIES

1. The Division shall require the AdSS to provide the following:

a. Coordination of covered dental services for enrolled Division Members;

b. Documentation of current valid contracts with Dental Providers who practice within the AdSS service area(s);

c. Primary care provider to initiate Member referrals to Dental Provider(s) when the Member is determined to need emergency dental services, or Members may self-refer to a Dental Provider when in need of emergency dental services;

d. Monitoring of the provision of dental services and reporting of encounter data to the Division; and

e. Assurance that copies of adult emergency dental policies and procedures have been provided to contracted Dental Provider(s).

2. The Division shall ensure the annual $1,000 adult emergency dental limit is Member specific and remains with the Member if the Member transfers between AdSS's or between Fee-For-Service (FFS) and an AdSS.
3. The Division shall ensure dental services provided to American Indian/Alaska Native Members within an IHS/638 Tribal facility are not subject to the $1,000 adult emergency dental limit.
4. The Division shall require the AdSS or Tribal Case Manager transferring the Member notifies the accepting entity regarding the current balance of the dental benefit.
5. The Division shall require the relinquishing AdSS to use the ALTCS Enrollment Transition Information (ETI) (DDD-1541A) and Division Medical Policy 520 for reporting dental benefit balance to the receiving AdSS that meet the following requirements:
   a. All services are subject to retrospective review to determine whether they satisfy the criteria for a Dental

Emergency. Services determined to not meet the criteria for a Dental Emergency are subject to recoupment;.

b. The Member is not permitted to carry-over unused benefit from one year to the next; and

c. A year begins on October 1st and ends September 30th.

6. The Division shall not require prior authorization for emergency dental services for Members enrolled with either FFS or Managed Care.

E. NOTIFICATION REQUIREMENTS FOR CHARGES TO MEMBERS

1. The Division shall ensure emergency dental services of $1,000 per contract year for Members age 21 years and older are covered. Billing of Division Members for emergency dental services in excess of the $1,000 annual limit is permitted only when the provider meets the requirements of A.A.C R9-22-702 for acute Members, and A.A.C. R9-28-701.10 for ALTCS Members.

2. The Division shall ensure providers who bill Members for emergency dental services exceeding the $1,000 limit conduct the following:

a. The provider must first inform the Member or Responsible Person in a way they understand, that the requested dental service exceeds the $1,000 limit and is not covered by the Division;

b. The provider must furnish the Member or Responsible Person with a document to be signed in advance of the service stating that the Member understands that the dental service will not be fully paid by the Division;

c. The document shall contain information describing the type of service to be provided and the charge for the service;

d. The Member agrees to pay for the amount exceeding the $1,000 emergency dental services limit, as well as services not covered by the Division; and

e. The Member must sign the document before receiving the service in order for the provider to bill the Member.

F. FACILITY AND ANESTHESIA CHARGES

1. The Division shall ensure facility and anesthesia charges are subject to the $1,000 emergency dental limit when:

a. A Member has an underlying condition which necessitates that services provided under the emergency dental benefit be provided in:

i. An ambulatory service center, or

ii. An outpatient hospital.

b. Anesthesia is required as part of the emergency service.

2. The Division shall require Dental Providers performing General Anesthesia (GA) on Members shall bill using dental codes and the cost will count towards the $1,000 emergency dental limit.

3. The Division shall require Physicians performing GA on Members for a dental procedure shall bill medical codes and the cost shall count towards the $1,000 emergency dental limit.

G. INFORMED CONSENT

1. The Division shall require providers to complete the appropriate Informed Consents and treatment plans for Members, in order to provide quality and consistent care.

2. The Division shall require Informed Consents for oral health treatment include the following:

a. A written consent for examination or any treatment measure, which does not include an irreversible procedure;

b. The consent is completed at the time of initial examination and is updated at each subsequent six-month follow-up appointment;

c. A separate written consent is completed for:

   i. Any irreversible procedures,

   ii. Invasive procedures,

   iii. Dental fillings, or

   iv. Pulpotomies.

d. Consent is used in a manner that protects the Member and is easily understood by the:

   i. Member,

   ii. Guardian, or

   iii. Designated representative.

e. A written treatment plan must be reviewed and signed by a Responsible Person with the Member;

f. Consents and treatment plans must be:

   i. In writing, and

ii. Signed and dated by both the provider and the Member, or Responsible Person, if:

1) The Member is under 18 years of age, or

2) The Member is 18 years of age or older and considered an incapacitated adult as specified in A.R.S. §14-5101.

g. The Responsible Person receives a copy of the complete treatment plan.

h. Extends to all Contractor mobile unit providers.

3. The Division shall require completed consents and treatment plans be maintained in the Members chart and are subject to audit.

Signature of Chief Medical Officer: Anthony Dekker (Jul 13, 2023 09:15 PDT)

Anthony Dekker, D.O.