310-D2 ARIZONA LONG TERM CARE SYSTEM ADULT ROUTINE DENTAL SERVICES

EFFECTIVE DATE: July 19, 2023
REFERENCES: AMPM 310-D2

PURPOSE

This Policy establishes requirements regarding the provision of medically necessary dental services for members in the Arizona Long Term Care Program (ALTCS).

DEFINITIONS

1. "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.

2. "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.
3. "Member" means the same as "Client" as defined in A.R.S. § 36-551.
4. "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.

POLICY

A. GENERAL REQUIREMENTS

1. The Division shall ensure the following medically necessary dental benefits are covered up to $1,000 per member per contract year for ALTCS members age 21 or older in accordance with A.R.S. § 36-2939:

a. Diagnostic care,

b. Therapeutic care, and

c. Preventative care, including dentures.

2. The Division shall refer to AMPM 430 for dental services for Members under the age of 21.

3. The Division shall require emergent services for Members are covered as specified in AMPM 310-D1. These services do not count towards the ALTCS $1,000 limit.

B. DIVISION OVERSIGHT

1. The Division shall ensure the following is provided:

a. Coordination of covered dental services for enrolled members;

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

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

d. Assurance that copies of dental policies and procedures have been provided to contracted dentist(s).

2. The Division shall require primary care providers initiate member referrals to dentist(s) when the member is determined to be in need of dental services. Members may also self-refer to a dentist when in need of dental services.
3. The Division shall ensure the annual dental benefit limit remains with the Member is the Member transfers to the following:
    a. Between one AdSS to another, or
    b. Between Fee-For-Service and an AdSS.
4. The Division shall require the transferring AdSS notifies the receiving AdSS regarding the current balance of the Member's dental benefit.
5. The Division shall ensure the AdSS utilizes the ALTCS Enrollment Transition Information (ETI) form, AMPM Policy 1620, Exhibit 1620-9, must be utilized for reporting any dental benefit balance.
6. The Division shall ensure dental services provided to American Indian/Alaska Native members within an Indian Health Service (IHS) or 638 Tribal Facility are also not subject to the ALTCS dental benefit $1,000 limit.

7. The Division shall require the Member is aware they are not permitted to carry-over unused benefit from one contract year to the next.
8. The Division shall refer to the Dental Uniform Prior Authorization List as listed on the AHCCCS website under Resources: Guides-Manuals-Policies to ensure frequency limitations and services that require prior authorization are met as specified in AMPM 431.

C. 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 may have an underlying medical condition which necessitates that services provided under the dental benefit be provided in an ambulatory surgery service center or an outpatient hospital, and
    b. Anesthesia is required as part of the routine service.
2. The Division shall require dentists performing General Anesthesia (GA) on members shall bill using dental codes and the cost will count towards the $1,000 limit.

D. INFORMED CONSENT

1. The Division shall require providers 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. Irreversible procedures,
        ii. Invasive procedures,
        iii. Dental fillings, or
        iv. Root canals and vital pulpotomies when indicated for the treatment of acute infection or to eliminate pain.
    d. Consent is used in a manner that protects the Member and is easily understood by the:

i. Member,

ii. Guardian, or

iii. Responsible Person.

e. A written treatment plan must be reviewed and signed by the 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.

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

E. NOTIFICATION REQUIREMENTS FOR CHARGES TO MEMBERS

1. The Division shall ensure medically necessary services are provided within the $1,000 dental benefit allowable amount.
2. The Division shall ensure services are provided as set forth in A.A.C. R9-28-701(10) and R9-22-702, when medically necessary services are greater than $1,000.
3. The Division shall require the following notification when the provider informs the Member that the dental service requested is not covered and exceeds the $1,000 limit:
    a. Verbally,
    b. In writing, and
    c. In the member's primary language.
4. The Division shall require the following if the Member agrees to pursue the receipt of services:
    a. The provider shall supply the member a document describing the service and the anticipated cost of the service, and
    b. Prior to service delivery, the Member must sign and date a document indicating that they understand that they will be

responsible for the cost of the service to the extent that it exceeds the ALTCS $1,000 limit.

Signature of Chief Medical Officer: Anthony Dekker (Jul 11, 2023 16:25 PDT)

Anthony Dekker, D.O.