CHAPTER 7 – DENTAL/ORAL HEALTH CARE

REVISION DATES: 6/24/2022, 11/10/16, 4/15/15, 4/16/14
EFFECTIVE DATE: March 29, 2013
REFERENCES: AHCCCS Medical Policy Manual (AMPM) policies 310-D1, 310-D2, 430 and 431

PURPOSE

The purposes of this policy are to provide information to Qualified Vendors regarding the provision of:

1. Medically necessary dental services for DDD members age 21 and older, as specified in AMPM Policy 310-D1;
2. Medically necessary, non-emergency (routine) dental services for DDD Arizona Long Term Care System (ALTCS) members age 21 years and older as specified in AMPM Policy 310-D2; and
3. Medically necessary dental services for members under 21 years of age are covered as specified in AMPM Policies 430 and 431.

DEFINITIONS

1. “Dental Emergency” means an acute disorder of oral health resulting in severe pain and/or infection as a result of pathology or trauma.
2. “Dental Provider” means:
   a. An individual licensed under A.R.S. Title 32, Chapter 11, whose scope of practice allows the individual to 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. A process by which the provider advises the member/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.

   b. A written consent for examination and/or any preventative treatment measure, which does not include an irreversible procedure.

4. “Responsible Person” means the same as in A.R.S. § 36-551.

5. “Simple restoration” means silver amalgam and/or composite resin fillings, stainless steel crowns or preformed crowns.

POLICY

A. DENTAL SERVICES PROVIDED BY A LICENSED DENTAL PROVIDER FOR MEMBERS WHO ARE 21 YEARS OF AGE OR OLDER
1. Following services shall be covered by AHCCCS:
   a. Emergency dental services up to $1,000 per member per Contract year (October 1\textsuperscript{st} to September 30\textsuperscript{th}) pursuant to A.R.S. § 36-2907.
   b. 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 physician service if furnished by a physician (A.A.C. R9-22-207 and A.A.C. R9-28-202(A)).

2. The services specified in subsection A(1)(b) shall be related to the treatment of a medical condition such as acute pain (excluding Temporomandibular Joint Dysfunction [TMJ] pain), infection, or fracture of the jaw. Covered services include a limited problem-focused examination of the oral cavity, required radiographs, complex oral surgical procedures such as treatment of maxillofacial fractures, administration of an appropriate anesthesia, and the prescription of pain medication and antibiotics. Diagnosis and treatment of TMJ shall not be covered except for reduction of trauma. Services specified in this section shall not be subject to the $1,000 adult emergency dental limit.

3. Exception for Transplant Cases
For members who require medically necessary dental services as a prerequisite to AHCCCS-covered organ or tissue transplantation, covered dental services shall include the elimination of oral infections and the treatment of oral disease, which include dental cleanings, treatment of periodontal disease, medically necessary extractions, and the provision of simple restorations. AHCCCS covers these services only after a transplant evaluation determines that the member is an appropriate candidate for organ or tissue transplantation. These services are not subject to the $1,000 adult emergency dental limit.

4. Exception for Cancer Cases

Prophylactic extraction of teeth in preparation for radiation treatment of cancer of the jaw, neck, or head is covered. These services are not subject to the $1,000 adult emergency dental limit.

5. Exception for Ventilator Cases

Cleanings for members who are in an inpatient hospital setting and are placed on a ventilator or are physically unable to perform oral hygiene shall be covered for dental cleanings performed by a hygienist working under the supervision of a physician. These services shall not be subject to the $1,000 adult emergency dental limit.
limit. If services are billed under the physician, then medical codes shall be submitted and shall not be subject to the $1000 adult emergency dental limit.

B. EMERGENCY DENTAL SERVICES COVERAGE FOR MEMBERS AGE 21 YEARS AND OLDER

1. Medically necessary emergency dental care and extractions shall be covered for members age 21 years and older who meet the criteria for a dental emergency.

2. The following services and procedures shall be covered as emergency dental services:
   a. Emergency oral diagnostic examination (limited oral examination – problem focused),
   b. Radiographs and laboratory services, limited to the symptomatic teeth,
   c. Composite resin due to recent tooth fracture for 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, but not limited
to, periapical and periodontal infections and 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. Follow up procedures necessary to stabilize teeth as a result of the
emergency service shall be covered and subject to the $1,000 limit.
C. EMERGENCY DENTAL SERVICES LIMITATIONS COVERAGE FOR MEMBERS AGE 21 YEARS AND OLDER

1. Maxillofacial dental services provided by a Dental Provider shall not be covered except to the extent prescribed for the reduction of trauma, including reconstruction of regions of the maxilla and mandible.

2. Diagnosis and treatment of temporomandibular joint dysfunction shall not be covered except for the reduction of trauma.

3. Routine restorative procedures and routine root canal therapy shall not be considered emergency dental services.

4. Treatment for the prevention of pulpal death and imminent tooth loss shall be limited to non-cast fillings, crowns constructed from pre-formed stainless steel, pulp caps, and pulpotomies only for the tooth causing pain or in the presence of active infection.

5. Fixed bridgework to replace missing teeth shall not be covered.

6. Dentures shall not be covered.

D. CONTRACTOR AND FEE-FOR-SERVICE (FFS) PROGRAM RESPONSIBILITIES

1. Contractors shall provide at least the following:
   a. Coordination of covered dental services for enrolled AHCCCS members,
b. Documentation of current valid contracts with Dental Providers who practice within the Contractor service area(s),
c. Primary care provider to initiate member referrals to Dental Provider(s) when the member is determined to be in need of 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 AHCCCS, and
e. Assurance that copies of adult emergency dental policies and procedures have been provided to contracted Dental Provider(s).

2. Tribal ALTCS and FFS providers shall provide at least the following:
   a. Coordination of covered dental services for enrolled AHCCCS members, and
   b. Documentation of Primary Care Provider’s initiation of member referrals to a Dental Provider when the member is determined to be in need of emergency dental services. Members also may self-refer to a Dental Provider when in need of emergency dental services.

3. The annual $1,000 adult emergency dental limit shall be member
specific and shall remain with the member if the member transfers between Contractors or between FFS and Contractors. Dental services provided within an IHS/638 Tribal facility shall also be subject to the $1,000 adult emergency dental limit. Contractor or Tribal Case Manager transferring the member shall notify the accepting entity regarding the current balance of the dental benefit. AMPM Policy 520, Attachment A, and AMPM Exhibit 1620-9 for ALTCS Contractors including Tribal ALTCS, shall be utilized for reporting dental benefit balance. The following applies:

a. All services shall be 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 shall be subject to recoupment,

b. The member shall not be permitted to “carry-over” unused benefit from one year to the next, and

c. Services shall be utilized within a year that begins on October 1st and ends on September 30th.

4. Prior authorization for emergency dental services shall not be required for members enrolled with either FFS or a Contractor.

E. NOTIFICATION REQUIREMENTS FOR CHARGES TO MEMBERS AGE 21 YEARS AND OLDER
1. Emergency dental services of $1,000 per Contract year shall be covered for AHCCCS members age 21 years and older. Billing of AHCCCS members for emergency dental services in excess of the $1,000 annual limit shall be permitted only when the provider meets the requirements of A.A.C R9-22-702 and/or A.A.C. R9-28-701.10.

2. In order to bill the member for emergency dental services exceeding the $1,000 limit, the provider shall first inform the member in a way the member understands, that the requested dental service exceeds the $1000 limit and is not covered by AHCCCS. Before providing the dental services that will be billed to the member, the provider shall furnish the member 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 AHCCCS and that the member agrees to pay for the amount exceeding the $1,000 emergency dental services limit, as well as services not covered by AHCCCS.

3. The member shall sign the document before receiving the service in order for the provider to bill the member. The document shall contain information describing the type of service to be provided and the charge for the service.
F. FACILITY AND ANESTHESIA CHARGES

1. If an underlying medical condition of a member necessitates that the services provided under the emergency dental benefit be provided in an ambulatory surgery center or an outpatient hospital and may require anesthesia as part of the emergency service, the facility and anesthesia charges shall be subject to the $1,000 emergency dental limit.

2. Dentists performing General Anesthesia (GA) on members shall use dental codes and the cost shall count toward the $1,000 emergency dental limit.

3. Physicians performing GA on members for a dental procedure shall bill medical codes and the cost shall count toward the $1,000 emergency dental limit.

G. INFORMED CONSENT

6. Informed consent for oral health treatment shall be completed at the time of initial examination and shall be updated at each subsequent six-month follow-up appointment.

a. A separate written consent shall be completed for any irreversible, invasive procedure, including but not limited to dental fillings, pulpotomies.

b. A written treatment plan shall be reviewed and signed by
both parties, as specified below, with the
member/Responsible Person receiving a copy of the complete
treatment plan.

7. All providers shall complete the appropriate informed consents and
treatment plans for AHCCCS members as listed above, in order to
provide quality and consistent care, in a manner that protects and
is easily understood by the member/Responsible Person. This
requirement shall extend to all Contractor mobile unit providers.

8. Consents and treatment plans shall be in writing and signed and
dated by both the provider and the member/Responsible Person.

9. Completed consents and treatment plans shall be maintained in the
members’ chart and shall be subject to audit.

H. ARIZONA LONG TERM CARE SYSTEM (ALTCS) ADULT DENTAL SERVICES

1. In accordance with A.R.S. § 36-2939, ALTCS members age 21 or
older may receive medically necessary dental benefits up to
$1,000 per member per Contract year (October 1\textsuperscript{st} to September
30\textsuperscript{th}) for diagnostic, therapeutic, and preventative care, including
dentures.

2. ALTCS members under age 21 shall be eligible for services as
specified in AMPM Policy 431.
3. ALTCS members shall also be eligible for services as specified in AMPM Policy 310-D1.

4. The services specified in AMPM Policy 310-D1 shall not count toward the ALTCS $1,000 limit.

I. CONTRACTOR AND TRIBAL ALTCS RESPONSIBILITIES

1. Contractors shall provide at least the following:
   a. Coordination of covered dental services for enrolled ALTCS members,
   b. Documentation of current valid contracts with Dental Providers who practice within the Contractor service area(s),
   c. Primary care provider to initiate member referrals to Dental Provider(s) when the member is determined to be in need of ALTCS dental services, or members may self-refer to a Dental Provider when in need of dental services,
   d. Monitoring of the provision of dental services and reporting of encounter data to AHCCCS, and
   e. Assurance that copies of ALTCS dental policies and procedures have been provided to contracted Dental Providers.

2. Tribal ALTCS and FFS providers shall provide at least the following:
   a. Coordination of covered dental services for enrolled AHCCCS
members, and

b. Documentation of Primary Care Provider’s initiation of member referrals to a Dental Provider when the member is determined to be in need of emergency dental services. Members also may self-refer to a Dental Provider when in need of emergency dental services.

3. The annual ALTCS dental benefit limit shall be member specific and shall remain with the member if the member transfers between Contractors or between FFS and a Contractor. The ALTCS Contractor, or Tribal ALTCS Case Manager, transferring the member shall notify the receiving entity regarding the current balance of the ALTCS dental benefit. AMPM Exhibit 1620-9 shall be utilized for reporting an ALTCS dental benefit balance.

4. Dental services provided within an Indian Health Service (IHS) or 638 Tribal Facility shall also be subject to the ALTCS dental benefit $1,000 limit.

5. The member may not “carry-over” unused benefit from one Contract year to the next.

6. Frequency limitations and services that require prior authorization apply. The Contractor shall refer to the Dental Uniform Prior Authorization List as listed on the AHCCCS website under
J. FACILITY AND ANESTHESIA CHARGES

1. If an underlying medical condition of an ALTCS member necessitates that the services provided under the ALTCS dental benefit be provided in an ambulatory service center or an outpatient hospital and may require anesthesia, the facility and anesthesia charges shall be subject to the ALTCS $1,000 limit.

2. Dental Providers performing General Anesthesia (GA) on ALTCS members shall use dental codes and the cost shall count toward the ALTCS $1,000 limit.

3. Physicians performing GA on an ALTCS member for a dental procedure shall bill medical codes and the cost shall count toward the ALTCS $1,000 limit.

K. NOTIFICATION REQUIREMENTS FOR CHARGES TO ALTCS MEMBERS

1. Providers shall provide medically necessary services within the ALTCS $1,000 dental benefit allowable amount.

2. If medically necessary services are greater than $1,000, the provider may perform the services as set forth in A.A.C. R9-28-701.10 and R9-22-702, after the following notifications take place:
   
a. In accordance with A.A.C. R9-28-701.10 and R9-22-702,
the provider shall inform/explain to the member both verbally and in writing, in the member’s primary language, that the dental service requested is not covered and exceeds the ALTCS $1,000 limit.

b. If the member agrees to pursue the receipt of services:
   i. The provider shall supply the member a document describing the service and the anticipated cost of the service.
   ii. Prior to service delivery, the member shall sign and date a document indicating that the member understands that the member shall be responsible for the cost of the service to the extent that it exceeds the ALTCS $1,000 limit.

L. Dental Services for Members Age 20 and Younger

Members who are Medicaid eligible (ALTCS and Targeted Support Coordination) and age 20 years and younger shall be covered for both preventative and restorative dental services. These services include, but are not limited to:

a. Examinations
b. Cleanings
c. Extractions
d. Sealants

e. X-rays

f. Amalgam or resin restorations

g. Fluoride varnish