CHAPTER 7 DENTAL/ORAL HEALTH CARE

REVISION DATES: 8/16/2023, 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 purpose of this document is to provide information to Qualified Vendors regarding the provision of medically necessary dental services for Division of Developmental Disabilities (Division) Members age 21 and older. This document also provides information for medically necessary, routine dental services for Division Arizona Long Term Care System (ALTCS) for Members aged 21 and older and covered medically necessary dental services for Members under 21 years of age.

DEFINITIONS

1. "Dental Emergency" means an acute disorder of oral health resulting in severe pain 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 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.

INFORMATION

A. COVERED DENTAL SERVICES

1. The following services are covered when provided by a licensed Dental Providers 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 or Physician Service.
2. The services specified in subsection (b) shall be related to the treatment of the following medical conditions:

a. Acute pain excluding Temporomandibular Joint Dysfunction (TMJ) pain,

b. Infection, or

c. Facture of the jaw.

3. Covered emergency services include:

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 diagnosis and treatment of Temporomandibular Joint Dysfunction (TMJ) are not covered except for reduction of trauma.

5. For Members who require medically necessary dental services as a prerequisite to AHCCCS-covered organ or tissue transplantation, covered dental services include:

a. The 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. AHCCCS covers the services outlined in subsection (5) of this section only after a transplant evaluation determines that the Member is an appropriate candidate for organ or tissue transplantation.

7. Prophylactic extraction of teeth in preparation for radiation treatment of cancer of the jaw, neck, or head is covered.

8. The services outlined in subsection (4), (5), and (7) of this section are not subject to the $1,000 adult emergency dental limit.

9. Dental cleanings are only covered in a hospital setting when performed by a hygienist working under the supervision of a Physician or Dentist Provider for Members who are in an inpatient hospital setting and are experiencing the following:

   a. Placed on a ventilator, or

   b. Physically unable to perform oral hygiene.

10. Services outlined in subsection 9 (a)(b) are not subject to the $1,000 adult emergency dental limit. If services are billed under the physician, medical codes are submitted and are not subject to the $1000 adult emergency dental limit.

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

1. Medically necessary emergency dental care and extractions are covered for Members aged 21 and older who meet the criteria for a Dental Emergency.
2. The following services and procedures are 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 or 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. Follow up procedures necessary to stabilize teeth as a result of the emergency service are covered and subject to the $1,000 limit.

C. EMERGENCY DENTAL SERVICES LIMITATIONS FOR MEMBERS AGE 21 AND OLDER

1. The following adult dental services are not covered:

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:

i. Non-cast fillings;

ii. Crowns constructed from pre-formed stainless steel;

iii. Pulp caps; and

iv. 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. AdSS AND FEE-FOR-SERVICE (FFS) PROGRAM RESPONSIBILITIES

1. The AdSS provides 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 AdSS 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 provide 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 is Member specific and remains with the Member if the Member transfers between AdSS's or between FFS and an AdSS.

4. 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.
5. AdSS or Tribal Case Manager transferring the Member will notify the accepting entity regarding the current balance of the dental benefit.
6. The relinquishing AdSS will use the ALTCS Enrollment Transition Information (ETI) (DDD-1541A), AMPM Policy 520, Attachment A, and AMPM Exhibit 1620-9 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 be permitted to carry-over unused benefit from one year to the next; and
    c. Services need to be utilized within a year that begins on October 1st and ends on September 30th.

7. Prior authorization for emergency dental services are not required for Members enrolled with either FFS or Managed Care.

E. NOTIFICATION REQUIREMENTS FOR CHARGES TO MEMBERS AGE 21 AND OLDER

1. Emergency dental services of $1,000 per contract year will be covered for AHCCCS Members age 21 and older. Billing of AHCCCS 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 services and A.A.C. R9-28-701.10 for ALTCS Members.
2. In order to bill the Member for emergency dental services exceeding the $1,000 limit, the following will occur:
    a. The provider must 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;
    b. The provider will 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;

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

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

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

F. FACILITY AND ANESTHESIA CHARGES

1. 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. Dental Providers performing General Anesthesia (GA) on Members will use dental codes and the cost will count toward the $1,000 emergency dental limit.
3. Physicians performing GA on Members for a dental procedure will bill medical codes and the cost shall count toward the $1,000 emergency dental limit.

G. INFORMED CONSENT

1. Informed Consent for oral health treatment will be completed at the time of initial examination and will be updated at each subsequent six-month follow-up appointment.
    a. A separate written consent will be completed for any irreversible, invasive procedure, including but not limited to dental fillings, pulpotomies.
    b. A written treatment plan will be reviewed and signed by both parties, as specified below, with the Member or Responsible Person receiving a copy of the complete treatment plan.
2. All providers will 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 or Responsible Person. This requirement will extend to all Contractor mobile unit providers.

3. Consents and treatment plans will be in writing and signed and dated by both the provider and the Member or Responsible Person.
4. Completed consents and treatment plans will be maintained in the Members' chart and will 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 1st to September 30th) for diagnostic, therapeutic, and preventative care, including dentures.
2. ALTCS Members under age 21 are eligible for services as specified in AMPM Policy 431.

3. ALTCS Members are also eligible for services as specified in AMPM Policy 310-D1.
4. The services specified in AMPM Policy 310-D1 do not count toward the ALTCS $1,000 limit as they are separate.

I. CONTRACTOR AND TRIBAL ALTCS RESPONSIBILITIES

1. Contractors provide 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 provide 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 is Member specific and remains with the Member if the Member transfers between AdSS's or between FFS and an AdSS.
4. The ALTCS Contractor, or Tribal ALTCS Case Manager, transferring the Member will notify the receiving entity regarding the current balance of the ALTCS dental benefit. AMPM Exhibit 1620-9 will be utilized for reporting an ALTCS dental benefit balance.

5. Dental services provided within an Indian Health Service (IHS) or 638 Tribal Facility also shall not be subject to the ALTCS dental benefit $1,000 limit.
6. Frequency limitations and services that require prior authorization apply. The AdSS will refer to the Dental Uniform Prior Authorization List as listed on the AHCCCS website under Resources: Guides-Manuals-Policies.

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 are subject to the ALTCS $1,000 limit.
2. Dental Providers performing General Anesthesia (GA) on ALTCS Members will use dental codes and the cost will count toward the ALTCS $1,000 limit.
3. Physicians performing GA on an ALTCS member for a dental procedure will bill medical codes and the cost will count toward the ALTCS $1,000 limit.

K. NOTIFICATION REQUIREMENTS FOR CHARGES TO ALTCS MEMBERS

1. Providers will 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 will inform and 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 will supply the Member a document describing the service and the anticipated cost of the service.
        ii. Prior to service delivery, the Member will sign and date a document indicating that the Member

understands that the Member is 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

1. Members who are Medicaid eligible and age 20 years and younger are covered for the following preventative and restorative dental services:
    a. Examinations,
    b. Cleanings,
    c. Extractions,
    d. Sealants,
    e. X-rays,
    f. Amalgam or resin restorations,
    g. Fluoride varnish, and
    h. Other covered services.