



Dental Updates

September 27, 2017

Introduction

- Senate Bill 1527 established a \$1,000 emergency dental benefit for emergency dental care and extractions, for all members 21 years of age and older. This benefit is \$1,000 per member per contract year (October 1st to September 30th).
- This affects our Fee-For-Service Acute members 21 years of age and older, and our ALTCS and Tribal ALTCS members 21 years of age and older.

What is a Dental Emergency?

- As defined in AMPM 310-D1 a dental emergency is “an acute disorder of oral health resulting in severe pain and/or infection as a result of pathology or trauma.”

Examples of Covered Services in a Dental Emergency

- Emergency oral diagnostic examination (limited oral examination – problem focused),
- Radiographs and laboratory services, limited to the symptomatic teeth,
- Composite resin due to recent tooth fracture for anterior teeth,
- Prefabricated crowns, to eliminate pain due to recent tooth fracture only,
- Re-cementation of clinically sound inlays, onlays, crowns, and fixed bridges,
- Pulp cap, direct or indirect plus filling,
- Root canals and vital pulpotomies when indicated for the treatment of acute infection or to eliminate pain,
- Apicoectomy performed as a separate procedure, for treatment of acute infection or to eliminate pain, with favorable prognosis,
- Immediate and palliative procedures, including extractions if medically necessary, for relief of pain associated with an oral or maxillofacial condition,
- Tooth re-implantation of accidentally avulsed or displaced anterior tooth, with favorable prognosis,
- Temporary restoration which provides palliative/sedative care (limited to the tooth receiving emergency treatment),
- Initial treatment for acute infection, including, but not limited to, periapical and periodontal infections and abscesses by appropriate methods,
- Preoperative procedures and anesthesia appropriate for optimal patient management, and
- Cast crowns limited to the restoration of root canal treated teeth only

What Does This Change for FFS Acute Members 21 Years of Age and Older?

- These members previously had no dental benefit. They only had medical and surgical services furnished by a dentist covered, only to the extent that 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), per AMPM 310-D1.
- Now members 21 years of age and older have a \$1,000 dental benefit per member, per contract year to cover emergency dental care and extractions.

What does this change for ALTCS and Tribal ALTCS members?

- Previously ALTCS and Tribal ALTCS members had a \$1,000 benefit per member, per contract year to cover medically necessary diagnostic, therapeutic, and preventative care services (this included dentures).
- Now ALTCS and Tribal ALTCS members also have a \$1,000 benefit per member, per contract year to cover emergency dental care and extractions.
- ***Overall they now have \$2,000 per year, but the allotments are separated out into the two categories:
 1. \$1,000 for diagnostic, therapeutic and preventative care; and
 2. \$1,000 for emergency dental care and extractions.

Important Note

- Any unused benefits by Fee-For-Service members, 21 years of age and older, ALTCS members, or Tribal ALTCS members will not be permitted to “carry-over” into the next contract year.

Informed Consent

What is an informed consent?

- Informed consent is a process by which the provider advises the member/ guardian/designated representative 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.

Informed consents for oral health treatment include:

- A written consent for examination and/or any treatment measure, which does not include an irreversible procedure, as mentioned below. This consent is completed at the time of initial examination and is updated at each subsequent six month follow-up appointment.
- A separate written consent for any irreversible, invasive procedure, including but not limited to dental fillings, pulpotomy, etc. In addition, a written treatment plan must be reviewed and signed by both parties, as described below, with the member/ guardian/designated representative receiving a copy of the complete treatment plan.

Informed Consent

All providers shall complete the appropriate informed consents and treatment plans for AHCCCS members as listed previously, in order to provide quality and consistent care, in a manner that protects and is easily understood by the member / guardian / designated representative.

- This requirement extends to all Contractor mobile unit providers. Consents and treatment plans shall be in writing and signed/dated by both the provider and the patient, or patient's representative, if under 18 years of age or is 18 years of age or older and considered an incapacitated adult (as specified in A.R.S. §14-5101).
- Completed consents and treatment plans must be maintained in the members' chart and are subject to audit.

Charges to Members

- Emergency dental services of **\$1000** per contract year are covered for AHCCCS members age 21 years and older. Billing of AHCCCS members for emergency dental services in **excess** of the \$1000 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).
- In order to bill the member for emergency dental services exceeding the \$1000 limit, the provider must first inform the member in a way s/he understands, that the requested dental service exceeds the \$1000 limit and is not covered by AHCCCS.

Charges to Members

- Before providing the dental services that will be billed to the member, the provider must 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 \$1000 emergency dental services limit, as well as services not covered by AHCCCS.
- The member **MUST** sign the document before receiving the service in order for the provider to bill the member. It is expected that the document contain information describing the type of service to be provided and the charge for the service.

For ALTCS Members

Notification Requirements for Charges to Members

- Providers shall provide medically necessary services within the ALTCS \$1,000 dental benefit allowable amount.
- In the event that 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.

For ALTCS Members

Notification Requirements for Charges to Members

- In accordance with A.A.C. R9-28-701.10 and R9-22-702 (Charges to Members), the provider must 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.
- If the member agrees to pursue the receipt of services:
 - The provider must supply the member a document describing the service and the anticipated cost of the service.
 - Prior to service delivery, the member must sign and date a document indicating that he/she understands that he/she will be responsible for the cost of the service to the extent that it exceeds the ALTCS \$1,000 limit.



DFSM Provider Education and Training Unit

DFSM Provider Training

The DFSM Provider Education and Training Unit can assist providers with the following:

- How to submit and status claims or prior authorization requests through the AHCCCS Online Provider Portal (FFS programs, including AIHP, TRBHAs and Tribal ALTCS).
- Submission of documentation using the Transaction Insight Portal (i.e. the AHCCCS Daily Trip report, requested medical records, etc.).

Additionally, the DFSM Provider Training unit offers trainings with informational updates to program changes, system updates, and changes to the AHCCCS policy, AHCCCS guides and manuals.

Education and Training Questions?

The DFSM Provider Education and Training Unit does not instruct providers on how to code or bill for a particular service.

For additional information on rates and coding please follow the below guidelines:

- Rates - Questions on AHCCCS FFS rates should be directed to the rates team at FFSRates@azahcccs.gov
- Coding - Questions on AHCCCS Coding should be directed to the coding team at CodingPolicyQuestions@azahcccs.gov
 - NOTE: The Coding team cannot instruct providers on how to code or bill for a particular service. Those questions should be directed to the provider's professional coder/biller.
- ACC Plan Claims - Questions regarding the submission of claims to an AHCCCS Complete Care (ACC) Health Plan should be directed to the appropriate ACC Health Plan.

The DFSM Provider Training Team can be reached at ProviderTrainingFFS@azahcccs.gov

Technical Questions?

For technical assistance with the AHCCCS Online Provider Portal, please call:

- AHCCCS ISD Customer Support Desk at 602-417-4451 or ISDCustomerSupport@azahcccs.gov

Claims Questions?

For claims questions that cannot be resolved on the portal, please outreach the Claims Customer Service team at:

- Phone: (602) 417-7670 – Select Option 4
- From: Monday – Friday from 7:30am – 4:00pm (Phoenix Time).

The Claims Customer Service team can assist with the following items:

- Details regarding a claim status that cannot be answered on the AHCCCS Online Provider Portal;
- Providing denial codes and general information regarding denied claims; and
- Providing general information about approved and pended claims.

NOTE: Providers should not call the Claims Customer Service team if they have questions on rates, CPT/HCPCS codes and modifiers, billing questions, the address a check was mailed to, and payment details for approved claims.

Prior Authorization Questions?

For prior authorization questions, please visit the AHCCCS Online Provider Portal or the AHCCCS website at:

- AHCCCS Online Provider Portal:
 - <https://azweb.statemedicaid.us/Account/Login.aspx?ReturnUrl=/>
- DFSM Prior Authorization Web Page:
 - <https://www.azahcccs.gov/PlansProviders/FeeForServiceHealthPlans/PriorAuthorization/requirements.html>

Providers can check the status of a submitted authorization request online and view messages from PA staff under the Prior Authorization Inquiry link.

Prior Authorization Questions?

For questions that cannot be resolved on the portal, please outreach the Fee-for-Service Authorization Phone Line at:

- Within Maricopa County: 602-417-4400, Select option 1 for transportation
- Statewide: 1-800-433-0425
- Outside Arizona: 1-800-523-0231
- FESP Dialysis: 602-417-7548

NOTE: Providers should not call the FFS Prior Authorization team if they have questions on rates, CPT/HCPCS codes and modifiers, billing questions, claims, or for status updates.

Policy Information

AHCCCS FFS Provider Billing Manual:

- <https://www.azahcccs.gov/PlansProviders/RatesAndBilling/FFS/providermanual.html>

AHCCCS IHS/Tribal Provider Billing Manual:

- <https://www.azahcccs.gov/PlansProviders/RatesAndBilling/ProviderManuals/IHStribalbillingManual.html>

AHCCCS Medical Policy Manual

- <https://www.azahcccs.gov/shared/MedicalPolicyManual/>

Questions?

Thank You.