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

EFFECTIVE DATES: 10/01/94, 10/01/16, 04/01/17, 10/01/17, 10/01/18, 10/01/19, 04/14/23

APPROVAL DATES: 03/01/95, 06/01/98, 06/01/01, 10/01/01, 0/01/06, 10/01/09, 10/01/10, 07/01/16, 10/06/16, 02/02/17, 09/07/17, 05/30/18, 12/09/19, 02/09/23

I. PURPOSE

This Policy applies to ACC, ACC-RHBA, ALTCS E/PD, and DES/DDD (DDD) Contractors; Fee-For-Service (FFS) Programs including: American Indian Health Program (AIHP), Tribal ALTCS; and all FFS populations, excluding Federal Emergency Services (FES). (For FES, refer to AMPM Chapter 1100). This Policy establishes requirements regarding the provision of medically necessary dental services for members age 21 and older. Dental services for members under 21 years of age are covered as specified in AMPM Policy 431 and additional medically necessary non-emergency dental services for ALTCS members age 21 years and older are specified in AMPM Policy 310-D2.

II. DEFINITIONS

Definitions are located on the AHCCCS website at: AHCCCS Contract and Policy Dictionary.

III. POLICY

A. AHCCCS COVERS THE FOLLOWING DENTAL SERVICES PROVIDED BY A LICENSED DENTAL PROVIDER FOR MEMBERS WHO ARE 21 YEARS OF AGE OR OLDER:

1. Emergency dental services up to $1,000 per member per Contract year (October 1st to September 30th) as a result of A.R.S. §36-2907. The emergency dental services are as specified in this Policy.

2. 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)).

3. The services specified in paragraph III.A.2. of this policy, 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 is not covered except for reduction of trauma. Services specified in this paragraph are not subject to the $1,000 adult emergency dental limit.

4. Exception for Transplant Cases
   For members who require medically necessary dental services as a pre-requisite to AHCCCS-covered organ or tissue transplantation, covered dental services 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. For purposes of this Policy, a simple restoration means silver amalgam and/or composite resin fillings, stainless steel crowns or preformed crowns. 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.

5. 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.

6. 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 are covered for dental cleanings performed by a hygienist working under the supervision of a physician. These services are not subject to the $1,000 adult emergency dental limit. If services are billed under the physician, then medical codes will be submitted and are not subject to the $1000 adult emergency dental limit.

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

Medically necessary emergency dental care and extractions are covered for persons age 21 years and older who meet the criteria for a dental emergency. A dental emergency is an acute disorder of oral health resulting in severe pain and/or infection as a result of pathology or trauma.

1. 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 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, 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.

Follow up procedures necessary to stabilize teeth as a result of the emergency service are covered and subject to the $1,000 limit.

C. LIMITATIONS

Adult Emergency Dental Services Limitations for Persons age 21 Years and Older

1. Maxillofacial dental services provided by a Dental Provider are not 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 are not covered except for the reduction of trauma.

3. Routine restorative procedures and routine root canal therapy are not emergency dental services.

4. Treatment for the prevention of pulpal death and imminent tooth loss is 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 is not covered.

6. Dentures are not covered.

D. CONTRACTOR AND FFS PROGRAM RESPONSIBILITIES

1. AHCCCS requires Contractors to 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. AHCCCS requires Tribal ALTCS and FFS providers to 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 is member specific and remains with the member if the member transfers between Contractors or between FFS and Contractors. 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. It is the responsibility of the Contractor or Tribal Case Manager to 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 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. That services shall be utilized within a year begins on October 1st and ends September 30th.

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

E. NOTIFICATION REQUIREMENTS FOR CHARGES TO MEMBERS

Emergency dental services of $1,000 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 $1,000 annual limit is permitted only when the provider meets the requirements of A.A.C R9-22-702 and/or A.A.C. R9-28-701.10.

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 they understand 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.

The member shall sign the document before receiving the service in order for the provider to bill the member. It is expected that the document contains information describing the type of service to be provided and the charge for the service.

F. FACILITY AND ANESTHESIA CHARGES

AHCCCS expects that in rare instances a member may have an underlying medical condition which necessitates that 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. In those instances, the facility and anesthesia charges are subject to the $1,000 emergency dental limit.

Dentists performing General Anesthesia (GA) on members will bill using dental codes and the cost will count towards the $1,000 emergency dental limit.

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

G. INFORMED CONSENT

Informed consent is a process by which the provider advises the member or the member's Health Care Decision Maker 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.

1. Informed consents for oral health treatment include:
   a. 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, and
   b. A separate written consent for any irreversible, invasive procedure, including but not limited to dental fillings and pulpotomies. In addition, a written treatment plan shall be reviewed and signed by both parties, as specified below, with the member or the member's Health Care Decision Maker receiving a copy of the complete treatment plan.

2. 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 or the member's Health Care Decision Maker. 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 member, or member's Health Care Decision Maker. Completed consents and treatment plans shall be maintained in the members' chart and are subject to audit.