

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

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

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

I. PURPOSE

This Policy applies to ALTCS E/PD and DES/DDD (DDD) Contractors; Fee-For-Service (FFS) Programs including 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 in the Long Term Care Program.

II. DEFINITIONS

Definitions are located on the AHCCCS website at: [AHCCCS Contract and Policy Dictionary](#).

III. POLICY

In accordance with A.R.S. §36-2939, Arizona Long Term Care System (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. The dental policy for ALTCS members under age 21 is specified in AMPM Policy 431. ALTCS members are also eligible for services as specified in AMPM Policy 310-D1. The services specified in AMPM Policy 310-D1 does not count towards the ALTCS \$1,000 limit.

A. CONTRACTOR AND TRIBAL ALTCS RESPONSIBILITIES

1. AHCCCS requires Contractors to 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. 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 ALTCS dental benefit limit is member specific and remains with the member if the member transfers between Contractors or between Fee-For-Service and a Contractor. It is the responsibility of the ALTCS Contractor, or Tribal ALTCS Case Manager, transferring the member to 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.

Dental services provided to American Indian/Alaska Native members within an Indian Health Service (IHS) or 638 Tribal Facility are not subject to the ALTCS dental benefit \$1,000 limit.

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

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 Resources: Guides-Manuals-Policies.

B. FACILITY AND ANESTHESIA CHARGES

AHCCCS expects that in rare instances an ALTCS member may have an underlying medical condition which necessitates that services provided under the ALTCS dental benefit be provided in an ambulatory surgery center or an outpatient hospital and may require anesthesia. In those instances, the facility and anesthesia charges are subject to the ALTCS \$1,000 limit. Dental Providers performing General Anesthesia (GA) on ALTCS members will bill using dental codes, and the cost will count towards the ALTCS \$1,000 limit.

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

C. INFORMED CONSENT

Informed consent is a process by which the provider advises the member or 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 preventative 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, pulpotomy, etc. In addition, a written treatment plan shall be reviewed and signed by both parties, as specified below, with the member/or 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 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 and designated representative. Completed consents and treatment plans shall be maintained in the members' chart and are subject to audit.

D. 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.

In accordance with A.A.C. R9-28-701.10 and R9-22-702 (Charges to Members), 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. If the member agrees to pursue the receipt of services:

1. The provider shall supply the member with a document describing the service and the anticipated cost of the service.
2. Prior to service delivery, the member shall 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.