310-D1[1] DENTAL SERVICES FOR MEMBERS 21 YEARS OF AGE AND OLDER

REVISION DATES: 07/01/16, 10/01/10, 10/01/09, 10/01/06, 10/01/01, 06/01/01, 06/01/98, 03/01/95

INITIAL EFFECTIVE DATE: 10/01/1994

DESCRIPTION

As described in this Policy, AHCCCS covers medical and surgical services furnished by a dentist only to the extent that such services:

1. May be performed under State law by either a physician or by a dentist and

2. The services would be considered physician services if furnished by a physician.

Subject to the terms of this Policy, AHCCCS also covers limited dental services as a prerequisite to AHCCCS covered transplantation and when they are in preparation for radiation treatment for certain cancers.

Dental services for members younger than age 21, including preventive and therapeutic dental services, are discussed in AHCCCS Medical Policy Manual (AMPM) Chapter 400 of this Manual.

AMOUNT, DURATION AND SCOPE

Services furnished by dentists which are covered for members 21 years of age and older must 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.

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 are limited to the elimination of oral infections and the treatment of oral disease, which include dental cleanings, treatment of periodontal disease, medically necessary extractions and the

[1] Subheading added – ALTCS policy added as separate policy below 310-D2

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.

EXCEPTION FOR CANCER CASES

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

LIMITATIONS

Except for limited dental services covered for pre-transplant candidates and for members with cancer of the jaw, neck or head described above, covered services furnished by dentists to members 21 years of age and older do not include services that physicians are not generally competent to perform. These services include, but are not limited to, dental cleanings, routine dental examinations, dental restorations including crowns and fillings, extractions, pulpotomies, root canals, and the construction or delivery of complete or partial dentures. Diagnosis and treatment of TMJ is not covered except for reduction of trauma.

310-D2[2] ARIZONA LONG TERM CARE SYSTEM ADULT DENTAL SERVICES

REVISION DATES: 10/01/16, 07/01/16, 10/01/10, 10/01/09, 10/01/06, 10/01/01, 06/01/01, 06/01/98, 03/01/95

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Description

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. The dental policy for ALTCS members under age 21 is described in the AHCCCS Medical Policy Manual (AMPM) Policy 430.

ALTCS members are eligible for services outlined in AMPM Policy 310-D1 for members over the age of 21. Services that fall into the exception for transplant and cancer cases as outlined in 310-D1 would not count towards the $1,000 limit.

Amount, Duration and Scope

In accordance with A.R.S. §36-2939, dental services, are covered for adult ALTCS members up to a maximum of $1,000 annually and in accordance with this Policy. Dentures are a covered service.

Contractor Responsibilities

The annual limit is member specific and remains with the member if the member transfers between Managed Care Organizations or between Fee-For-Service and Managed Care. 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 dental benefit. The ALTCS Enrollment Transition Information (ETI) form, Exhibit 1620-9 must be utilized for reporting an ALTCS Dental benefit balance.

Dental services provided within an Indian Health Service (IHS) or 638 Tribal Facility are also subject to the $1,000 limit.

The member is not permitted to "carry-over" unused benefit from one year to the next. Frequency limitations and services that require prior authorizations still apply.

Facility and Anesthesia Charges

[2] Dental benefit pursuant to §36-2939

AHCCCS expects that in rare instances an ALTCS member may have an underlying medical condition that necessitates that services provided under the ALTCS dental benefit be provided in an Ambulatory Service Center or an Outpatient Hospital and may require anesthesia. In those instances, the facility and anesthesia charges are subject to the $1,000 limit.

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

Physicians performing GA on an ALTCS patient for a dental procedure will bill medical codes and the cost will count towards the $1000 limit.

Informed Consent

Informed consent is a process by which the provider advises the member/member's 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:

1. 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.

2. 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/member's representative receiving a copy of the complete treatment plan.

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 and/or member's representative. This requirement extends to all Contractor mobile unit providers. Consents and treatment plans must 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 defined in A.R.S. §14-5101). Completed consents and treatment plans must be maintained in the members' chart and are subject to audit.

Notification Requirements for Charges to Members

Providers will provide medically necessary services within the $1,000 allowable amount. In the event that medically necessary services are greater than $1,000, the

provider may perform the services after the following notifications take place.

In accordance with A.A.C. 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 $1,000 limit. If the member agrees to pursue the receipt of services:

1. The provider must supply the member a document describing the service and the anticipated cost of the service.

2. 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 $1,000 limit.