



Dental Services and the Arizona Long Term Care System (ALTCS)

June 11, 2021

ALTCS Dental Benefit Summary

ALTCS Members & Dental Benefits

ALTCS members have two dental benefits:

1. As of 10/1/2016, dental services are covered up to \$1000 per benefit year for **diagnostic, therapeutic and preventative care**.
2. As of 10/1/2017, **Emergency Dental Services** are covered up to \$1000 per benefit year for members 21 years of age and older.

Authority

Dental Legal Authorities

ALTCS Dental Benefit Legal Authorities

- A.R.S. §36-2939.A.6.
- Effective 10/01/2016
- Restoration of the ALTCS Dental Benefit was approved in the 2016 Legislative Session (HB 2704)

Emergency Dental Benefit Legal Authorities

- A.R.S. §36-2907
- Effective 10/01/2017
- An emergency dental benefit for members 21 years of age and older has been granted to members, to cover emergency dental care and emergency extractions.



ALTCS Dental Benefit

Diagnostic, Therapeutic and Preventative Care

Summary of the \$1000 Limit

ALTCS Dental Benefit Summary

- ALTCS members age 21 and older may receive medically necessary dental benefits up to \$1000 per contract year, for **diagnostic, therapeutic and preventative care.**
- Services provided within an IHS/638 facility are also subject to the \$1000 limit per contract year.
- Contract year is defined as 10/01 through 9/30.
- Member is not permitted to “carry-over” unused benefits from one year to the next.

Summary of the \$1000 Limit

General Anesthesia

- General Anesthesia (GA) is included as part of the \$1000 benefit limit per contract year.
 1. Dentists performing GA on ALTCS members will bill dental codes and the cost will count towards the \$1000 limit.
 2. Per previous policy, if a physician performs GA on an ALTCS member undergoing a dental procedure it will count towards the \$1000 limit and be billed through medical.

Summary of the \$1000 Limit

Anesthesia at an Ambulatory Surgical Center (ASC) or at an Outpatient Hospital

- If services provided in an Ambulatory Service Center or an Outpatient Hospital require anesthesia (under the ALTCS dental benefit) then the facility and anesthesia charges are subject to the \$1000 limit.

Summary of the \$1000 Limit

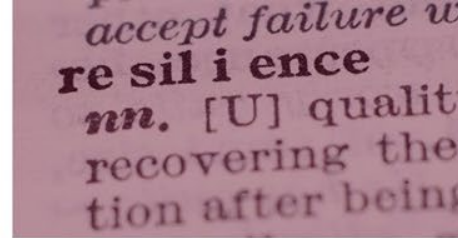
Member Charges

- Members can be billed for any covered services that exceed the \$1000/year limit as long as they are notified by the provider ahead of time and agree to pay for such services in writing.
 1. The provider must supply the member with a document describing the services and the cost of the services.
 2. Prior to delivery of the service the member must sign and date a document indicating he/she will be responsible for the cost of the services to the extent that it exceeds the \$1000 limit.
 3. This includes tribal member.

Exceptions/Limitations

Limitations

- ALTCS members receiving services that fall into the exception for transplant and cancer cases as outlined in 310-D1 would not count towards the \$1000 limit.
- Frequency limitations and services that require prior authorization still apply.



Emergency Dental Services

For members 21 years of age and older

Emergency Dental Benefit 21+

Emergency Dental Coverage

- In accordance with A.R.S. 36-2907 (Senate Bill 1527) established an emergency dental benefit in an annual amount not to exceed \$1,000 per member per contract year (October 1st to September 30th) for emergency dental care and emergency extractions.
- This benefit is for 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.
 - Note: For **ALTCS members only**, this emergency dental benefit is **in addition** to the \$1000 annual benefit per member per contract year for diagnostic, therapeutic and preventative dental care.

What is a Dental Emergency?

Dental Emergencies

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

Dental Emergency Examples

Examples of Dental Emergencies

- 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;

Dental Emergency Examples

Examples of Dental Emergencies

- 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 Did This Change for Members 21 Years of Age and Older?

What does the Emergency Dental Benefit change?

- Prior to 10/1/2017, members who were 21 years of age and older, who were *not* ALTCS members, had no dental benefit. The only dental benefit available to this population, was as follows:
 - *“Medical and surgical services furnished by a dentist 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 and A.A.C. R9-28-202(A)).” - AMPM 310-D1.*
- As of 10/12017, 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 Did This Change for ALTCS and Tribal ALTCS Members?

ALTCS - What does the Emergency Dental Benefit change?

- 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).
- As of 10/1/2017, ALTCS and Tribal ALTCS members also gained a \$1,000 benefit per member, per contract year to cover emergency dental care and extractions.
- Altogether, ALTCS & Tribal ALTCS members 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.

Charges to Members

Charges to Members

- Billing of AHCCCS members for emergency dental services in excess of the \$1000 emergency 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 they understand, that the requested dental service exceeds the \$1000 limit and is not covered by AHCCCS.

Charges to Members

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.

Prior Authorization

Prior Authorization

- Prior Authorization is not required for emergency dental services.
- Prior Authorization is never required for emergency services.
- For additional information on FFS and Prior Authorization, please review the DFSM Prior Authorization web page:
 - <https://www.azahcccs.gov/PlansProviders/FeeForServiceHealthPlans/PriorAuthorization/requirements.html>

Billing Requirements

Billing Requirements for Emergency Dental Claims

- When submitting a claim for emergency dental services, providers must bill on the ADA 2012 claim form using CDT-4 codes.
- Providers shall indicate that the service was an emergency dental service in Field 35 Remarks. Per the ADA 2012 Claim Form Instructions for Field 35:
 - *“It (Field 35) can also be used to convey additional information you believe is necessary for the payer to process the claim (e.g., for a secondary claim, the amount the primary carrier paid).”*

Documentation Requirements

Documentation Requirements for Emergency Dental Claims

- Documentation to substantiate that the dental service met emergency dental criteria shall be submitted with the claim.
- All claims submitted to AHCCCS may be subject to post payment review and audit, to determine if services are provided according to AHCCCS policy as it relates to medical necessity and emergency services.
- It is the provider's responsibility to submit requested additional documentation, if AHCCCS requests additional documentation.



Other Items of Consideration Regarding Dental

Reimbursement Rates and Codes

Dental Rates and Codes

- Reimbursement is subject to the Dental FFS Rates and Codes. Information on rates and billing can be found at:
 - <https://www.azahcccs.gov/PlansProviders/RatesAndBilling/FFS/Dental.html>
- For IHS/638 providers, dental services may be billed at the All Inclusive Rate (AIR).

Enrollment Transition Information (ETI)

Enrollment Changes

- The annual limit is member specific and remains with the member if transferring between Medicaid Health Plans. (i.e. Tribal ALTCS members can transfer between Tribal ALTCS Plans within their GSA.)
 - Note: As of 10/1/2018 MCOs are referred to as AHCCCS Complete Care (ACC) plans.
- **IMPORTANT:** It is the responsibility of the entity transferring the member to notify the accepting entity regarding the current balance of the dental benefit.
 - <https://www.azahcccs.gov/shared/Downloads/MedicalPolicyManual/Chap1600.pdf>

f

Unused Benefits

Unused Benefits

- 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. (This applies to both the ALTCS Dental Benefit and the Emergency Dental benefits.)
- This means that if a member only uses \$400 of their \$1000 emergency dental benefit by September 30 of the benefit year (the contract year, which runs October 1-September 30), that even though they had \$600 unused of that benefit, that on October 1st of the next benefit year they do not have \$1600 for emergency dental. The unused \$600 is forfeit and they start fresh with a new \$1000 on October 1st.

What Did This Change for ALTCS and Tribal ALTCS Members?

ALTCS Special Considerations

- 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

Informed Consent

What is 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 Continued

What is 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.



Tribal ALTCS Case Managers

Tribal ALTCS Case Manager

Dental Services and Case Managers

- Tribal ALTCS Case Managers are responsible for tracking all dental services on the member's service plan.
- All providers MUST notify the assigned Tribal ALTCS Case Manager of the member's dental services.
- For questions about the assigned Tribal Case Manager, please visit:
 - www.azahcccs.gov/AmericanIndians/LongTermCareCaseManagement



Dental Resources

Dental Coverage Summary

Dental Coverage Summary

EPSDT Coverage: AHCCCS covers comprehensive health care for members under 21 years of age through the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) program. Dental services for members under 21 years of age are covered as specified in [AMPM Policy 431, Oral Health Care for Early and Periodic Screening, Diagnosis and Treatment Aged Members](#).

ALTCS Coverage: As of 10/1/2016, medically necessary non-emergency dental services are covered for ALTCS members 21 years of age and older, up to \$1,000.00 per member per contract year (October 1st to September 30th) for diagnostic, therapeutic and preventative care. Coverage is outlined in [AMPM Policy 310-D2](#).

Emergency Dental: For dates of service 10/1/17 and on, medically necessary **emergency dental services** are covered for AHCCCS members 21 years of age and older in an annual amount not to exceed \$1,000 per member per contract year (October 1st to September 30th) for emergency dental care and emergency extractions.

Resources

Resources

For information on billing for dental services please visit:

- https://www.azahcccs.gov/PlansProviders/Downloads/FFSProviderManual/FFS_Chap10.pdf
- <https://www.azahcccs.gov/PlansProviders/Downloads/IHS-TribalManual/IHS-Chap08IndivPractitionerSvc.pdf>

For additional information on AHCCCS policies and coverage of dental services please visit the AHCCCS Medical Policy Manual:

- <https://www.azahcccs.gov/shared/Downloads/MedicalPolicyManual/300/310-D1.pdf>
- <https://www.azahcccs.gov/shared/Downloads/MedicalPolicyManual/300/310D2.pdf>
- <https://www.azahcccs.gov/shared/Downloads/MedicalPolicyManual/400/430.pdf>



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. Please work with your professional biller/coder for these questions, or visit the [AHCCCS Medical Coding Resources web page](#).

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. This can be done prior to submitting a claim to avoid any delays in payment.

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.