431 - ORAL HEALTH CARE FOR EARLY AND PERIODIC SCREENING, DIAGNOSIS AND TREATMENT AGED MEMBERS

EFFECTIVE DATES: 04/01/14, 04/01/17, 10/01/18, 10/01/19, 02/01/21, 10/01/22

APPROVAL DATES: 10/01/15, 07/01/16, 02/02/17, 06/07/18, 05/30/19, 11/06/20, 04/21/22

I. PURPOSE

This Policy applies to ACC, ACC-RBHA, ALTCS E/PD, DCS/CHP (CHP), and DES/DDD (DDD) Contractors; Fee-For-Service (FFS) Programs including: the 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 for Early and Periodic Screening, Diagnosis and Treatment (EPSDT) aged member oral health care.

II. DEFINITIONS

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

III. POLICY

An oral health screening shall be part of an EPSDT screening conducted by a Primary Care Provider (PCP). As part of the physical examination, the physician, physician's assistant, or nurse practitioner shall perform an oral health screening. A screening is intended to identify gross dental or oral lesions but is not a thorough clinical examination and does not involve making a clinical diagnosis resulting in a treatment plan. The oral health screening does not substitute for examination through direct referral to a dental provider. PCPs shall refer EPSDT members for appropriate services based on needs identified through the screening process and for routine dental care based on the AHCCCS EPSDT Periodicity Schedule. Evidence of this referral shall be documented on the EPSDT Clinical Sample Templates as specified in AMPM Policy 430, Attachment E and in the member's medical record.

Depending on the results of the oral health screening, referral to a dental provider shall be made as specified in Contract:

CATEGORY	APPOINTMENT STANDARDS
URGENT	As expeditiously as the member's health condition requires but no later than three business days of request
ROUTINE CARE	Within 45 calendar days of request.

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PCPs who have completed the AHCCCS required training, may be reimbursed for fluoride varnish applications completed at the EPSDT visits for members as early as six months of age with at least one tooth eruption. Additional applications occurring every three months during an EPSDT visit, up until member's second birthday, may be reimbursed according to AHCCCS-approved fee schedules. Application of fluoride varnish by the PCP does not take the place of an oral health visit.

AHCCCS recommended training for fluoride varnish application is located at: https://www.smilesforlifeoralhealth.org/. Refer to the website for training that covers caries-risk assessment, fluoride varnish, and counseling. Upon completion of the required training, providers shall submit a copy of their certificate to each of the Contractors in which they participate, as this is required prior to issuing payment for PCP applied fluoride varnish. This certificate may be used in the credentialing process to verify completion of training necessary for reimbursement.

Additional training resources may be found on the Arizona Department of Health Services website.

A. DENTAL HOME

The Dental Home shall provide:

1. Comprehensive oral health care including acute care and preventive services as specified in Attachment A.
2. Comprehensive assessment for oral diseases and conditions.
3. Individualized preventive dental health program based upon a caries-risk assessment and a periodontal disease risk assessment.
4. Anticipatory guidance about growth and development issues (i.e., teething, digit, or pacifier habits).
5. Plan for acute dental trauma.
6. Information about proper care of the child's teeth and gingivae. This would include the prevention, diagnosis, and treatment of disease of the supporting and surrounding tissues and the maintenance of health, function, and esthetics of those structures and tissues.
7. Dietary counseling.
8. Referrals to dental specialists when care cannot directly be provided within the dental home.

FFS members shall be referred to a dental provider by one year of age by their PCP and members enrolled with a Contractor shall be assigned to a dental home by six months of age or upon enrollment. All members shall receive care by a dental provider for routine preventive care as specified in Attachment A. Members shall be referred for oral health care concerns requiring additional evaluation and/or treatment.

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Attachment A identifies when routine referrals begin, however, PCPs may refer EPSDT members for a dental assessment at an earlier age if their oral health screening reveals potential carious lesions or other conditions requiring assessment and/or treatment by a dental professional. In addition to PCP referrals, EPSDT members are allowed self-referral to a dental provider who is included in the Contractor's provider network. FFS members may self-refer to any AHCCCS registered dental provider.

B. COVERED SERVICES

EPSDT covers the following dental services:

1. Emergency dental services including:
   a. Treatment for pain, infection, swelling and/or injury,
   b. Extraction of symptomatic (including pain), infected and non-restorable primary and permanent teeth, as well as retained primary teeth (extractions are limited to teeth which are symptomatic), and
   c. General anesthesia, conscious sedation or anxiolysis (minimal sedation, members respond normally to verbal commands) when local anesthesia is contraindicated or when management of the member requires it. Refer to AMPM Policy 430.

2. Preventive dental services provided as specified in Attachment A, including but not limited to:
   a. Diagnostic services including comprehensive and periodic examinations. Contractors shall allow two oral examinations and two oral prophylaxis per member per year) for all members up to 21 years of age. For members up to two (2) years of age, fluoride varnish may be applied four times a year (i.e., one every three months). Additional examinations or treatments shall be deemed medically necessary,
   b. Radiology services screening for diagnosis of dental abnormalities and/or pathology, including panoramic or full-mouth x-rays, supplemental bitewing x-rays, and occlusal or periapical films, as medically necessary and following the recommendations by the American Academy of Pediatric Dentistry (AAPD),
   c. Panorex films will be covered as recommended by the AAPD, up to three times maximum per provider for children between the ages of three to 20; further panorex films needed above this limit when deemed medically necessary, and
   d. Preventive services, which include:
      i. Oral prophylaxis performed by a dental provider or dental hygienist that includes self-care oral hygiene instructions to member, if able, or to the Health Care Decision Maker, and designated representative,
      ii. Application of topical fluorides and fluoride varnish. The use of a prophylaxis paste containing fluoride or fluoride mouth rinses do not meet the AHCCCS standard for fluoride treatment,
      iii. Dental sealants for first and second molars are covered twice per first or second molar, per provider/location, allowing for three years intervention between application up to 15 years of age. This includes the ADHS school-based dental sealant program (Cavity Free AZ - https://www.azdhs.gov/prevention/womens-childrens-health/oral-health/dental-programs/index.php) and the participating providers. Additional applications when deemed medically necessary, and
      iv. Space maintainers when posterior primary teeth are lost and when deemed medically necessary.

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3. All therapeutic dental services will be covered when they are considered medically necessary and cost effective but may be subject to PA by the Contractor or AHCCCS Division of Fee-For-Service Management for FFS members. These services include, but are not limited to:
   a. Periodontal procedures, scaling, root planing, curettage, gingivectomy, and osseous surgery,
   b. Crowns:
      i. When appropriate, stainless steel crowns may be used for both primary and permanent posterior teeth; composite, prefabricated stainless steel crowns with a resin window or crowns with esthetic coatings shall be used for anterior primary teeth, or
      ii. Precious or cast semi-precious crowns may be used on functional permanent endodontically treated teeth, except third molars, for members who are 18 up to 21 years of age,
   c. Endodontic services including pulp therapy for permanent and primary teeth, except third molars (unless a third molar is functioning in place of a missing molar),
   d. Restoration of carious permanent and primary teeth with accepted dental materials other than cast or porcelain restorations unless the member is 18 up to 21 years of age and has had endodontic treatment,
   e. Restorations of anterior teeth for children under the age of five, when medically necessary. Children five years and over with primary anterior tooth decay shall be considered for extraction, if presenting with pain or severely broken-down tooth structure, or be considered for observation until the point of exfoliation as determined by the dental provider,
   f. Removable dental prosthetics, including complete dentures and removable partial dentures, and
   g. Orthodontic services and orthognathic surgery are covered only when these services are medically necessary and determined to be the primary treatment of choice or an essential part of an overall treatment plan developed by both the PCP and the dental provider in consultation with each other. Orthodontic services are not covered when the primary purpose is cosmetic.
      Examples of conditions that may require orthodontic treatment include the following:
      i. Congenital craniofacial or dentofacial malformations requiring reconstructive surgical correction in addition to orthodontic services,
      ii. Trauma requiring surgical treatment in addition to orthodontic services, or
      iii. Skeletal discrepancy involving maxillary and/or mandibular structures.

      Services or items furnished solely for cosmetic purposes are excluded from AHCCCS coverage (A.A.C. R9-22-215).

C. PROVIDER REQUIREMENTS

Dental services are to be provided by AHCCCS-registered dental providers.

Informed consent is a process by which the dental provider advises the member/Health Care Decision Maker (HCDM) 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.

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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 shall be reviewed and signed by both parties, as described below, with the member/health care decision maker, and designated representative receiving a copy of the complete treatment plan.

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/health care decision maker, and designated representative. Consents and treatment plans shall be in writing and signed/dated by both the provider and the member/health care decision maker if the member is under 18 years of age or is 18 years of age or older and considered an incapacitated person, as specified in A.R.S. § 14-5101. Completed consents and treatment plans shall be maintained in the member's chart and are subject to audit.

D. CONTRACTOR REQUIREMENTS

Contractors shall:

1. Conduct annual outreach efforts to members receiving oral health care through school-based or mobile unit providers (whether in or out of network), ensuring members are aware of their dental home provider and contact information, as well as understand the availability of ongoing-access to care through the dental home provider, when school-based or mobile unit providers are not accessible.

2. Conduct written member educational outreach related to dental home, importance of oral health care, dental decay prevention measures, recommended dental periodicity schedule, and other Contractor selected topics at a minimum of once every 12 months. These topics may be addressed separately or combined into one written outreach material; however, each topic shall be covered during the 12-month period as specified in AMPM Exhibit 400-3.

3. Educate providers in the importance of offering continuously accessible, coordinated, family-centered care.

4. Develop processes to:
   a. Ensure members are enrolled into a dental home by six months of age or upon assignment to a Contractor to allow for an ongoing relationship providing comprehensive oral health care. This process shall allow members the choice of dental providers from within the Contractor's provider network and provide members instructions on how to select or change a dental home provider. Members not selecting a dental home provider will be automatically assigned a provider by the Contractor,
   b. Monitor member participation with the dental home and provide outreach to members who have not completed visits as specified in Attachment A,

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c. Develop, implement, and maintain a procedure to notify all members/health care decision makers and designated representatives of visits as specified in Attachment A and AMPM 430, Attachment A. Processes other than mailings shall be pre-approved by AHCCCS Quality Management (QM) Team. This procedure shall include notification to member/health care decision maker, and designated representative regarding due dates of dental visits every six months. If a dental visit has not taken place, a second notice shall be sent, and
d. Monitor provider engagement, related to scheduling and follow-up of missed appointments, to ensure care consistent with Attachment A for assigned EPSDT members.

5. Develop and implement processes to reduce no-show appointment rates for dental services.

6. Provide targeted outreach to those members who did not show for appointments.

7. Encourage all providers to schedule the next Dental screening at the current office visit, particularly for children 24 months of age and younger.

8. Include a statement that provides assistance with information on how to obtain medically necessary transportation as specified in AMPM Policy 310-BB including scheduling appointments to obtain EPSDT services, and a statement that there is no copayment or other charge for EPSDT Screening and resultant services as specified in this Policy.

9. Require the use of Attachment A by all contracted providers. The AHCCCS Dental Periodicity Schedule gives providers necessary information regarding timeframes in which age-related required screenings and services shall be rendered by providers.

10. Adhere to the Dental Uniform Prior Authorization List (List) as agreed upon by the Contractors. Refer to the AHCCCS website under Resources: Guides–Manuals– Policies. All requests for changes to the List shall be submitted to the AHCCCS DHCM designated Operations and Compliance Officer for review. Requests shall include supporting documentation and rationale for the proposed changes. CHP is excluded from the List requirement.

11. Adhere to the Uniform Warranty List as agreed upon by the Contractors. Refer to the AHCCCS website under Resources–Guides–Manuals–Policies. All requests for changes to the list shall be submitted to the AHCCCS DHCM designated Operations and Compliance Officer for review. Requests shall include supporting documentation and rationale for the proposed changes.

E. CONTRACTOR REQUIREMENTS FOR THE DENTAL PLAN AND EVALUATION

Contractors shall have a written Dental Plan that addresses minimum Contractor requirements as specified in the prior section, as well as the objectives of the Contractor's program that are focused on achieving AHCCCS requirements. The Contractor shall also incorporate into the Plan monitoring and evaluation activities for these minimum requirements as specified in Attachment B. The Dental Plan shall be submitted as specified in Contract. The written Dental Plan shall contain, at a minimum, the following:

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1. Dental Narrative Plan – A written narrative description of all planned activities to address the Contractor's minimum requirements for Dental services, as specified in the prior section. The narrative description shall also include Contractor activities to identify member needs and coordination of care, as well as follow-up activities to ensure appropriate treatment is received in a timely manner.

2. Dental Work Plan Evaluation – An evaluation of the previous year's Work Plan to determine the effectiveness of strategies, interventions, and activities used toward meeting stated objectives.

3. Dental Work Plan that includes:
   a. Specific measurable objectives. These objectives shall be based on AHCCCS established Minimum Performance Standards. In cases where AHCCCS Minimum Performance Standards have been met, other generally accepted benchmarks that continue the Contractor's improvement efforts will be used (e.g., National Committee on Quality Assurance, Healthy People 2020 standards). The Contractor may also develop their own specific measurable goals and objectives aimed at enhancing the Dental program when Minimum Performance Standards have been met,
   b. Strategies and specific measurable interventions to accomplish objectives (e.g., member outreach, provider education and provider compliance with mandatory components of the Dental program),
   c. Targeted implementation and completion dates of work plan activities,
   d. Assigned local staff position(s) responsible and accountable for meeting each established goal and objective, and
   e. Identification and implementation of new interventions, continuation of, or modification to existing interventions, based on analysis of the previous year's Work Plan Evaluation.

4. All relevant and any referenced policies and procedures in the Dental Plan, submitted as separate attachments.

F. AFFILIATED PRACTICE DENTAL HYGIENIST

In addition to the requirements as specified in A.R.S. § 32-1281 and § 32-1289, AHCCCS requires the following:

1. Both the dental hygienist and the dental provider in the affiliated practice relationship shall be registered AHCCCS providers.

2. The affiliated practice dental hygienist shall maintain individual patient records of AHCCCS members in accordance with the Arizona State Dental Practice Act. At a minimum this shall include member identification, health care decision maker identification, designated representative identification if applicable, signed authorization from health care decision maker for consent of services, member medical history, and documentation of services rendered.

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3. The affiliated practice dental hygienist shall register with AHCCCS and shall be identified as the treating provider under their individual AHCCCS provider identification number/NPI number. In addition, if the services are to be billed to an AHCCCS Contractor, the affiliated practice dental hygienist and the dental provider with whom they are affiliated shall be a credentialed network provider of the Contractor. The affiliated practice dental hygienist shall be identified as the treating provider under their individual AHCCCS provider identification number/NPI number when practicing under an affiliated practice agreement. When not working under an affiliated practice agreement no registration with AHCCCS is necessary.

4. The affiliated practice dental hygienist will only be reimbursed for providing services in accordance with State statute and regulations, AHCCCS policy and provider agreement, and their affiliated practice agreement.

5. AHCCCS reimbursement for dental radiographs is restricted to providers who are qualified to perform both the exposure and the interpretation of dental radiographs.

   Refer to AMPM Policy 820 for information related to prior authorization requirements for FFS members.

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