



310-D2¹ ARIZONA LONG TERM CARE SYSTEM ADULT DENTAL SERVICES

REVISION DATES: 10/06/16²

EFFECTIVE DATE: 10/01/16³

DESCRIPTION⁴

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, AMPM Policy 1620, 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.

¹ Dental benefit pursuant to §36-2939

² Date Policy presented at APC.

³ Effective date of the Policy

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Facility and Anesthesia Charges

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.