CHAPTER 20:

Oral Health Services

Reviewed/Revised: 10/1/18, 10/1/19, 1/1/20, 3/1/20

As part of the physical examination, the physician, physician's assistant or nurse practitioner must 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. Depending on the results of the oral health screening, referral to a dentist should be made.

Category	Recommendation for Next Dental Visit
Emergent	Within 24 hours of request
Urgent	Within three days of request
Routine	Within 45 days of request

An oral health screening must be part of an EPSDT screening conducted by a PCP however, it does not substitute for examination by a dentist. PCPs are expected to refer EPSDT members for appropriate services based on needs identified through the screening process and for routine dental care based on the AHCCCS Periodicity Schedule (see Exhibit 3.2). Evidence of this referral must be documented on the EPSDT form.

Note: Although the AHCCCS Dental Periodicity Schedule (See Exhibit 431-1A) identifies when routine referrals begin, 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 dentist who is included in the provider network.

20.0 EPSDT COVERED SERVICES (AGES 0-20)

The following services are covered benefits for Health Choice Arizona EPSDT eligible members from the age of birth through the age of twenty (20) years (as well for KidsCare members up to and including age twenty (20) years of age), and do not require referral from the PCP. Members may self-refer for services.

20.1 EMERGENCY DENTAL SERVICES

- Treatment for pain, infection, swelling and/or injury
- Extraction of symptomatic, infected and non-restorable primary and permanent teeth, as well as retained primary teeth (extractions are limited to teeth which are symptomatic)

- General anesthesia, conscious sedation or anxiolysis (minimal sedation, patient responds normally to verbal commands) when local anesthesia is contraindicated or when management of the patient requires it (conscious sedation policy included in this chapter).

20.2 PREVENTIVE DENTAL SERVICES

Provided as specified in the AHCCCS Dental Periodicity Schedule (Exhibit 431-1A), including:

- Diagnostic services including comprehensive and periodic examinations.
- Radiology procedures which are screening in nature for diagnosis of dental abnormalities, including panograph or full-mouth x-rays; supplemental bitewing x-rays; and occlusal or periapical films as needed
- Oral prophylaxis performed by a dentist or dental hygienist that includes self-care oral hygiene instructions to member, if able, or to the parent/legal guardian
- Application of fluoride varnish. Use of a prophylaxis paste containing fluoride and fluoride mouth rinse is not considered a separate fluoride treatment
- For members under the age of fifteen, dental sealants on all non-carious and non-restored permanent first and second molars
- Space maintainers when posterior primary teeth are lost prematurely

Updates to preventive dental services (Effective October 1, 2017)

Note: PCPs who have completed the AHCCCS required training, may be reimbursed for fluoride varnish applications completed during the EPSDT visit for members who are at least six months of age, with at least one tooth erupted. Additional applications occurring every six 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 Smiles For Life http://www.smilesforlifeoralhealth.org.

Please refer to Training Module 6 that covers caries risk assessment, fluoride varnish and counseling. Upon completion of the required training, providers should submit a copy of their certificate to each of the contracted health plans 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.
The ICD billable code is *v07.31(ICD9) and Z29.3 (ICD10).*

20.3 THERAPEUTIC DENTAL SERVICES

Covered only when they are considered medically/dentally necessary and cost effective and may be subject to prior authorization. These services include but are not limited to:

- Periodontal procedures, scaling/root planning, curettage, gingivectomy, osseous surgery

- Crowns:
    - Stainless steel crowns may be used for both primary and permanent posterior teeth; composite, prefabricated stainless steel crowns with a resin window or esthetic coating can be used for anterior primary teeth.
    - Precious or cast semi-precious crowns may be used on functional permanent endodontically treated teeth, except third molars, for members who are eighteen (18) through twenty (20) years old and adults over twenty-one as a result of a dental emergency.
- Endodontic services including pulp therapy for permanent and primary teeth, except third molars (unless it is functioning in place of a missing molar)
- Restoration of carious permanent and primary teeth with accepted dental materials other than cast or porcelain restorations unless the member is eighteen (18) through twenty (20) years of age and adults over twenty-one as a result of a dental emergency and who have had endodontic treatment.
- Removable dental prosthetics, including complete dentures and removable partial dentures to age twenty-one.
- Orthodontic services and orthognathic surgery are covered only when these services are necessary to treat a handicapping malocclusion. Services must be 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 dentist 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:
    - Congenital, craniofacial or dentofacial malformations requiring reconstructive surgery correction in addition to orthodontic services
    - Trauma requiring surgical treatment in addition to orthodontic services
    - Skeletal discrepancy involving maxillary and/or mandibular structures

Services or items furnished solely for cosmetic purposes are excluded from AHCCCS/ Health Choice Arizona coverage (9 A.A.C. 22, Article 2).

20.4 CONSCIOUS SEDATION

Conscious sedation is covered for members receiving *EPSDT* services. Conscious sedation provides a state of consciousness that allows the member to tolerate a procedure while continuously maintaining adequate cardiovascular and respiratory function, as well as the ability to respond purposely to verbal command and/or tactile stimulation.

Coverage is limited to the following procedures:

- Risk of toxicity due to local anesthetic
- Underlying medical condition which is clearly documented, and by its nature, would require conscious sedation in order for the dental care to be provided safely. Examples of such conditions might include: cerebral palsy; epilepsy; developmental delays; or movement disorders.

- Any alternative 'special' situation which is clearly documented and indicates that a greater degree of relaxation would be necessary for treatment may be considered when medically/dentally indicated.
- Oral conscious sedation is not generally considered a covered benefit for members 21 years of age and older.

Additional applications of conscious sedation for members receiving EPSDT Services will be considered on a case by case basis and require medical/dental review and prior authorization.

20.5 DENTAL SERVICES FOR MEMBERS TWENTY-ONE (21) YEARS OF AGE AND OLDER

AHCCCS allows for coverage of medical and surgical dental services furnished by a dentist only to the extent such services may be performed under state law either by a physician or by a dentist. The following is based on Health Choice Arizona interpretation of these covered services when it considers the services as medically/dentally necessary. AHCCCS covers the following dental services provided by a licensed dentist for members who are 21 years of age or older.

20.5.1 EMERGENCY DENTAL SERVICES COVERAGE FOR PERSONS AGE 21 YEARS AND OLDER:

DENTAL CRITERIA:
Medically necessary emergency dental care is covered for persons age 21 years and older who meet the criteria for a dental emergency. A dental emergency is an acute disorder of oral health resulting in severe pain and/or infection as a result of pathology or trauma. Emergency dental services are allowed up to $1000 per member contract year (October 1st to September 30th). Follow up procedures necessary to stabilize teeth as a result of the emergency service are covered and subject to the $1000 limit. The following services and procedures are covered as emergency dental services:

1. Emergency oral diagnostic examination (limited oral examination – problem focused)
2. Radiographs and laboratory services, **limited** to the **symptomatic** teeth
3. Composite resin due to **recent** tooth fracture for anterior teeth
4. Prefabricated crowns, to eliminate pain due to **recent** tooth fracture only
5. Recementation of **clinically sound** inlays, onlays, crowns, and fixed bridges
6. Pulp cap, direct or indirect plus filling, limited to the symptomatic teeth
7. Root canals and vital pulpotomies when indicted for the treatment of acute infection or to eliminate pain
8. Apicoectomy performed as a separate procedure, for treatment of acute infection or to eliminate pain, with **favorable** prognosis
9. Immediate and palliative procedures, including extractions if medically necessary, for relief of pain associated with an oral or maxillofacial condition
10. Tooth reimplantation of accidentally avulsed or displaced anterior tooth, with **favorable** prognosis

11. Temporary restoration which provides palliative/sedative care (limited to the tooth receiving emergency treatment)
12. Initial treatment for acute infection, including, but not limited to, periapical and periodontal infections and abscesses by appropriate methods
13. Preoperative procedures and anesthesia appropriate for optimal patient management
14. Cast crowns **limited** to the restoration of root canal treated teeth only

LIMITATIONS for Adult Emergency Dental Services Limitations for Persons age 21 Years and Older

1. Maxillofacial dental services provided by a dentist are not covered except to the extent prescribed for the reduction of trauma, including reconstruction of regions of the maxilla and mandible.
2. Diagnosis and treatment of temporomandibular joint dysfunction are not covered except for the reduction of trauma.
3. **Routine** restorative procedures and routine root canal therapy are **not** emergency dental services.
4. Treatment for the prevention of pulpal death and imminent tooth loss is limited to non-cast fillings, crowns constructed from pre-formed stainless steel, pulp caps, and pulpotomies only for the tooth causing pain or in the presence of active infection
5. Fixed bridgework to replace missing teeth is **not covered**

NOTIFICATION REQUIREMENTS FOR CHARGES TO MEMBERS

In order for a provider to bill the member for emergency dental services exceeding the $1000 limit, the provider must **first inform** the member in a way she/he understands, that the requested dental service **exceeds** the $1000 limit and is **not** covered by AHCCCS. 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 contains information describing the **type of service** to be provided and the charge for the service.

FACILITY AND ANESTHESIA CHARGES

AHCCCS expects that in **rare** instances a member may have an **underlying medical condition** which necessitates that services provided under the emergency dental benefit be provided in an Ambulatory Service Center or an Outpatient Hospital and may require anesthesia as part of the emergency service. In those instances, the facility and anesthesia charges **are subject** to the $1000 emergency dental limit.

Dentists performing General Anesthesia (GA) on members will bill using dental codes and the cost will count towards the $1000 emergency dental limit.

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

INFORMED CONSENT

Informed consent is a process by which the provider advises the member/guardian/designated representative 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 consent for oral health treatment include:
    a. 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.
    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 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.
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/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 patients representative, if under the 18 years of age or is 18 years of age or older and considered an incapacitated adult. Completed consents and treatment plans must be maintained in the members' chart and are **subject to audit.**

Medical Exceptions Not Subject To The $1000 Adult Emergency Dental Limit:

1. **Services related to the treatment of a medical condition such as acute pain, infection, or fracture of the jaw** excluding Temporomandibular Joint Dysfunction (TMJ) pain. Diagnosis and treatment of TMJ is not covered except for reduction of trauma. Covered services include:
    a. limited problem focused examination of the oral cavity
    b. required radiographs
    c. treatment of maxillofacial fractures
    d. administration of an appropriate anesthesia
    e. prescription of pain medication and antibiotics
2. **Dental Services for Member's Eligible for Transplantation Services** For members who require medically necessary dental services as a pre-requisite to AHCCCS covered organ or tissue transplantation. AHCCCS covers these services **only after** a transplant evaluation determines that the member is an **appropriate** candidate for organ or tissue transplantation. Covered dental services are limited to the elimination of oral infections and the treatment of oral disease. These services are **not** subject to the $1000 adult emergency dental limit. Covered services include:
    a. limited problem focused examination of the oral cavity

b. dental cleanings, treatment of periodontal disease
c. medically necessary extractions
d. 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

Procedure

i. The Dental Department must be notified by the Health Choice Arizona Transplant Coordinator of the need for a dental evaluation to assist in qualifying a potential transplant patient. A dental examination and necessary x-rays will be approved. The provider must submit a treatment plan with supporting documents to Health Choice Arizona.
ii. Once the Dental Unit has been notified that the member has been listed for transplant, an authorization for approved services as determined by the Dental Director will be sent to the treating dentist.

3. **Cancer of the jaw, neck or head**: The extraction of severely decayed and/or periodontally involved teeth in preparation for radiation treatment. These services are not subject to the $1000 adult emergency dental limit:
    a. Oral examination
    b. Necessary dental x-rays if extractions are to be performed
    c. Prophylactic extraction of teeth in preparation for radiation treatment of cancer of the jaw, neck or head is covered
4. **Lymphoma**: The elimination of oral infection and treatment of oral disease, including:
    a. dental cleanings, treatment of periodontal disease
    b. medically necessary extraction(s)
    c. provisions of simple restorations, oral examination
    d. necessary dental x-rays
    e. treatment with respect to the management of mucositis, hemorrhage, and related side effects of underlying disease

Procedure

i. When Health Choice Arizona receives a request for services on adult members with cancer of the jaw, neck or head or lymphoma, the medical documentation is reviewed by the Dental Director, Chief Medical officer or designee to determine if criteria is met
ii. If it is determined that the adult member meets the criteria, a dental examination and necessary x-rays will be approved. The provider must submit a treatment plan with supporting documentation to Health Choice Arizona

Family Planning Service Only Members

Members enrolled in the AHCCCS Family Planning Services program are ***not*** eligible for dental services. Family Planning only members are identified by rate codes (plan codes) **5500, 5510** and **5520**.

Refer to the Health Choice Arizona Dental Clinical Review Criteria for more detailed oral health service coverage. They can be found in the Provider Portal of the Health Choice Arizona web site, www.HealthChoiceAZ.com.

20.6 DENTAL PRIOR AUTHORIZATIONS AND MEMBER REFERRALS

Overview

Health Choice Arizona has confidence dentists are capable of providing the majority of medically necessary dental services to the patients who present to them.

However, should the need arise for medically necessary dental specialty services, the Health Choice Arizona Chief Medical Officer, Medical Director(s), Dental Director(s) or their designees make dental necessity determinations based upon nationally recognized, evidence-based standards of care and also based on what the AHCCCS program benefits will pay for.

Accurate and prompt dental necessity determinations depend upon the comprehensive content and the quality of dental documentation that Health Choice Arizona (or its delegated entities) receives with each request. Health Choice Arizona is committed to making the prior authorization process as efficient and simple as possible; however, the requesting provider should make a best effort to submit requests in a manner which can facilitate an effective review process.

Health Choice Arizona utilizes specific dental utilization Clinical Review Criteria (CRC) developed by Health Choice Arizona Dental Directors in order to consistently and accurately conduct prior authorization and ensure proper utilization/payment of AHCCCS-covered dental services. Health Choice Arizona's operational focus is to assure compliance with its Dental Clinical Review Criteria and AHCCCS coverage benefits and limitations.

For a complete listing of services which require Prior Authorization please refer to Exhibit 20.2*:* Health Choice Arizona Under 21 Dental Matrix. This 'Matrix' can also serve as a quick reference guide and answer many questions which may arise but which are not expressly referred to in the chapter text. Services that require authorization (non-emergent) for members ages 0 through 20 should not be initiated prior to Health Choice Arizona coverage determinations are made. Non-emergency treatment for members ages 0 through 20 started prior to the determination of coverage will be performed at the financial risk of the dental office. **Please note:** Primary coverage from another dental insurer does not limit the requirement for obtaining prior authorization. Any services requiring prior authorization as listed on the dental matrix is regardless if other insurance is prime.

For a complete listing of services for Adult Emergency services, please refer to Exhibit 20.3 Health Choice Arizona Over 21 and Transplant Members Dental Matrix. Prior Authorization for adult emergency dental services is not required. All adult emergency services are subject to retrospective review to determine whether they satisfy the criteria for a dental emergency. Services determined to not meet the criteria for a dental emergency are subject to recoupment.

Health Choice Arizona (per AHCCCS and Federal regulations) does not prior authorize Emergency services. All AHCCCS-covered, adult dental services are limited in nature and are reviewed for coverage and payment determination at the time the claim is submitted.
Dental Providers should become familiar with Health Choice Arizona and AHCCCS adult dental coverage limitations and provide services accordingly.
AHCCCS only covers medical and surgical services furnished by a dentist 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. (Excluded services which physicians are not generally competent to perform are 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).
Services rendered must be related to the treatment of a medical condition (such as acute pain, infection, or fracture of the jaw).

Covered services may include a limited examination of the oral cavity, required radiographs, and complex oral surgical procedures such as treatment of maxillofacial fractures, administration of an appropriate anesthesia and the prescription of pain medication and/or antibiotics.

Certain pre-transplant services and prophylactic extraction of teeth in preparation for radiation treatment of cancer of the jaw, neck or head are covered (elimination of oral infections, dental cleanings, and treatment of periodontal disease, medically necessary extractions and the provision of simple restorations deemed medically necessary for a covered transplantation). Prophylactic extraction of teeth in preparation for covered radiation treatment of cancer of the jaw/neck/head are covered.

Prior authorizations for non-emergent services for members ages 0 through 20 are to be submitted on a standard ADA claim form leaving the date of service blank. If a request for dental services is denied, the dental provider will be notified in writing (by mail and/or FAX) that the services requested have been denied. In the event that a denial is issued, the dental provider may submit a new PA request with additional documentation. In the absence of new documentation, a denial must be appealed by the member or by the dental provider when written permission from the member has first been obtained.

DENTAL PRIOR AUTHORIZATION MAILING ADDRESS**:**
Health Choice Arizona
Dental Authorizations
410 N. 44th St. Suite. 900
Phoenix, AZ 85008
Email: HCH.DentalDepartmentHCA@steward.org

Please follow these key steps when requesting a medically necessary prior authorization:

1. Offices must legibly complete all necessary fields of the most current ADA Claim form leaving the “date of service” field blank.
2. Offices must provide specific CPT codes (and HCPCS/J-codes when applicable).

3. Offices should only request PA for services listed on the Health Choice Arizona Dental PA Matrix as requiring authorization.
4. Offices must include ALL necessary documentation to support medical necessity in order to avoid unnecessary denials or inappropriate delays in the dental review/approval process.
5. Offices must clearly indicate whether the request is "Standard" or "Expedited" (see below for details). Offices must not abuse Expedited service requests as inappropriate "Expedited" requests result in slower response times for truly urgent medical authorizations from all network providers. Inappropriate "Expedited" requests will be downgraded to "Standard" by Health Choice Arizona which will then take up to 14-calendar days to complete.

The ADA Claim form should be mailed or emailed to the Health Choice Arizona Dental Authorization department **NOTE**: Receipt of an authorization from Health Choice Arizona ***does not*** guarantee payment of services.

- ✓ The claim must be billed correctly and timely
- ✓ The service must not be deemed experimental or investigational
- ✓ Services rendered must be covered under the AHCCCS program
- ✓ The member must be determined eligible on the date of service
- ✓ AHCCCS is (generally) the payer of last resort and primary insurance and/or other credible coverage must be billed first, regardless of primary benefit coverage

20.7 TIME FRAMES FOR HEALTH PLAN PRIOR AUTHORIZATION REVIEW

- ✓ **"Standard"**: **Up to 14 calendar days -** Standard means a request for which a Contractor must provide a decision as expeditiously as the member's health condition requires, but not later than 14 calendar days following receipt of the authorization request, with a possible extension* (see "*AHCCCS-required 14-day Extensions*" below) of up to 14 calendar days if the member or provider requests an extension or if the Contractor justifies a need for additional information and the delay is in the enrollee's best interest.

- ✓ **"Expedited": 72 Hours–** Expedited means a request for which a provider indicates or a Contractor determines that using the standard time frame could seriously jeopardize the member's life or health or ability to attain, maintain, or regain maximum function. The Contractor must make an expedited authorization decision and provide notice as expeditiously as the member's health condition requires no later than three working days following the receipt of the authorization request, with possible extension* (see "*AHCCCS-required 14-day Extensions*" below) of up to 14 days if the member or provider requests an extension or if the Contractor justifies a need for additional information and the delay is in the enrollee's best interest."

20.8 PRIOR AUTHORIZATION DETERMINATIONS

Authorizations which are correctly submitted to Health Choice Arizona will be processed and completed in one of the following standard methods:

1. **Approved – Meets Criteria/Guidelines**: The information received met all Health Choice Arizona requirements, and authorization is granted. No further action is required by the office except to notify the member/facility and facilitate the member in obtaining the approved services. :

   Note: In some instances, the Health Choice Arizona Dental Department will review the requested dental service and approve what may be considered an 'equivalent' service, which does not constitute a formal "reduction" (see below) of services. This action is intended to facilitate authorization of care which is covered by Health Choice Arizona /AHCCCS and eliminates unnecessary barriers to care.

   The Health Choice Arizona "Referral / Authorization" form which is issued will contain specific information regarding the equivalent service which has been issued.
2. **Approved – Payment Pending X-rays ***: In some instances, the Health Choice Arizona Dental Department will review the requested dental service and grant an authorization; however final payment requires documentation to show medical/dental necessity not yet demonstrated at the time the authorization is granted (this is unique to the provision of dental care and the capacity of Health Choice Arizona to perform prospective review a dental plan of care). Final coverage and payment of the amount, duration and scope of services is dependent upon documentation created at the time authorized care is rendered, which should be submitted with the claim.
   - The Health Choice Arizona "Referral / Authorization" form which is issued will contain specific information instructing the office what documentation (i.e. dental X-rays) should be submitted with the claim in order for it to be processed.
3. **Denied**: The information received did not meet all Health Choice Arizona requirements, and authorization is not granted. The requesting Provider will receive a denial notification letter.
4. **14-day Extension** (*see also below**): If Health Choice Arizona is provided with enough documentation to suggest the requested service may be approved in the event that specific, additional information can be obtained from the requesting Provider AND attempting to obtain this information is in the best interest of the member, Health Choice Arizona will issue a written "14-day extension", *Notice of Extension for Service Authorization (NOA)* to request additional records. (Health Choice Arizona will frequently make an initial attempt to call or fax the office in order to obtain the needed information before resorting to a formal 14-day extension).

   Note: In no case will the Health Choice Arizona decision be issued any later that total of 28 days for Standard requests OR 17 days for Expedited requests from the date the PA request was received.
5. **Partial Approved – reduced payment**: The information received met all Health Choice Arizona medical necessity requirements, and a partial authorization is granted. Requested services may be reduced when the documentation provided does not support the full amount, duration and/or scope of service at the time of request.

AHCCCS-required 14-day Extensions*

In some instances where PA has been requested, the documentation received by Health Choice Arizona *may* suggest the medical/dental necessity for the service exists but the records provided are insufficient to render authorization decision. When this occurs, additional information may be requested via fax or direct phone contact. When additional information cannot be obtained in order for Health Choice Arizona to meet AHCCCS mandated Expedited or Standard PA time frames, Health Choice Arizona will issue an AHCCCS-required *Notice of Extension for Service Authorization (NOE)* letter to both the member and the requesting provider.

This 14-day extension will afford both Health Choice Arizona and the requesting Provider up to 14 additional calendar days to obtain the additional information necessary to render a final determination. If at the end of the 14-day Extension Health Choice Arizona has not received the necessary additional information, the request will be denied, and both the Provider and member will be notified.

20.9 SUPPORTING DOCUMENTATION

Documentation of medical/dental necessity must accompany all requests for prior authorization. For most PA requests, supporting documentation should include:

- Current diagnosis and treatment already provided by the PCP/PDP/requesting Provider
- All pertinent medical/dental history and physical (dental/oral) examination findings;
- Diagnostic imaging (and laboratory reports, if applicable)
- Indications for the procedure or service
- Alternative treatments, risks and benefits (including the indication of such discussions with patient)
- For Out-Of-Network (OON) providers/facilities/ services, and/or Non-Formulary (NF) medication requests, specific information which explains the medical necessity for an OON or NF service is required. A PA is required in order for any service to be covered at OON providers/facilities.

Refer to Exhibit 20.2, Dental Benefit Matrix and Exhibit 20.3, Health Choice Arizona Over 21 and Transplant Members Dental Matrix for more information on supporting document requirements.

20.10 AUTHORIZATION DENIALS

AHCCCS policies mandate all members must be notified of a denial of service request within 72 hours for Expedited requests, and within 14 calendar days for Standard request. When a denial is issued, the health plan must inform the member of the denial of service and the reason for denial in clearly understood language in the form of a “Notice of Adverse Benefit Determination” (NOA) letter.

Please be aware AHCCCS requires NOA letters to communicate the basis for a denial in ‘easily understood’ language, therefore NOA letters will be written in a simplistic fashion in order to comply with this specific AHCCCS requirement. For more information about what a member can do if they receive an NOA, please see Chapter 15: *Claim Disputes and Member Appeals.*

Written information which communicates a denial of service will also be sent to the requesting provider (or their designee). Provider denial letters are sent to the individual who has requested the prior authorization and will contain varying degrees of detail in order to explain the basis for denial.

20.11 DENTAL SPECIALTY REFERRALS

Dental Referrals which require Health Choice Arizona approval

- ✓ Oral Surgery Referrals
- ✓ Endodontic Referrals
- ✓ Periodontal Referrals

To obtain prior authorization for a referral to a dental specialist, the Primary Care Dentist will mail Health Choice Arizona the request (Exhibit 20.1). The Health Choice Arizona Benefit Examiner will review all requests within the "Standard" and "Expedited" frames. A prior authorization will be issued for the referral to the specialist if the request meets Health Choice Dental Clinical Review Criteria and is approved. The authorization will be faxed back to the general dentist who will then contact the member to inform them of the name of the dental specialists to whom the member has been referred.

Health Choice Arizona does require an approved referral to a dental specialist for adult emergency dental. The referring dental provider and accepting dental specialist must coordinate care. Dental providers should become familiar with Health Choice Arizona and AHCCCS adult dental coverage limitations for urgent/emergency dental care and provide services accordingly.

In the event a referral is needed for an Adult (members 21 years of age and older), the referring dental provider and accepting dental specialist must coordinate care. Dental Providers should become familiar with Health Choice Arizona and AHCCCS adult dental coverage limitations for urgent/emergency dental care and provide services accordingly.
Supporting documentation and radiographs must be provided with the dental claim(s) at the time they are submitted. The information provided with the claim will be retrospectively reviewed and approved or denied for payment.

Special considerations and information regarding Dental Prior Authorizations

- The Primary Dental Provider (PDP) must determine if a service requires prior authorization.
- Health Choice Arizona members should be instructed not to self-refer to specialists without the express recommendation of their PCP and/or PDP.
- Health Choice Arizona will provide notice of approval/denial within the allowable time frames via fax and/or phone to the requesting provider.
- If the service required prior authorization and an authorization was not approved, or if the member was ineligible at the time of service, the claim will be denied.

- The authorization number or denial should be noted in the member medical record.
- Prior Authorization approval number(s) should be provided BY the requesting provider TO the Specialist/Facility/Vendor PRIOR to the member's appointment.
- The Specialist, facility or vendors are responsible to ensure that necessary authorizations have been issued prior to rendering service.
- The PCP/PDP (or ordering Provider) is responsible to facilitate coordination of care and assist/alert the member to make the necessary appointments for approved services.
- When difficulty arises in coordinating and/or facilitating care, the referring provider should contact the plan for additional assistance.
- Authorization is NOT a guarantee of payment for services.
- Authorizations are valid for 90 days.
- Specialty Referrals are valid for 60 days.
- Contracted health professionals, hospitals, and other providers are required to comply with Health Choice Arizona Prior Authorization policies and procedures.
- Health Choice Arizona Dental directors and dental prior authorization staff are available to discuss the review determinations with the attending dentist or other ordering providers.

Retrospective (a.k.a. "RETRO") Authorizations

Health Choice Arizona requires prior authorization be obtained for some non-emergent/non-urgent services for member as defined by this Chapter and the Health Choice Arizona Dental Prior Authorization Matrix. Health Choice Arizona does not generally entertain requests for 'retro' prior authorization as these are, by definition, contradictory. It is the responsibility of the Provider or Facility rendering care to verify insurance eligibility, as well as benefit coverage and/or authorization requirements/status.

In the event prior authorization is not obtained, and a non-authorized service is rendered as a direct result of an urgent or emergent medical/dental condition, the dental provider should take the following measure:

- The dental provider should submit the claim for the urgent/emergent, <u>non-authorized</u> service(s) with documentation to:
  1. Support the medical/dental necessity of the care rendered
  2. Support that the care rendered was either:
     a. Required on an urgent or emergent basis
     b. Required as a direct result of a necessary, unexpected modification of the dental care plan

The claim and supporting documentation will be reviewed by the Health Choice Arizona Chief Medical Officer and/or Dental Director, or their designee, for approval or denial.

Providers/Facilities have the right to file a Claims Dispute if a claim is denied (see Chapter 15: Claim Disputes, Members Appeals and Member Grievances). Simply, if the Provider submits a claim which is denied for no prior authorization being obtained, the claim can be disputed along with documentation of medical necessity and a basis for why prior authorization was not obtained.

20.12 PROVIDER PORTAL

For your assistance, the "Provider" area of the Health Choice Arizona website allows Providers/Offices who become registered to log-in to the Health Choice Arizona Provider Portal and utilize helpful features, such as:

- Checking claims status
- Checking member eligibility
- Checking Health Choice Arizona Dental Clinical Review Criteria (PA CRC) Prior Authorization Guidelines in order to better assist Providers with the information that may be needed to obtain a prior authorization.
- The Provider Portal will soon allow offices to submit a PA Form for "Standard" service requests on-line and get immediate feedback of plan receipt. Instructions will be provided on how to submit supporting documentation via FAX until such time that Health Choice Arizona can also accept on-line submission of electronic and/or scanned medical records.

Health Choice Arizona uses the following protocol to resolve appeals regarding authorizations:

1. The requesting provider may resubmit a new PA request with new/additional information pertinent to the original non-authorized request to the Prior Authorization Department.
   Please note: Requests should only be resubmitted to the Health Choice Arizona Prior Authorization Department IF new/additional pertinent information is being provided with the resubmission
2. The original information (denial packet) will be gathered from short-term or long-term storage, combined with the current request which contains new/additional information, and will be presented to the Health Choice Arizona Dental Director, or their designee, for re-review.
3. If no new and/or additional information is received, the resubmitted request will be "Cancelled" (C) and the office notified by telephone or FAX. New and/or additional information is needed to constitute a new PA request. If the member wishes to file an appeal on a denied authorization, please refer them to their Member Handbook, Member Services, or Chapter 15: Claim Disputes, Members Appeals and Member Grievances of this Provider Manual for details.

NOTE: Contracted providers, as a requirement of their contract with Health Choice Arizona, MUST submit all necessary documentation with a Prior Authorization request in order for the Plan to make an informed, accurate, and timely determination of medical necessity.

20.13 IMPORTANT NOTICE TO ALL HEALTH CHOICE ARIZONA PROVIDERS

Participating providers must hold the Member, Health Choice Arizona, and AHCCCS harmless as set forth in the Provider Participation Agreement if coverage is denied for failure to adhere to the Health Choice Arizona prior authorization and referral guidelines as outlined in this Chapter.