



Emergency Dental Benefit

21+

March 1, 2018



Introduction

Senate Bill 1527 established a \$1,000 emergency dental benefit for emergency dental care and extractions, for all members 21 years of age and older. This benefit is \$1,000 per member per contract year (October 1st to September 30th).

- This affects 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.

What is a Dental Emergency?

- 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.”

Examples of Covered Services in a Dental Emergency

- 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,
- 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 Does This Change for FFS Acute Members 21 Years of Age and Older?

- These members previously had no dental benefit. They only had medical and surgical services furnished by a dentist covered, 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), per AMPM 310-D1.
- Now 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 does this change for ALTCS and Tribal ALTCS members?

- 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).
- Now ALTCS and Tribal ALTCS members also have a \$1,000 benefit per member, per contract year to cover emergency dental care and extractions.
- ***Overall they now 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.

Important Note

- 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.

Informed Consent

What is an 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...

- **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.

Charges to Members

- Emergency dental services of **\$1000** per contract year are covered for AHCCCS members age 21 years and older. Billing of AHCCCS members for emergency dental services in **excess** of the \$1000 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 s/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 contain information describing the type of service to be provided and the charge for the service.

For ALTCS Members

- Providers shall provide medically necessary services within the ALTCS \$1,000 dental benefit allowable amount. In the event that medically necessary services are greater than \$1,000, the provider may perform the services as set forth in A.A.C. R9-28-701.10 and R9-22-702, after the following notifications take place.
- 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 limit.

Questions?

Please email:

ProviderTrainingFFS@azahcccs.gov



Thank you!

