CHAPTER 20:

Oral Health Services

Reviewed/Revised: 10/1/18, 10/1/19, 1/1/20, 7/8/20, 2/5/21, 4/1/21, 7/1/21, 9/2/21, 3/17/22, 9/3/22, 3/27/23, 8/1/23, 1/1/24, 5/27/24, 7/8/24, 1/18/25, 05/1/2025, 12/19/2025

As part of the physical examination, the physician, nurse practitioner or physician's assistant must perform an oral health screening. 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, a request to a dentist should be made.

Category	**Recommendation for Next Dental Visit**
Urgent	As expeditiously as the member's health condition requires, but no later than three business 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 an 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 EPSDT Periodicity Schedule (see attachment 430-A). Evidence of this referral must be documented on the EPSDT Clinical Sample Template and in the member's medical record.

Note: Although the AHCCCS Dental Periodicity Schedule (See attachment 431-A) 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 in the provider network.

20.0 EPSDT COVERED SERVICES (AGES 0 THROUGH 20)

The following services are covered benefits for EPSDT eligible members from the age of birth up to the age of twenty-one (21) years (as well as for KidsCare members up to and through the age eighteen (18) years of age) and do not require a 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 the 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 (Attachment 431-A), including but not limited to:

- Diagnostic services, including comprehensive and periodic oral examinations. We allow two oral examinations and two oral prophylaxis per member per year up to 21 years of age. Additional examinations or treatments must be medically necessary
- Radiology procedures which are screening in nature 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)
- 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. Additional panorex films above this limit are allowed when deemed medically necessary
- Oral prophylaxis performed by a dentist or dental hygienist that includes self-care oral hygiene instructions to the member, if able, or to the Health Care Decision Maker, and designated representative
- Application of topical fluoride and fluoride varnish. Use of a prophylaxis paste containing fluoride and fluoride mouth rinse is not considered a separate fluoride treatment. For members up to five (5) years of age, fluoride varnish may be applied four times a year (i.e., one every three months).
- For members under the age of fifteen years, dental sealants on all non-carious and non-restored permanent first and second molars. 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 participating providers. Dental sealants are covered twice per first or second molar, per provider/location, allowing for three years of intervention between applications. Additional applications are allowed when deemed medically necessary.
- Space maintainers when posterior primary teeth are lost prematurely**. Exception is missing primary first molars when the first permanent molar has erupted.**

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 three months during an EPSDT visit, up until the member's fifth birthday, may be reimbursed according to AHCCCS approved fee schedules. The 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.aap.org/en/patient-care/oral-health/oral-health-education-and-training/

Please refer to the website for training that covers caries-risk assessments, fluoride varnish, and counseling. Upon completion of the required training, providers should submit a copy of their certificate to us, as this is required prior to issuing payment for PCP applied fluoride varnish. This certificate may be used in the credentialing process to verify the completion of the training necessary for reimbursement. The ICD billable code is *Z29.3 (ICD10).*

20.3 THERAPEUTIC DENTAL SERVICES

These services are covered only when they are considered medically/dentally necessary and cost-effective and may be subject to prior authorization. They 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 due to a dental emergency and who have had endodontic treatment.
- Restorations of anterior teeth for children under the age of five, when medically necessary. Children five years and over with primary anterior tooth decay should 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,
- Removable dental prosthetics, including complete dentures and removable partial dentures to age twenty-one.
- Dental appliances
- Orthodontic services (comprehensive and interceptive) and orthognathic surgery are covered only when these services are necessary to treat a handicapping malocclusion (i.e., CRS, Cleft Palate). 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/ BCBSAZ Health Choice coverage (A.A.C. R9-22-215).

We adhere to the Dental Uniform Warranty List as outlined in AMPM Policy 431.

PROFESSIONALLY ACCEPTED TREATMENT OR ALTERNATIVE SERVICES

Dental providers are required to consider the most cost-effective means of replacing lost dental function for qualified members with complex dental disease. We will allow for the Least Expensive Professionally Acceptable Alternative Treatment (LEPAAT) as determined by professional review.

Applying the LEPAAT standard is not to be considered as dictation of treatment but to notify the treating dentist of the services we will reimburse. Complex dental care is identified as the treatment of multiple teeth with root canal, build ups, and/or laboratory type crowns in a six-month period and/or certain member/patient situations that includes extensive dental restorative treatment.

Complex dental care may not be warranted in these cases and alternative benefits to the requested procedure may be applied. In this instance, we require the submission of a complete treatment plan with appropriate diagnostic radiographs.

Those situations include but are not limited to:

- Rampant dental caries
- Gross or extensive caries
- Missing teeth
- Unrestorable teeth
- Periodontal disease (i.e. Gingivitis, Periodontitis, etc.)
- Inadequate home care
- Lack of arch integrity
- Poor dental history
- Poor prognosis
- Substance abuse
- Intellectual developmental and/or behavioral disorders
- Eating disorders (i.e., Anorexia Nervosa and Bulimia Nervosa)

Under these situations, we may not approve multiple root canal treatments and subsequent buildups and crowns, however, may consider allowing the extractions of the teeth and placing removable prosthetics when the medical necessity can be established and coverage, guidelines, and criteria are met.

Complex dental care may only be approved when medically necessary and when there is documentation for a high probability for success.

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 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 a greater degree of relaxation would be necessary for treatment may be considered when medically/dentally indicated.

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 our 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 aged 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 due to pathology or trauma. Emergency dental services are allowed up to $1000 per member contract year (October 1st to September 30th).

**American Indian/American Native (AI/AN) members who receive dental treatment at an I.H.S/638 Tribal facility are not subject to this $1000 per member contract year limit. Services performed outside of I.H.S/638 Tribal facilities for AI/AN members (i.e. by our contracted providers) remain limited to the $1000 Emergency Dental Benefit for members 21 years of age and over.*

Follow-up procedures necessary to stabilize teeth after emergency services 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 aged 21 Years and Older

1. Maxillofacial dental services provided by a dental provider 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, routine root canal therapy, and tooth/teeth extractions in preparation for a denture fabrication 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. Dentures, fixed bridgework, and implants to replace missing teeth are **not covered**

NOTIFICATION REQUIREMENTS FOR CHARGES TO MEMBERS

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 that they understand 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 the member understands the dental

service will **not** be fully paid by AHCCCS and 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 for the provider to bill the member. The document is expected to contain information describing the **type of service** to be provided and the charge for the service.

FACILITY AND ANESTHESIA CHARGES

AHCCCS expects in **rare** instances a member may have an **underlying medical condition** which necessitates 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/Health Care Decision Maker, and 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.

1. Informed consent 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.
    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 or the member's Health Care Decision Maker 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, to provide quality and consistent care, in a manner that protects and is easily understood by the member, or the member's Health Care Decision Maker, and 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 member**, **or the member's Health Care Decision Maker, and designated 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 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. Oral examination, necessary dental x-rays
    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 our 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 us.
    ii. Once the Dental Department has been notified 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

    Procedure

    i. When we receive a request for services on adult members with cancer of the jaw, neck or head, the medical documentation is reviewed by the Dental Director, Chief

Medical officer or designee to determine if criteria is met [NCQA HPA 2025, UM 4A-1,2]

ii. If it is determined 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 us

4. **Ventilator Cases**
    a. Members who are in an inpatient hospital setting and are placed on a ventilator or are physically unable to perform oral hygiene are covered for dental cleanings performed by a hygienist working under the supervision of a physician. If services are billed under the physician, then medical codes will be submitted. These services are **not** subject to the $1,000 adult emergency dental limit.

Refer to the Dental Clinical Review Criteria for more detailed oral health service coverage which are found under the 'For Providers' Tab of the Plan's website, Health Choice AZ .

20.6 DENTAL PRIOR AUTHORIZATIONS AND MEMBER REFERRALS

We have confidence dentists can provide most medically necessary dental services to the patients who present to them.

However, should the need arise for medically necessary dental specialty services, our 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. [NCQA HPA 2025, UM 4A-1,2]

Accurate and prompt dental necessity determinations depend upon the comprehensive content and the quality of dental documentation we (or its delegated entities) receive with each request. The Plan 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.

We use specific dental utilization Clinical Review Criteria (CRC) developed by the Plan Dental Directors to consistently and accurately conduct prior authorization and ensure proper utilization/payment of AHCCCS-covered dental services. [NCQA HPA 2025, UM 2A-1]
Our operational focus is to assure compliance with the Dental Clinical Review Criteria and AHCCCS coverage benefits and limitations.

For a complete listing of services which require Prior Authorization please refer to our Dental Prior Authorization Matrix located on our website: https://www.azblue.com/health-choice-az/providers/dental-matrix/ and is also available as Exhibit 20.2 BCBSAZ Health Choice Arizona under 21 Dental Matrix, of this provider manual chapter.

The *AHCCCS Uniform Prior Authorization List of Dental Codes* can be referred to by visiting AHCCCS online at: https://azahcccs.gov/PlansProviders/GuidesManualsPolicies/index.html.

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 which require authorization (non-emergent) for members ages 0 through 20 should not be initiated prior to coverage determinations being 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.

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. For a complete listing of services for Adult Emergency services, please refer to Exhibit 20.3 BCBSAZ Health Choice Arizona Over 21 and Transplant Members Dental Matrix.

We (per AHCCCS and Federal regulations) do 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 our and AHCCCS' adult dental coverage limitations and provide services accordingly.

AHCCCS only covers medical and surgical services furnished by a dentist to the extent 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 covered transplantation). Prophylactic extraction of teeth in preparation for covered radiation treatment of cancer of the jaw/neck/head are covered. Dental Cleanings for members who are in an inpatient hospital setting and are placed on a ventilator 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 or via the secure provider portal. If a request for dental services is denied, the dental provider will be notified in writing (by mail and/or Fax) the services requested have been denied. In the event 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 providers may discuss a determination by requesting a Peer-to-Peer with the BCBSAZ Health Choice Dental Director within 10 business days of receiving determination notification.

DENTAL PRIOR AUTHORIZATION MAILING ADDRESS**:**
BCBSAZ Health Choice
Attn: Dental Prior Authorizations
8220 N. 23rd Ave.
Phoenix, AZ 85021
OR
DENTAL PRIOR AUTHORIZATION SECURED EMAIL ADDRESS:
HCHDentalDeptHCA@azblue.com
OR
THE PROVIDER PORTAL

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 CDT codes (and HCPCS/J-codes when applicable).
3. Offices should only request PA for services listed on our Dental PA Matrix as requiring authorization.
4. Offices must include ALL necessary documentation to support medical necessity to avoid unnecessary denials or inappropriate delays in the dental review/approval process. [NCQA 2025 HPA, UM 6A]
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" which may then take up to 14-calendar days to complete.

The ADA Claim form should be mailed to our Dental Authorization department **NOTE**: Receipt of an authorization ***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 no 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. [NCQA HPA 2025, UM 5A-4]

- **"Expedited":** Up to **72 Hours**– Expedited means a request for which a provider indicates, or a Contractor determines 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 72 hours following the receipt of the authorization request, with possible extension* [NCQA HPA 2025, UM 5A-2]

  *(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

Prior authorization requests which are correctly submitted will be processed and completed in one of the following standard methods:

1. **Approved – Meets Criteria/Guidelines**: The information received met all 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 Dental Department will review the requested dental service and allow 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 the Plan/AHCCCS and eliminates unnecessary barriers to care.

   The "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 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 our capacity to perform prospective review of 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 Provider notification letter 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 requirements, and authorization is not granted. The requesting Provider will receive a denial notification letter.

4. ***14-day Extension:** If we are provided with enough documentation to suggest the requested service may be approved in the event specific, additional information can be obtained from the requesting Provider and attempting to obtain this information is in the best interest of the member, we will issue a written "14-day extension", *Notice of Extension for Service Authorization (NOE)* to request additional records. (We will frequently make an initial attempt to call or fax the office to obtain the needed information before resorting to a formal 14-day extension).
   Note: In no case will the decision be issued any later than 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 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 the request.

AHCCCS-required 14-day Extensions

In some instances where PA has been requested, the documentation we receive *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 for us to meet AHCCCS mandated Expedited or Standard PA time frames, we 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 the Plan 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 we haven't received the necessary additional information, the request will be denied, and both the Provider and member will be notified. [NCQA HPA 2025, UM 5A-2,4]

20.9 SUPPORTING DOCUMENTATION

Documentation of medical/dental necessity must accompany all requests for prior authorization. [NCQA 2025 HPA, UM 6A]. 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, BCBSAZ Health Choice under 21 Members Dental Matrix and Exhibit 20.3, BCBSAZ Health Choice 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 requests. 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. [NCQA HPA 2025, UM 7B-1]

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 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, Member Appeals and Member Grievances.*

Written information that communicates a denial of service will also be sent to both the requesting and the treating provider (or their designee). Provider denial letters will contain varying degrees of detail to explain the basis for the denial [NCQA HPA 2025, UM 7B-1]

20.11 DENTAL SPECIALTY REFERRALS

Dental Referrals that require approval

- Oral Surgery Referrals
- Endodontic Referrals
- Periodontal Referrals
- Orthodontic Referrals

To obtain prior authorization for a referral to a dental specialist, the Primary Care Dentist will mail us the request (Exhibit 20.1). The Dental 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 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.

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 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.
- Members should be instructed not to self-refer to specialists without the express recommendation of their PCP and/or PDP.

- We will provide notice of approval/denial within the allowable time frames via fax, mail 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's 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 vendor is responsible to ensure 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 180 days.
- Specialty Referrals are valid for 90 days.
- Contracted health professionals, hospitals, and other providers are required to comply with Prior Authorization policies and procedures.
- Dental directors and dental prior authorization staff are available to discuss the review determinations with the attending dentist or other ordering providers.

We require prior authorization be obtained for some non-emergent/non-urgent services for member as defined by this Chapter and our Dental Prior Authorization Matrix.

Retrospective Authorizations
We do not accept requests for 'retro' 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 benefits 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, non-authorized service(s) with documentation to:
  1. Support the medical/dental necessity of the care rendered
  2. Support 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 our Chief Medical Officer and/or Dental Director, or their designee, for approval or denial. [NCQA HPA 2025, UM 4A-1,2]

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.

We use 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 Prior Authorization Department IF **new/additional pertinent information** is being provided with the resubmission.
2. The original information (denial packet) will be gathered and combined with the current request which contains new/additional information then presented to our Dental Director, or their designee, for re-review. [NCQA HPA 2025, UM 4A-1,2]
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 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.

20.12 PROVIDER PORTAL

For your assistance, The Provider Portal allows Providers/Offices who become registered to utilize helpful features, such as:

- Checking claims status
- Checking member eligibility/dental and vision history
- Dental Prior Authorization and Dental Specialty Referral requests submission
- Member roster
- Claim status
    - Claim reconsideration and dispute/appeal submission
- Provider Demographic Requests

20.13 IMPORTANT NOTICE TO PROVIDERS

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

Providers may request to speak to the BCBSAZ Health Choice dental program manager regarding dental-related issues.

20.14 AFFILIATED PRACTICE DENTAL HYGIENIST

In addition to the requirements as specified in A.R.S. §32-1281, §32-1289, and 32-1291.01 AHCCCS requires the following:

1. The dental hygienist and the dentist in the affiliated practice relationship must be registered AHCCCS providers.
2. The affiliated practice dental hygienist shall register with AHCCCS and must 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.
3. The affiliated practice dental hygienists must provide documentation of the affiliation practice agreement with an AHCCCS registered dentist that is recognized by the dental board confirming the affiliation agreement.
4. The affiliated practice dental hygienist and the affiliated dentist must be contracted providers to bill for services provided. The affiliated practice dental hygienist must maintain individual patient records of AHCCCS members in accordance with the Arizona State Dental Practice Act.
5. The affiliated practice dental hygienist will only be reimbursed for providing services in accordance with State statutes and regulations, AHCCCS policy and provider agreement, and their affiliated practice agreement.

The following requirements apply to all dental hygiene services provided through an affiliated practice relationship:

1. Members who have been assessed by the dental hygienist should be directed to the affiliated practice dentist for diagnosis, treatment, or planning that is outside the affiliated dental hygienist's scope of practice.
2. The affiliated practice dental hygienist should consult with the affiliated practice dentist before initiating further treatment on members who have not been seen by a dentist within twelve months of initial treatment by the dental hygienist.
3. The affiliated practice dental hygienist should consult with the affiliated practice dentist prior to initiating treatment on members presenting with a complex medical history or medication regimen.
4. Reimbursement for dental radiographs is restricted to providers who are qualified to perform both the exposure and the interpretation of dental radiographs.