20 Oral Health Services

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 through direct referral to a dentist. PCPs are expected to refer EPSDT members for appropriated 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 430-1A) 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.

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.

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); and
- 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).

Preventive dental services provided as specified in the AHCCCS Dental Periodicity Schedule (Exhibit 430.1A), 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 treatments; and
- For members under the age of sixteen, dental sealants on all non-carious permanent first and second molars, and
- Space maintainers when posterior primary teeth are lost prematurely.

UPDATES TO PREVENTIVE DENTAL SERVICES (Effective April 1, 2014)

Note: PCPs who have completed the AHCCCS required training, may be reimbursed for fluoride varnish applications completed at the EPSDT visits 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
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).*
Therapeutic dental services will be 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 planing, 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 should be used for anterior primary teeth but will be reimbursed as a composite crown.
- 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.

- 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 members is eighteen (18) through twenty (20) years of age and has had endodontic treatment.
- Removable dental prosthetics, including complete dentures and removable partial dentures.
- 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, or
  - Trauma requiring surgical treatment in addition to orthodontic services, or
  - 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).

CONSCIOUS SEDATION

Conscious sedation is covered for members receiving ***EPSDT*** services. Conscious sedation provides a state of consciousness that allows the member to tolerate an unpleasant 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:

- Bone marrow biopsy with needle or trocar,
- Bone marrow aspiration,
- Intravenous chemotherapy administration, push technique,
- Chemotherapy administration into central nervous system by spinal puncture,
- Diagnostic lumbar spinal puncture , and
- Therapeutic spinal puncture for drainage of cerebrospinal fluid.

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.

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 if such services can be performed under state law either by a physician or by a dentist and when the services would be considered physician services if furnished by a physician.

1. Dental criteria:

- Treatment performed by a dentist must be related to a medical condition such as acute pain, infection or fracture of the jaw.
- Covered dental services include the examination of the oral cavity, required radiographs, complex oral surgical procedures such as treatment of maxillofacial fractures and the administration of anesthesia and prescription of medications and antibiotics.
- Refer to the Dental Benefit Matrix (Exhibit 20.2) for a list of covered adult procedures.

2. Exclusions

- Services that physicians are not generally competent to perform.
- Diagnosis and treatment of temporomandibular joint dysfunction are not covered except for the reduction of trauma.

3. Dental Services for Member's Eligible for Transplantation Services

- Health Choice Arizona covers a dental examination and diagnosis for the elimination of oral infection and treatment of oral disease, which includes dental cleanings, treatment of periodontal disease, medically/dentally necessary extractions and the provisions of simple restorations as a medically necessary pre-requisite to transplantation of organs or tissues only after the member has been established as an otherwise appropriate candidate for transplantation. (Simple restorations: silver amalgam or composite resin fillings, stainless steel crowns or preformed crowns.)

5. Other Dental Services

- Cancer of the jaw, neck or head: Prophylactic extraction of severely decayed teeth in preparation for radiation treatment. Oral examination and necessary dental x-rays if extractions are to be performed.

- Leukemia and lymphoma: The elimination of oral infection and treatment of oral disease, which includes dental cleanings, treatment of periodontal disease, medically necessary extraction and the provisions of simple restorations Oral examination and necessary dental x-rays. Management of mucositis, hemorrhage, and related side effects of underlying disease.

- Heart valve repair or replacement: the elimination of oral infection and treatment of oral disease, which includes dental cleanings, treatment of periodontal disease, medically necessary extraction and the provisions of simple restorations

prior to or following repair or replacement of valve. Oral examination and necessary dental x-rays.

Limitation

Except for limited dental series covered for pre-transplant candidates and for members with conditions listed above, covered services furnished by dentists to members 21 years of age and older do not include services that physicians are not generally competent to perform such as 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. Diagnosis and treatment of TMJ is not covered except for reduction of trauma.

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.

Dental Prior Authorizations and Member Referrals

Overview

Health Choice Arizona has confidence that 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 conducts prior authorization, and ensures 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 Dental Matrix. This 'Matrix' can also serve as 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.

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 member's 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. Ste. 520
Phoenix, AZ 85008

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 to the Health Choice Arizona Dental Authorization departme**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 payor of last resort and primary insurance and/or other credible coverage must be billed first, regardless of primary benefit coverage.

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": Three Working Days**– 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 dqys 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."

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 that 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 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.

If Health Choice Arizona does not respond to the authorization request within the required timeframe, the request is considered "denied", as stated above.

AHCCCS-required 14-day Extensions*

In some instances where PA has been requested, the documentation received by Health Choice Arizona *may* suggest that medical/dental necessity for the service exists but the records provided are insufficient to render an authorization. When this occurs, additional information may be requested via fax or direct phone contact. When additional information can not 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 "*14-day Extension 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.

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 for more information on supporting document requirements.

Authorization Denials

AHCCCS policies mandate that all members must be notified of a denial of service request within 3 business days 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 Action" (NOA) letter. Please be aware that 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.

DENTAL SPECIALTY REFERRALS

Dental Referrals which require Health Choice Arizona approval

- ✓ Oral Surgery Referrals for members ages 20 and younger
- ✓ Endodontic Referrals for members ages 20 and younger
- ✓ Periodontal Referrals for members ages 20 and younger

To obtain prior authorization for a referral to a dental specialist, the Primary Care Dentist will FAX or 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 Arizona 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 not 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 that 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.
- The Primary Dental Provider should initiate the referral process (Dental and alternative Oral Specialists should not generally refer directly to other specialists. Although this practice is not expressly prohibited, it may fragment care coordination performed by the PDP and reduce the capacity of to provide a 'Dental Home' for your patient).
- 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 that prior authorization be obtained for some non-emergent/non-urgent services for member's ages 0 through 20, 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 that 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; and
  2. Support that the care rendered was either:
     a. Required on an urgent or emergent basis; OR
     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 and Member Appeals). 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.

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 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.

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.