Are Your Kids Covered?

Medicaid Coverage for the Essential Oral Health Benefits

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Oral health care is a vitally important service for children's well-being, and coverage of dental insurance codes by both public and private insurers is key in ensuring access to comprehensive oral health care for children. This brief illustrates the importance and shows state coverage of key codes in improving access to oral health care as of 2020.

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Pediatric Oral Health Research & Policy Center

Introduction

The American Academy of Pediatric Dentistry **(AAPD)** has a long history of promoting optimal oral health and oral health awareness for infants, children, adolescents and patients with special health care needs, as well as championing initiatives that have widened access to care for the nation's youngest and most vulnerable populations. The AAPD works on both national and state levels to address barriers to care, such as affordability, parent oral health literacy, administrative burdens for payment and far-below-market reimbursement, and stronger investment in community-based initiatives providing care to underserved children.[1] Federal and state governments are likely to reassess their level of commitment to providing dental care to the country's most vulnerable populations in the years ahead, which provides a unique opportunity for increasing dental care coverage for those patients. Advocacy for critical health care services for poor and underserved children is critical, particularly during this politically divisive time, and the AAPD's vision of optimal oral health for all children necessitates the inclusion of effective diagnostic, preventive and restorative dental services in state Medicaid dental plans.

This publication evaluates Medicaid coverage for a select group of insurance codes that address barriers to optimal oral health. These codes extend beyond traditional procedures most commonly covered by dental insurance plans to provide access-related services that protect the oral and total health for children. The goal of this analysis is to raise awareness of the existence of these procedure codes and the importance of advocating for their inclusion in state fee schedules. The selected codes represent a range of services that promote oral health, disease prevention and establishment of a dental home; mitigate the high demand for dental rehabilitation under general anesthesia; and address logistical and social barriers to care. They are discussed in two categories: Providing Essential Services for Oral Health and Addressing Barriers to Optimal Oral Health. The dental fee schedules for the 50 states and the District of Columbia were accessed online to ascertain whether the codes are covered. The report of codes covered by individual states is current as of October 2020. During the time of writing, some services covered here may have been in the legislative process and not listed. To find the status of your state's coverage for all codes, there is a table on pages 12-13. Many state Medicaid websites provide fee schedules illustrating most-recent coverage status for these codes and others.

How are dental insurance codes created?

The American Dental Association **(ADA)** first published in 1969 the Uniform Code on Dental Procedures and Nomenclature (Current Dental Terminology or CDT Codes) to appropriately identify, standardize and categorize dental procedures, which allows for efficient documentation and insurance claim submission.[2] The Code Maintenance Committee is responsible for CDT code changes, and is composed of representatives of the ADA (Council on Dental Benefit Programs), Academy of General Dentistry and dental specialty organizations (including the AAPD), as well as several third-party payer organizations and the Center for Medicaid and Medicare Services (CMS).[3]

Why are insurance codes so important to children's oral health care?

The codification of procedures positively affects the delivery of oral health care in several ways. First, communication: By assigning a code to a dental service, the dentist tells the insurance program – and the patient's family – exactly what care was provided. Second, awareness: The inclusion of a specific procedure code, as well as a description of the service in a state Medicaid provider manual, can serve to heighten awareness for that procedure and encourage its use. For example, providers who become aware of CDT Code D1320 (Tobacco Counseling) may be more likely to discuss tobacco cessation with patients because the code explicitly confirms that the service is within their scope of practice. Third, financial clarity: Codifying dental procedures is essential to ensuring reimbursement to providers and managing provider expectations via contracted fee schedules. Fourth, documentation of health outcomes: Procedure codification leads to more accurate patient recordkeeping and follow-up care. When providers can properly document completed treatment on a patient through a particular code, they are able to track the effects of the procedure more thoroughly and plan follow-up care. Furthermore, procedures can then be tracked via insurance claims data to verify what procedures work for different situations and diagnoses. Thus, this collection of data directly affects the availability of outcomes research. Fifth, health equity: Codification and record-keeping of dental services provide valuable data on the crucial disease factors related to social determinants of health. Analysis of service utilization and their respective effects will promote positive action to help eliminate disparities and inequities in our nation's population.

Providing Essential Services for Oral Health

Codes D1110 and D1120 – Prophylaxis

Removal of plaque, calculus and stains from the tooth structures in the primary, permanent and transitional dentition. It is intended to eliminate and/or reduce local irritants.

Codes D1206 and D1208 – Topical Fluoride Applications

Prescription-strength fluoride product designed solely for use in the dental office, delivered to the teeth under the direct supervision of a dental professional. Fluoride must be applied separately from prophylaxis paste. (D1206 is fluoride varnish, and D1208 is all fluoride applications excluding varnish.)

Code D1351 – Sealants

Mechanically and/or chemically prepared enamel surface sealed to prevent decay.

Rationales and Recommendations

Prophylaxis. Removing plaque, calculus, and staining during dental visits is crucial, because dental professionals can more easily detect demineralized or decayed areas after teeth have been cleaned. Moreover, assessing plaque, calculus, staining and tissue inflammation helps dental professionals evaluate the patient's oral hygiene at home. Additionally, the prophylaxis enables patients and their caregivers to receive a visual demonstration of plaque removal, aiding the dentist in giving appropriate oral hygiene instruction.

Topical Fluoride Applications. The AAPD supports the application of acidulated phosphate fluoride (APF) or fluoride varnish on children's teeth at least twice per year.[4] Fluoride varnish and APF reduce the prevalence of dental decay (caries) and has a high rating of safety. Professionally-applied topical fluoride products such as 5 percent NaFV or 1.23 percent APF preparations are effective in reducing tooth decay in children at caries risk.[4] Medicaid has included coverage of fluoride varnish application by medical providers as part of well-child visits.

Sealants. Medicaid frequently covers dental sealants on both permanent and primary molars. Many studies validate the use of sealants as a caries-preventive measure. The AAPD supports use of sealants for prevention of tooth decay on at-risk teeth.[5] Dental sealants are non-invasive, relatively easy to apply and more cost effective than such restorative procedures as fillings or crowns. Advocates should continue to support their inclusion in state dental plans and push for coverage by all states for sealants on teeth exhibiting increased risk of decay.

Rating

Nearly all state Medicaid dental plans include coverage for prophylaxis (Codes D1110 and D1120), topical fluoride application (Codes D1206 and D1208) and sealants (Code D1351). These services are widely acknowledged as important prevention procedures, especially for populations at moderate-to-high risk of tooth decay.

Results

Despite nearly universal state coverage for cleanings, fluoride applications and sealants on permanent molars, early childhood caries remains a persistent public health concern, particularly for children from low socioeconomic backgrounds and those with special health care needs. The consequences of tooth decay in early childhood can be drastic—missed school days, dental pain, sleep disruptions, emergency room visits, hospitalizations, life-threatening infections and higher treatment costs. Advocates for the improvement of children's oral health should continue to fight for expanded coverage of important dental procedure codes by state Medicaid plans.

Addressing Barriers to Optimal Oral Health

Code D0145 – Oral Evaluation

Diagnostic services including recording the oral and physical health history, development of an appropriate preventive oral health regimen and communication with and counseling of the child's parent, legal guardian and/or primary caregiver.

Rationale

Early dental visits can reduce the incidence of childhood tooth decay and help to avoid the need for more invasive dental treatments.[6] Children who have a first visit by age one have fewer treatment procedures and incur less cost than those who have a first preventive visit at two or three years of age, suggesting that early intervention benefits children and their caretakers both clinically and financially.[7] When the first dental visit is delayed until age four, children need an average of 3.6 more dental procedures, equaling about $360 over years of follow-up care. Establishment of a Dental Home by age one increases access to and utilization of preventive dental services and contributes toward a reduction in dental caries, especially among underserved populations.[8]

The majority of Medicaid plans cover CDT code D0145, a service that enhances efforts to establish a Dental Home and encourages preventive oral habits early in life. Many states also allow physicians and other trained medical providers to perform oral evaluations for children under age three and submit insurance claims with a separate medical procedure code. This extensive coverage reflects the heightened awareness among physicians, caregivers and policymakers of the connection between oral health and systemic health. Advocates should continue to engage in interdisciplinary preventive health efforts to continue improving oral health outcomes for children.

Recommendation

Medicaid coverage of oral evaluation for children under the age of three is important for addressing risk factors unique to this age group. The components of this oral evaluation are distinct from those of older age groups, and include discussion of fluoride, dietary choices, breastfeeding and bottle feeding, oral hygiene, pacifiers, caries risk, accident prevention, and needed medical consultations.

Rating

Fourty-two states (82 percent) cover code D0145: Alabama, Alaska, Arizona, California, Colorado, Delaware, Florida, Hawaii, Idaho, Indiana, Iowa, Kansas, Kentucky, Louisiana, Maine, Maryland, Massachusetts, Michigan, Minnesota, Mississippi, Missouri, Montana, Nebraska, Nevada, New Hampshire, New Jersey, New York, North Carolina, North Dakota, Oklahoma, Oregon, Pennsylvania, Rhode Island, South Carolina, South Dakota, Tennessee, Texas, Vermont, Virginia, West Virginia and Wyoming, as well as the District of Columbia (D.C.).

Results

Code D0145 serves as a checklist of items that providers should include in their oral evaluations of very young children. Coverage for this code helps to ensure that the components most relevant to this age group are included in a comprehensive dental visit. The AAPD supports the inclusion of coverage for this code in state Medicaid plans so that children are provided with tools for optimal oral health starting from a very young age. Enhanced prevention among this age group will reduce the incidence of childhood caries and more costly interventions at future dental appointments.

Code D1310 – Nutritional Counseling for Control of Dental Disease

Counseling on food selection and dietary habits as a part of treatment and control of periodontal disease and caries.

Rationale

High-frequency consumption of sugary drinks and foods can have devastating effects on children's oral and systemic health. Children can develop early childhood caries, childhood obesity and Type 2 diabetes. Moreover, childhood obesity leads to higher risk of cardiovascular disease, depression and other systemic morbidities in adulthood.[9] Pediatric dentists are knowledgeable about the dietary causes of early childhood caries and able to make dietary recommendations. One survey found that 71 percent of pediatric dentists routinely offered nutritional counseling to their patients, and 79 percent of them found nutritional counseling to be at least somewhat effective in caries prevention.[10] Pediatric dentists can help tame the high rates of obesity and Type 2 diabetes among our nation's children. Additionally, many sugar-sweetened beverages (SSBs) contain caffeine, which makes it extra difficult for children experiencing dental nocturnal pain to fall and stay asleep.[11] Pediatric dentists can provide counsel on this prevalent, but largely unrecognized, issue of caffeinated drinks and disrupted sleep patterns in children.

Only three states currently allow code D1310 to be submitted on claims as a distinct service, while many other states assume nutritional counseling to be an inherent component of periodic dental visits and consequently will not cover it as a separate procedure. Lack of coverage for nutrition counseling may be a hindrance to its incorporation into dental visits. A survey of pediatric dentists in North Carolina found that practice constraints, including insufficient coverage for dietary counseling and lack of time to make dietary recommendations, were major limitations on dentists' abilities and attitudes towards providing nutritional counseling for infants and young children.[12] Coverage of code D1310 would help ensure that dentists make nutritional counseling a routine and integral part of their practices, and that children are given guidance in making healthy dietary choices.

Recommendation

Nutritional counseling is of utmost importance in caries prevention and overall health of children. The AAPD supports coverage for dietary and nutrition counseling in conjunction with other preventive services for their patients.[9]

Rating

Nutritional counseling is covered by only three states (six percent): Montana, New Hampshire and Wyoming.

Results

Dentists are capable of providing useful nutrition counseling to children for the prevention of caries and other systemic health conditions. Expanded coverage for code D1310 is important to encourage providers to counsel caregivers on healthy dietary choices and feeding practices.

Code D1320 – Tobacco Counseling for the Control and Prevention of Oral Disease

Tobacco prevention and cessation services to reduce patient risks of developing tobacco-related oral diseases and conditions and improves prognosis for certain dental therapies.

Rationale

Tobacco is the leading cause of preventable and premature death in the United States. In terms of oral health, tobacco use can lead to oral cancer, periodontal disease, impaired wound healing, stained teeth, halitosis (chronic bad breath), and caries. The epidemic of tobacco addiction most often begins in adolescence, placing a vital part of prevention in the hands of pediatric health professionals. According to the Substance Abuse and Mental Health Services Administration's 2019 National Survey on Drug Use and Health, 13 percent of adolescents ages 12-17 have used tobacco products within their lifetime, including cigarettes, smokeless tobacco and cigars.[13] This is a notable improvement from the 2015 survey, in which about 35 percent of adolescents reported tobacco use in their lifetimes, but there still is room for improvement.

Smoking can have drastic long-term health consequences, particularly for those who start early, including cardiovascular and respiratory conditions such as atherosclerosis, chronic obstructive pulmonary disease (COPD) and lung cancer. Moreover, the recent rise in e-cigarettes and vaping poses risks to overall health as well; the AAPD strongly supports more studies being conducted on the oral health hazards of these new nicotine delivery methods.[14] Given the negative consequences of cigarette smoking and smokeless tobacco on oral health, dentists are in a particularly important position to counsel patients on tobacco use.

Unfortunately, state coverage for code D1320 places limitations on tobacco cessation counseling. In a semi-structured interview with 11 executives of dental insurance companies, all executives expressed belief that smoking cessation was a part of routine care during dental visits.[15] Despite this, only 13 states cover this service in their dental plans.

Providers have reported lack of coverage as one of several factors hindering them from performing such counseling for their patients. A nationwide survey showed that over half of dentists who were not currently providing tobacco counseling in their office reported that they would be more likely to do so if it was a covered service.[16] If the myriad of costs—both financial and to patient health—of treating chronic diseases associated with tobacco use are to be reduced in children and future adults, then tobacco counseling for prevention and cessation must be encouraged.

Recommendation

The AAPD encourages pediatric dentists to determine tobacco use among their patients, educate parents and patients about the health consequences of tobacco use, and provide prevention and evidence-based cessation services when needed.[17] Expanded coverage for Code D1320 will encourage more targeted conversations about tobacco use between dentists and adolescent patients and contribute to efforts to reduce these damaging habits among susceptible adolescents.

Rating

Reimbursement for code D1320 is allowed by 13 states (25 percent) including Arkansas, California, Connecticut, Maine, Montana, New York, Ohio, Oklahoma, Oregon, Pennsylvania, Vermont, West Virginia and Wyoming.

Results

A person is much less likely to develop a tobacco addiction if they do not start using it before adulthood. As pediatric dentists encourage tobacco use cessation, they will supplement the current public health programs guiding youths away from tobacco use. Coverage for tobacco counseling will therefore help to reduce the disastrous health consequences and astronomical health care costs of treating chronic diseases associated with tobacco use.

Code D1354 – Interim Caries Arresting Medication Application

Conservative treatment of an active, non-symptomatic carious lesion by topical application of a caries arresting or inhibiting medicament and without mechanical removal of sound tooth structure.

Rationale

Tooth decay has long been a public health crisis that can lead to a myriad of negative and long-term effects on both the oral and overall health of children.[18] Nearly 20 percent of children under the age of 5, half of children aged 6-11, and over half aged 12-19 have experienced dental caries.[19] Moreover, this issue is particularly salient to socioeconomically disadvantaged families. Compared to their more affluent peers, children living in poverty are twice as likely to experience tooth decay and more than twice as likely to go without needed treatment.[20]

Silver diamine fluoride (SDF) has emerged as a promising interim decay management technique. SDF combines the remineralizing properties of fluoride with the antibacterial properties of silver,[21] and is effective at halting the progression of disease for about 80 percent of cavities.[22] Compared to treatment by other active materials, SDF is 66 percent more effective in arresting decay, and it is 154 percent more effective than no treatment.[23] SDF's advantages include ease of application and a relatively low cost.

Research has shown that use of SDF as an interim treatment often results in fewer restorative visits and lower total costs for patients and their families, as well as lower expenditures for Medicaid programs.[24,25] Discoloring effects are its most obvious limitation to acceptability. Aside from esthetic concerns, however, SDF's contraindications are limited, and its possibilities are promising in alleviating urgent treatment needs among children with caries, particularly in their primary teeth.[26] In clinical trials, thousands of patients have reported no serious adverse effects from SDF use.[27,28] Generally, SDF use is acceptable to parents, particularly as behavioral barriers increase.[29] Recent studies have indicated that two applications of SDF may be more effective in arresting caries than a single application.[21,30,31]

The AAPD has successfully advocated for the coverage of general anesthesia for dental rehabilitation by public medical insurance plans, and dental treatment under general anesthesia is a covered benefit in at least 32 states.[32] Although serious morbidities of dental rehabilitation under general anesthesia are extremely rare, the treatment is not without risks. Hospital care also comes at a significant financial cost. Moreover, wait times for "non-urgent" treatments requiring general anesthesia and sedation can often be long, and the COVID-19 crisis has exacerbated this problem.[33] When restorative services are not accessible in a timely fashion due to these restrictions, caries management with non-invasive techniques such as SDF may be an appropriate and effective alternative.[9]

Interim treatment with SDF has increased in coverage in recent years, yet many states still do not allow coverage for code D1354. While SDF may be an appropriate interim or permanent choice for many patients, it is not universally the best solution for all children with early childhood caries. Thus, advocates should argue for the inclusion of code D1354 as a supplemental addition to state dental plans rather than a replacement for other important services.

Recommendation

The AAPD supports the coverage of SDF by both public and private dental insurers. To be more specific, SDF should be reimbursed as a per-tooth procedure so the effectiveness of SDF can be measured more accurately in terms of both patient health outcomes and as well as fiscal responsibility. The frequency of SDF application must be based upon the patient characteristics, current and future risk assessment, and medical and dental health status. Unfortunately, Medicaid programs require multiple SDF applications to have a specific time period between applications, such as 3 to 6 months, based on decay risk. In addition, SDF should be covered as a non-definitive therapeutic agent for arresting tooth decay rather than a definitive restorative procedure. In other words, dental insurance programs should continue to cover treatment when a patient requires a restoration or extraction down the road. Lastly, lifetime limits per tooth should be determined by an individual patient's oral and general health needs and status.

Rating

Code D1354 is covered by 35 states (69 percent): Alabama, Arizona, Colorado, Connecticut, Delaware, Florida, Hawaii, Illinois, Indiana, Iowa, Kentucky, Maine, Massachusetts, Michigan, Minnesota, Missouri, Montana, Nebraska, Nevada, New Hampshire, New Jersey, North Carolina, North Dakota, Ohio, Oklahoma, Oregon, Pennsylvania, South Dakota, Tennessee, Vermont, Virginia, Washington, West Virginia, Wisconsin and Wyoming.

Results

SDF application is a safe and cost-effective interim measure for treating early childhood caries. Expanded coverage for code D1354 would encourage providers to stay abreast of the latest science and clinical guidelines on SDF, and investigate the benefits of SDF in the care of children, while also preserving conventional, proven approaches to caries prevention and management.

Code D9920 – Behavior Management, by Report

Rationale

Behavior guidance techniques are used to alleviate anxiety, nurture a positive dental attitude, and perform quality oral health care safely and efficiently for infants, children, adolescents, and patients with special health care needs. Selection of techniques must be tailored to the needs of the individual patient and parental preferences.[34] Behavior guidance can result in the successful completion of clinical dentistry on young children, without the need for sedation or general anesthesia. When employed appropriately, behavior guidance results in more positive attitudes among children toward dentistry and lays the foundation for a lifetime of positive oral health experiences. In the medical field, there are a number of CPT codes dedicated to coverage for health behavior assessment and intervention. These are used in a wide variety of medical inpatient and outpatient settings, and focus on mitigating psychological factors that impact physical health and illness.[35]

The necessity for general anesthesia to complete dental care may be reduced by increased employment of behavior guidance techniques. Coverage of code D9920 allows for extra time and customized strategies to help patients successfully complete restorative treatment in clinical settings. About half of Medicaid state dental plans currently cover code D9920.

Pediatric dentists submit claims for CDT code D9920 at least ten times as frequently as general dentists, but general dentists represent a much larger portion of the Medicaid provider workforce and serve as an important safety net for children enrolled in public-funded health care.[36,37] This gap in reported use of behavior guidance strategies could be decreased through workshops and courses to educate general dentists in the latest techniques. Expanded coverage for behavior guidance would allow more dentists to feel confident in using these approaches, leading to more positive dental experiences for children.

Recommendation

The AAPD supports Medicaid coverage for the appropriate use of behavior guidance strategies to improve children's dental care experiences and attitudes toward oral health, and to reduce the need for dental rehabilitation through more invasive techniques such as sedation and general anesthesia.

Rating

Reimbursement for behavior management is covered in 29 states (57 percent): Alaska, Arkansas, California, Connecticut, Delaware, Florida, Georgia, Idaho, Indiana, Kansas, Louisiana, Maine, Massachusetts, Michigan, Minnesota, Montana, New Jersey, New York, North Dakota, Oregon, Pennsylvania, Rhode Island, South Carolina, South Dakota, Texas, Vermont, Virginia, Washington, West Virginia, Wisconsin and Wyoming.

Results

Coverage for code D9920 is important for providing practitioner support in taking necessary time to apply behavior guidance. Documentation of behavior guidance results in purposeful employment of specific techniques according to the individual patient's needs. It also ensures that a patient's dental record includes information on the particular techniques that will result in successful outcomes, thus aiding providers in reproducing positive dental experiences for patients during future visits. Adoption of this code is clearly trending in the right direction.

Code D9311 – Consultation with Medical Health Care Professional

Communication regarding medical issues that may affect a patient's planned dental treatment is crucial in dentists' ability to provide the best possible care.

Rationale

Many of our youngest citizens face complex medical conditions affecting their dental health and the provision of dental treatment. For example, more than 15 million children have special health care needs.[38] Patients with a compromised medical status are at high risk for developing oral disease, and untreated tooth decay can exacerbate other health conditions.[39] Additionally, dentists who treat young children can identify various issues that predict long-term health.[40] Although virtually every pediatric dentist (99.5 percent) provides services to patients with special health care needs, access to dental care for children with medical, physical or behavioral challenges is a serious unmet necessity.[41]

Access to dental care for patients with complex medical histories may be improved through dental-medical consultation to gain insight into a patient's medical condition to make informed decisions regarding dental treatment. The purpose of the medical consultation is educating the dentist regarding safe and appropriate treatment and will ultimately instill confidence in the dentist providing care. Coverage for this code may be particularly beneficial for children with special health care needs, who make up about 20 percent of the population of American children.[42] Pediatric dentists regularly interact with and communicate with their local pediatrician colleagues to better promote coordination of care for their patients.

Coverage for medical consultations is essential to the AAPD's mission of promoting optimal oral health for all children. Dentists who have a better understanding of the suitability of certain in-office treatments may be less likely to refer patients with complex medical histories to other providers or for dental treatment under general anesthesia. Coverage for D9311 would enable providers to treat more children with complex health care needs confidently and comprehensively. Medicaid providers treat a significant proportion of children with special health care needs in the US,[43] and coverage for this code may encourage increased participation by dentists in Medicaid plans.

Recommendation

Consultation with other health providers should be a covered service, particularly for patients with chronic medical conditions with oral manifestations, or medically compromised patients who require invasive dental procedures. When patients with special health care needs require treatment beyond periodic recall visits, the patient's other care providers should be consulted regarding medications, sedation, general anesthesia and any concerns regarding the safety of oral health care.[44]

Rating

Three states (six percent) currently include code D9311 in their fee schedules: Colorado, Kansas and Nevada.

Results

Expanded coverage for code D9311 will encourage dental providers to treat patients with acute medical conditions and special health care needs safely in office settings, and may reduce the number of patients who are referred unnecessarily to hospital-based settings for standard dental procedures.

Code D9991 – Addressing Appointment Compliance Barriers

Rationale

Caregivers of children enrolled in Medicaid have reported a lack of reliable transportation and difficulty in scheduling as barriers to compliance with appointments.[45] Additionally, caregivers may struggle to find childcare for siblings of patients or get permission from employers to miss work hours to take their children to the dentist. Children with high caries rates who require multiple appointments and have urgent treatment needs place additional strain on parents facing these challenges.

Recommendation

The AAPD supports efforts to assist caregivers of Medicaid enrollees in finding appropriate transportation, childcare and other services to enable better compliance with scheduled dental appointments.

Ratings

Code D9991 is currently covered by only one state plan (Nevada).

Results

Coverage of code D9991 may increase utilization of dental treatment among children with oral health care needs by mitigating some of the practical challenges faced by caregivers in complying with dental appointments. Better compliance with dental appointments may result in a shift away from urgent, invasive dental treatments to a higher frequency of preventive and minimally invasive dental care among children.

Code D9992 – Care Coordination

Rationale

The process of obtaining health care from multiple providers/different specialists, and through various health care settings and payment channels, is complex and presents challenges for many families. Dentists and their staff are in a position to aid those requiring additional assistance with tasks like completion of insurance paperwork or arranging additional evaluations by other dental specialists or physicians. Care coordination has been effective in increasing treatment adherence and care engagement among patients in other health care settings[46] and can result in reduced hospital admission rates, emergency room visits, and harmful misuse of medications.[47] In the medical arena, the Medicaid Primary Care Case Management (PCCM) program has been established as a way for Medicaid patients with complex health needs to access comprehensive and coordinated care.[48] Dental care faces many of the same issues that systems like the Medicaid PCCM program mitigate. Code D9992 allows providers to guide their patients through a complex health care system and smooth the transition between providers, specialties and settings.

Recommendation

Care coordination allows dentists to dedicate additional time and resources necessary to aid their patients in receiving comprehensive, individualized oral health care. The AAPD supports efforts among dentists to assist caregivers in arranging for coordinated services that will improve oral health outcomes for children.

Rating

Code D9992 is currently covered by four states (eight percent): Colorado, Montana, Nevada and Vermont.

Results

Coverage of Code D9992 may help to ensure more effective and thorough dental care and allow for practitioners and researchers to build greater understanding of the positive effects of related interventions.

Code D9993 – Motivational Interviewing

Rationale

Motivational interviewing (MI) is the practice of using patient-centered, individualized counseling to identify behaviors that are detrimental to oral health outcomes, and to help patients determine how they can accomplish changes in these behaviors to reach their oral health goals. MI is a communication technique that can reflect the willingness of dentist and staff to engage in a patient/parent-centered approach.[49]

MI allows caretakers to explore their own attitudes about their child's oral health care and gives them ownership over decisions on how to change harmful habits. This skill helps providers communicate with parents on important topics such as oral hygiene instruction and feeding practices without provoking anger or sounding judgmental.[50] MI can help improve pediatric health behaviors and outcomes in oral health, diet, physical activity, smoking cessation, second-hand smoke and healthy weight.[51] This code helps patients acknowledge the personal obstacles preventing them from achieving optimal oral health. Moreover, MI helps decrease staff burnout, and it is especially helpful in higher levels of resistance, anger, or entrenched patterns in patients.[49]

Recommendation

The AAPD encourages dentists to employ MI to provide individualized and purposeful care to caregivers of pediatric patients. Coverage for MI by Medicaid dental plans will allow providers the additional time needed to guide caregivers through this process.

Rating

Code D9993 is currently covered by one state (Nevada).

Results

Expanded coverage will help create further awareness of the MI practice method, encourage caregivers to make beneficial behavioral changes, and ultimately improve oral health outcomes for children.

Code D9994 – Patient Education to Improve Oral Health Literacy

Customized communication of information to assist the patient in making appropriate health decisions, explained in a manner acknowledging the patient's full context, and adapting information and services to that context, is key in providing quality care, but also requires the expenditure of time and resources beyond that of an oral evaluation or case presentation.

Rationale

Oral health literacy is defined as the degree to which individuals have the capacity to obtain, process and understand basic oral health information and services needed to make appropriate health decisions.[52] It is affected by personal factors, including language, education, income, and cultural perceptions of dental treatment. Lower health literacy levels result in reduced utilization of health care, less effective communication between providers and patients, and lower adherence to treatment recommendations. These, in turn, result in poorer treatment and health outcomes, delayed diagnoses of health conditions, more hospitalizations and higher health care costs.[46] Though oral health literacy has been increasing, there is still plenty of room for improvement; for example, 74 percent of American parents still do not take their child to the dentist before their first birthday, and almost 80 percent of parents report engaging in practices they know are bad for their children's teeth.[53]

In dentistry, poor oral health literacy is associated with compliance issues such as missed dental appointments.[54] A focus group study found that the oral health beliefs of parents of children enrolled in Medicaid affected their children's utilization of dental services. Parents whose oral health beliefs focused on prevention, dental growth and acclimation of their child to the dentist had higher rates of utilization than those who considered dentistry more important for the treatment of emergencies, esthetics and halitosis.[55] Caregivers utilizing dental services also had more positive views of parental responsibilities toward their children's oral health care, such as taking their child for preventive visits, and had more knowledge of the Medicaid services available to them, as well as how to find providers. Additionally, there is an association between higher oral health literacy and improved oral health status and self-efficacy.[56]

Code D9994 addresses barriers to care resulting from limited oral health literacy. In practice, this means taking the time to inform caretakers of children's oral conditions, including the results of neglect and available strategies for improving oral health, in a culturally appropriate and understandable way. Coverage for this code would alleviate some of the burdens placed on Medicaid dentists to provide these important services and may encourage participation in state plans.

Recommendation

The AAPD supports Medicaid coverage for efforts to improve patients' oral health literacy through individualized, customized communication of information.

Rating

Two states (four percent) currently cover code D9994: Nevada and Virginia.

Results

Interventions meant to address lower health literacy can help mitigate the effects of the socioeconomic and cultural barriers that prevent successful utilization of dental services for children.[57] Coverage for code D9994 should be included in state plans to allow for improved oral health outcomes for children.

Code D9995 – Teledentistry – Synchronous; Real-Time Encounter

Code D9996 – Teledentistry – Asynchronous; Information Stored and Forwarded to Dentist for Subsequent Review

Reported in addition to other procedures (e.g., diagnostic) delivered to the patient on the date of service.

Rationale

Teledentistry refers to the use of virtual services and systems to provide patients with dental care and education.[58] It allows for patients to access oral health care when they are not able to be in the same location at the same time as their provider. This is particularly important given the many socioeconomic barriers families face in accessing quality dental care, as well as events like the COVID-19 pandemic that limit in-person access on a widespread scale.

Synchronous teledentistry occurs when there is live interaction using audiovisual technology between the patient and dental provider. The use of synchronous teledentistry allows for providers and patients to interact in a natural way, and providers can see what is happening and communicate in real time. It is important to note that services provided under teledentistry must be equivalent to how they would be delivered in person.[59]

Meanwhile, asynchronous teledentistry does not occur in real time, but rather involves delivery of recorded health information to a practitioner to use at a later time. Asynchronous teledentistry has the benefit of providing extra flexibility for differing availabilities in scheduling and time. Unfortunately, it does not allow for real-time communication. Asynchronous teledentistry can be used easily in combination with live exams for enhanced efficiency and effectiveness.[53]

The ADA has developed two CDT codes specifically for teledentistry practice, effective as of January 2018.[52] Code D9995 allows patients to receive quality dental care and education in real time without needing to be in the same physical location as their provider. Code D9996 allows patients to record and send information to their providers to store and view later.

Recommendation

Teledentistry has been shown to be a viable option comparable to a clinical examination in the screening of early childhood caries and has been shown to result in improved oral health.[60,61,62,63] Although it should not serve as a substitute for the establishment of a dental home, the AAPD supports teledentistry as an adjunct to in-person clinical care and a valuable tool to improve access to care for pediatric patients. It should be provided in accordance with evidence-based clinical guidelines and maintain security and privacy rules for protected health information. In addition, the AAPD upholds the recognition of teledentistry as a subset of telehealth and encourages reimbursement of teledentistry services on par with in-person delivery of care.[52]

Rating

Sixteen states (31 percent) cover code D9995 (synchronous teledentistry): California, Colorado, Florida, Georgia, Iowa, Maine, Minnesota, Missouri, Montana, New Jersey, New Mexico, New York, North Carolina, Oregon, Utah, Virginia, Washington and West Virginia.

Code D9996 (asynchronous teledentistry) is currently covered by nine states (18 percent): Colorado, Florida, Georgia, Maine, Minnesota, Missouri, Montana, New York, North Carolina, Oregon, Virginia and Washington.

Results

Coverage of codes D9995 and D9996 may help to ensure greater access to consistent quality dental care by expanding access to services that can be performed virtually, particularly in conjunction with live exams.

Conclusion

The AAPD and its 11,000 members advocate for the continued and enhanced coverage by Medicaid/CHIP of services to improve the oral health of children from socioeconomically disadvantaged backgrounds. In fact, pediatric dentists have the highest rate of participation in public-insured dental benefit programs in dentistry. Over 70 percent of pediatric dentists accept Medicaid/CHIP programs, and this patient population represents an average of 34 percent of their practices.[37] From their front-line perspective, pediatric dentists see the benefits of improved oral health to patients–greater comfort and self-confidence, better attendance and performance in school, and enhanced total health.

Through comprehensive Medicaid coverage, oral health diseases can be prevented and treated more effectively. Moreover, inclusive public insurance for children's oral health services can facilitate positive attitudes toward dentistry, decrease the need for dental rehabilitation under general anesthesia, and increase access to preventive dental services. In essence, it offers healthier smiles and better quality of life for more children in every state. The support of Medicaid, CHIP and other public insurance programs is essential to the AAPD's commitment to achieving optimal oral health for all children.

State-by-State Listing of Codes Covered by Medicaid

All state names are interactive and link to the state Medicaid website.

State	D0145	D1310	D1320	D1354	D9920	D9311	D9991	D9992	D9993	D9994	D9995	D9996	Date updated
Alabama	Y	N	N	Y	N	N	N	N	N	N	N	N	October 2020
Alaska	Y	N	N	N	Y	N	N	N	N	N	N	N	October 2020
Arizona	Y	N	N	Y	N	N	N	N	N	N	N	N	September 2020
Arkansas	N	N	Y	N	Y	N	N	N	N	N	N	N	April 2019
California	Y	N	Y	N	Y	N	N	N	N	N	Y	N	October 2020
Colorado	Y	N	N	Y	N	Y	N	N	N	N	Y	Y	July 2020
Connecticut	N	N	Y	Y	Y	N	N	Y	N	N	N	N	September 2020
D.C.	Y	N	N	N	N	N	N	N	N	N	N	N	October 2020
Delaware	Y	N	N	Y	Y	N	N	N	N	N	N	N	October 2020
Florida	Y	N	N	Y	Y	N	N	N	N	N	Y	Y	October 2020
Georgia	N	N	N	N	Y	N	N	N	N	N	Y	Y	October 2020
Hawaii	Y	N	N	Y	N	N	N	N	N	N	N	N	March 2020
Idaho	Y	N	N	N	Y	N	N	N	N	N	N	N	March 2020
Illinois	N	N	N	Y	N	N	N	N	N	N	N	N	June 2020
Indiana	Y	N	N	Y	Y	N	N	N	N	N	N	N	October 2020
Iowa	Y	N	N	Y	N	N	N	N	N	N	Y	N	May 2020
Kansas	Y	N	N	N	Y	Y	N	N	N	N	N	N	August 2020
Kentucky	Y	N	N	Y	N	N	N	N	N	N	N	N	May 2020
Louisiana	Y	N	N	N	Y	N	N	N	N	N	N	N	July 2019
Maine	Y	N	Y	Y	Y	N	N	N	N	N	Y	Y	May 2020
Maryland	Y	N	N	N	N	N	N	N	N	N	N	N	January 2020
Massachussetts	Y	N	N	Y	Y	N	N	N	N	N	N	N	June 2020
Michigan (Delta Dental)	Y	N	N	Y	Y	N							2020
Minnesota	Y	N	N	Y	Y	N	N	N	N	N	Y	Y	June 2020
Mississippi	Y	N	N	N	N	N	N	N	N	N	N	N	October 2020

Missouri	Y	N	N	Y	N	N	N	N	N	N	Y	Y	October 2020
Montana	Y	Y	Y	Y	Y	N	N	Y	N	N	Y	Y	July 2020
Nebraska	Y	N	N	Y	N	N	N	N	N	N	N	N	July 2020
Nevada	Y	N	N	Y	N	Y	Y	Y	Y	Y	N	N	August 2019
New Hampshire	Y	Y	N	Y	N	N	N	N	N	N	N	N	2020
New Jersey	Y	N	N	Y	Y	N	N	N	N	N	Y	N	October 2020
New Mexico	N	N	N	N	N	N	N	N	N	N	Y	N	October 2020
New York	Y	N	Y	N	Y	N	N	N	N	N	Y	Y	February 2020
North Carolina	Y	N	N	Y	N	N	N	N	N	N	Y	Y	September 2020
North Dakota	Y	N	N	Y	Y	N	N	N	N	N	N	N	July 2020
Ohio	N	N	Y	Y	N	N	N	N	N	N	N	N	January 2020
Oklahoma	Y	N	Y	Y	N	N	N	N	N	N	N	N	May 2020
Oregon	Y	N	Y	Y	Y	N	N	N	N	N	Y	Y	October 2020
Pennsylvania	Y	N	Y	Y	Y	N	N	N	N	N	N	N	August 2019
Rhode Island	Y	N	N	N	Y	N	N	N	N	N	N	N	February 2020
South Carolina	Y	N	N	N	Y	N	N	N	N	N	N	N	July 2019
South Dakota	Y	N	N	Y	Y	N	N	N	N	N	N	N	October 2020
Tennessee	Y	N	N	Y	N	N	N	N	N	N	N	N	September 2020
Texas	Y	N	N	N	Y	N	N	N	N	N	N	N	October 2020
Utah	N	N	N	N	N	N	N	N	N	N	Y	N	March 2020
Vermont	Y	N	Y	Y	Y	N	N	N	N	N	N	N	October 2020
Virginia	Y	N	N	Y	Y	N	N	Y	N	Y	Y	Y	March 2020
Washington	N	N	N	Y	Y	N	N	N	N	N	Y	Y	October 2020
West Virginia	Y	N	Y	Y	N	N	N	N	N	N	Y	N	April 2020
Wisconsin	N	N	N	Y	N	N	N	N	N	N	N	N	November 2020
Wyoming	Y	Y	Y	Y	Y	N	N	N	N	N	N	N	October 2020

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