Are Your Kids Covered?

Medicaid Coverage for the Essential Oral Health Benefits

AMERICA'S PEDIATRIC DENTISTS
THE BIG AUTHORITY on little teeth®

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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 needs. As a result, the AAPD has championed initiatives that have widened access to care for the nation's youngest and most vulnerable populations. The AAPD's Strategic Plan 2020 highlights goals to address barriers to care, such as parent oral health literacy and affordability; reduce administrative burdens for payment and reimbursement; and invest in community-based initiatives providing care to underserved children.[1] The strategic plan promotes research conducted by the organization's Pediatric Oral Health Research and Policy Center (POHRPC), an important resource for advocates within the field of pediatric dentistry. This research is the backbone for AAPD's oral health policies and recommendations in its mission to advance optimal oral health for all children.

In the months and years ahead, federal and state governments are likely to reassess their level of commitment to providing dental care to the country's most vulnerable populations. At such a politically divisive period in history, the importance of advocacy for critical health care services for poor and underserved children cannot be overstated. The insistence on inclusion of effective diagnostic, preventive and restorative dental services in state Medicaid dental plans is essential to fulfill the AAPD's vision of optimal oral health for all children.

Codifying and clearly describing dental procedures are essential to ensuring reimbursement to providers and managing provider expectations via contracted fee schedules. The American Dental Association (ADA) established Codes on Dental Procedures and Nomenclature (CDT Codes) to appropriately identify, standardize and categorize dental procedures, allowing for more efficient documentation and insurance claim submission.[2] The ADA's Council on Dental Benefit Programs is responsible for CDT code changes. This group comprises representatives of the ADA and the nine recognized dental specialty organizations, including the AAPD, as well as several third-party payor organizations, the Academy of General Dentistry and Center for Medicaid and Medicare Services (CMS).[3]

Codification of procedures has positive effects on oral health care. The inclusion of a specific procedure code and a description of the service in a state Medicaid provider manual may heighten awareness for that procedure and encourage its use among practitioners, regardless of the allowed fee for the procedure. For example, providers who become aware of CDT Code D1320 (Tobacco Counseling) may be more likely to approach the topic of tobacco cessation with patients simply because the code confirms that the service is within their scope of practice.

Another effect of procedure codification may be more accurate patient record-keeping and follow-up to care. When providers have the ability to properly document completed treatment on a patient through a particular code, they are able to more thoroughly track the effects of the procedure and plan follow-up care. Further, procedures can be tracked via insurance claims data to verify what procedures work best for certain diseases and situations. This collection of data directly affects the availability of outcomes research.

Following a brief overview of essential preventive services, this paper evaluates Medicaid coverage for a select group of CDT codes that address barriers to optimal oral health and extend beyond traditional procedures most commonly covered by dental insurance plans for the management of childhood caries. 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. Ten CDT codes were selected by members of the AAPD's POHRPC to represent a range of services that promote oral health and disease prevention, mitigate the high demand for dental rehabilitation under general anesthesia, and address logistical and social barriers to care. The dental fee schedules for the fifty states and the District of Columbia were accessed online to ascertain whether those codes were covered, and individual representatives were then reached by phone or email at the majority of state Medicaid agencies to further verify coverage. The report of codes covered by individual states is current as of July, 2017.

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 control local irritants.

Codes D1206 and D1208 – Topical Fluoride Applications

Prescription strength fluoride product designed solely for use in the dental office, delivered to the dentition 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. The removal of plaque, calculus and staining is an important component of periodic dental visits, since clean teeth allow demineralized or carious areas to be more easily detected. The assessment of plaque, calculus, staining and tissue inflammation are also important for determining the extent of the patient's home oral hygiene regimen. In addition, the prophylaxis enables patients and their caregivers to have a visual demonstration of plaque removal, aiding the dentist in giving appropriate oral hygiene instruction.

Topical Fluoride Applications. The AAPD supports the application of fluoride varnish on children's teeth at least twice per year, with more frequent application warranted for those with moderate to high caries risk.[4] Evidence confirms that the application of fluoride varnish reduces the prevalence of dental caries with a very low risk of adverse events. As a demonstration of the acceptability of fluoride varnish by providers, insurers and parents, Medicaid has initiated coverage of fluoride varnish application by medical providers as part of well-child visits. Pediatricians and other health care providers who have undergone specific oral health care training are included in this allowance by many state plans. For example, Maine's Medicaid plan covers treatment by physicians, physician assistants and nurse practitioners for fluoride varnish application when documentation of dental history, Dental Home, caries risk and needed referrals is included in the patient record.

Sealants. Dental sealants on permanent molars are frequently covered by Medicaid, and many state dental plans allow sealants on primary molars as well. Various studies have validated the use of sealants as a caries-preventive measure. The AAPD supports use of sealants for prevention of pit and fissure caries on at-risk teeth, including those with incipient non-cavitated lesions to prevent caries progression.[5] Dental sealants are non-invasive, relatively easy to apply and more cost effective than restorative procedures. Advocates should continue to support their inclusion in state dental plans and push for coverage by all states for sealants on primary teeth exhibiting increased risk of decay.

Rating

The majority of state Medicaid dental plans include coverage for prophylaxis (Code D1110), 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 caries risk.

Results

Despite almost universal state coverage for cleanings, fluoride applications and sealants on permanent molars, early childhood caries remains a persistent endemic public health concern, particularly for children from low socioeconomic backgrounds and those with special health care needs. The consequences of early childhood caries can be drastic, including missed school days, dental pain resulting in sleep disruptions, reduced nutritional intake, 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 for a Patient Under Three Years of Age

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 may reduce the incidence of childhood caries and help to obviate the need for more invasive dental treatments. For example, Savage et al. reported that children who had a first visit by age one had fewer treatment procedures and incurred less cost than those who had a first preventive visit at two or three years of age, suggesting that early intervention can be effective both clinically and financially.[6] Establishment of a Dental Home by age one may increase access to and utilization of preventive dental services and contribute toward a reduction in dental caries among poor and minority children.[7]

Recommendation

Medicaid coverage of an oral evaluation for children under the age of three is important to address risk factors unique to this age group. The components of this oral evaluation are distinct from those of older age groups, and include a discussion of fluoride, dietary choices, breastfeeding and bottle feeding, oral hygiene rituals, non-nutritive oral habits, caries risk, trauma prevention, and needed medical consultations.

Rating

Thirty-eight states (75 percent) cover code D0145: Alabama, Alaska, Arizona, Colorado, Delaware, Florida, Hawaii, Idaho, Indiana, Iowa, Kansas, Kentucky, Louisiana, Maryland, Maine, Massachusetts, Michigan, Minnesota, Missouri, Montana, Nevada, Nebraska, New Hampshire, New Jersey, New York, North Carolina, North Dakota, Oklahoma, Oregon, Pennsylvania, South Carolina, South Dakota, 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 the oral evaluation of very young children. Coverage for this code helps to ensure that the components most relevant to this age group are incorporated into a comprehensive dental visit. AAPD supports the inclusion of coverage for this code in state Medicaid plans so that children may be 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, including development of early childhood caries, childhood obesity and diabetes mellitus. Childhood obesity leads to higher risk of cardiovascular disease, depression and other systemic morbidities in adulthood.[8] Pediatric dentists are knowledgeable about the dietary causes of early childhood caries and proficient in making 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.[9] Additionally, pediatric dentists are part of the body of health care professionals who can help tame the high rates of obesity and Type 2 diabetes among our nation's children.

Recommendation

Nutritional counseling, particularly when provided as part of anticipatory guidance, is of utmost importance in caries prevention and encouragement of overall health of children. The AAPD supports coverage for dietary and nutrition counseling in conjunction with other preventive services for their patients.[10]

Rating

Nutritional counseling is covered by only four states (8 percent): Massachusetts, Montana, New Hampshire and Wyoming.

Results

Dentists are capable of providing useful nutrition counseling to children for 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 disease and conditions and improves prognosis for certain dental therapies.

Rationale

Tobacco is the leading cause of preventable and premature death in the United States. The epidemic of tobacco addiction most often begins in adolescence. Every day, over 3,800 youths under age 18 try their first cigarette and over 1,000 people under age 18 become daily smokers. More than 80 percent of adult smokers try their first cigarette by age 18, and 99 percent do by age 26. [11] According to the Substance Abuse and Mental Health Services Administration's 2015 National Survey on Drug Use and Health, 17.1 percent of adolescents ages 12-17 have used tobacco products within their lifetime, including cigarettes, smokeless tobacco and cigars.[12] 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.

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. Tobacco use can lead to oral cancer, periodontal disease, impaired wound healing, stained teeth, halitosis, and caries.

Recommendation

The AAPD encourages pediatric dentists to make strong efforts 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.[13] Expanded coverage for Code D1320 would encourage more targeted conversations about tobacco use between dentists and adolescent patients and contribute to efforts to reduce such deleterious habits among susceptible adolescents.

Rating

Reimbursement for code D1320 is allowed by 13 states (25 percent) including Alaska, Arkansas, Connecticut, Iowa, Maine, Massachusetts, Montana, New Jersey, New York, Oklahoma, Oregon, West Virginia and Wyoming.

Results

If tobacco use can be prevented prior to reaching adulthood, a person is much less likely to develop a tobacco addiction. 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

Rationale

Traditional restorative treatment of caries in children is complicated by patient behavior, complex medical histories, and limitations of access to advanced behavior management such as general anesthesia. Successful efforts by the AAPD to advocate for the coverage of general anesthesia for dental rehabilitation by public medical insurance plans have made the dental treatment under general anesthesia a covered benefit in at least 32 states.[14] Nonetheless, coverage for a procedure is not equivalent to access, and the availability of operating room facilities and treatment providers are limited. When restorative services may not be rendered in a timely fashion due to these restrictions, caries management with non-invasive techniques may be an appropriate alternative.

Recommendation

The AAPD recommends immediate intervention in children with early childhood caries, with non-surgical interventions to be implemented when possible to postpone or lower the need for surgical treatment.[15] Silver diamine fluoride (SDF) has been shown to arrest caries through a combination of remineralization and antimicrobial action, and its use as an interim medicament is becoming increasingly popular among pediatric dentists treating early childhood caries.

Rating

Code D1354 is covered by 19 states (37 percent): Alaska, Arizona, California, Florida, Georgia, Indiana, Iowa, Kentucky, Massachusetts, Michigan, Minnesota, Nevada, New Hampshire, New Jersey, North Carolina, Oklahoma, Oregon, Tennessee and Virginia.

Results

SDF application is a safe and cost-effective interim measure for treating early childhood caries. Coverage for this code should be promoted by oral health advocates. Expanded coverage for code D1354 would encourage providers to explore alternative channels for caries management that extend beyond more traditional invasive restorative therapies.

Code D9920 – Behavior Management, by Report

Rationale

The AAPD defines behavior guidance as a process by which dentists can help patients identify appropriate and inappropriate behavior, learn problem-solving strategies, and develop impulse control, empathy, and self-esteem. This process can aid in the development of a positive trusting relationship between the patient and provider and can alleviate anxiety and fear associated with dental treatment. Behavior guidance can result in the successful completion of clinical dentistry on young children, without the need for such advanced behavior management techniques as procedural 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.

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 with advanced behavior management techniques such as general anesthesia.

Rating

Reimbursement for behavior management is covered in 27 states (53 percent): Alaska, Arkansas, Connecticut, Delaware, Florida, Georgia, Idaho, Indiana, Kansas, Louisiana, Maine, Massachusetts, Minnesota, Montana, New Jersey, New Mexico, New York, North Dakota, Pennsylvania, Rhode Island, South Dakota, Tennessee, Texas, Vermont, Virginia, Washington and Wyoming.

Results

Coverage for code D9920 is important to provide practitioners support for taking the time necessary to apply behavior guidance. Documentation of behavior guidance results in purposeful employment of specific techniques according to the individual patient's needs, ensures that a patient's dental record includes information on the particular techniques that will result in successful outcomes, and aids providers in reproducing positive dental experiences for patients at future visits.

Code D9311 – Consultation with Medical Health Care Professional

Communication regarding medical issues that may affect a patient's planned dental treatment.

Rationale

Several factors may hinder provider willingness to treat patients with complex medical histories. Insufficient education regarding particular medical conditions and lack of confidence in the ability to properly manage the oral health of a child with a compromised medical status may discourage a provider from completing a patient's dental care. Providers may hesitate to become responsible for patients who require additional management prior to dental treatment, such as prescribing antibiotics prior to dental therapy or more involved monitoring of vital signs during appointments. Therefore, access to care may be enhanced through dental-medical consultation to gain insight into a patient's medical condition and to make informed decisions regarding treatment. The purpose of the medical consultation is to educate the dentist regarding safe and appropriate treatment in the office setting and will ultimately instill confidence in the dentist providing care.

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.[16]

Rating

Four states (eight percent) currently include code D9311 in their fee schedules: Colorado, Massachusetts, Nevada and New Jersey.

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 lack of reliable transportation and difficulty in scheduling appointments as barriers to compliance with appointments.[17] Additionally, caregivers may have difficulty finding childcare for siblings of patients or getting 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 more 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 those families without the education or experience to navigate the current oral health care system. Dentists and their staff are in a position to aid those requiring additional assistance with such tasks as 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[18] and can result in reduced hospital admission rates, fewer emergency room visits, and harmful misuse of medications.[19]

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 one state (Nevada).

Results

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

Code D9993 – Motivational Interviewing

Rationale

Motivational interviewing is the practice of using patient-centered and individualized counseling to identify behaviors detrimental to oral health outcomes and help patients determine how they can accomplish changes in their behavior to reach their oral health goals. Motivational interviewing allows caretakers to explore their own attitudes about their child's oral health care and gives parents ownership over decisions of 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.[20] A recent meta-analysis of motivational interviewing for parent-child health interventions found evidence to support the use of this strategy to improve pediatric health behaviors and outcomes including oral health, diet, physical activity, smoking cessation, second-hand smoke and healthy weight.[21]

Recommendation

The AAPD encourages dentists to employ motivational interviewing to provide individualized and purposeful care to caregivers of pediatric patients. Coverage for motivational interviewing 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 for motivational interviewing will help create further awareness of this practice method, encourage caregivers to make beneficial behavioral changes and improve oral health outcomes for children.

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 economic circumstances and different cultural beliefs, values, attitudes, traditions and language preferences, and adopting information and services to these differences, which 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.[22] Oral health literacy is affected by personal factors including a patient's cultural perceptions of dental treatment, language, education and income. 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.

In dentistry, poor oral health literacy is associated with compliance issues such as missed dental appointments.[23] 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. Those 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 understood dentistry to be more important for the treatment of emergencies, esthetics and halitosis.[24] Caregivers utilizing 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 and how to find providers. Lee et al. found an association of higher oral health literacy with improved oral health status and self-efficacy.[25]

Recommendation

The AAPD supports Medicaid coverage for efforts to improve patients' oral health literacy through individual, customized communication of information. When needed, translation services for caregivers should be provided.

Rating

Only one state currently covers code D9994 (Nevada).

Results

Interventions meant to address lower health literacy can help to overcome some of the non-modifiable socioeconomic and cultural barriers that affect successful utilization of dental services for children.[26] Coverage for code D9994 should be included in state plans to allow for improved oral health outcomes for this patient population.

Determining Code Coverage Processes and Criteria

Because coverage for services is determined on a state level, inconsistencies in coverage between states often reflect variations in the processes used to determine coverage for CDT codes. States differ in administrative models, budgetary considerations, and the use of consultants or advisory groups.

- In Alabama, a Medicaid advisory group meets quarterly to discuss evidence-based literature and recommendations for coverage. Information from this advisory group, providers and a dental consultant, in combination with recommendations from CMS and budgetary considerations, determine state coverage for each CDT code.

- Maine has a coding committee and a dental advisory committee that review coding annually. The state's dental consultant works with a rate-setting department to determine allowances for each CDT code.

- Oregon's Health Evidence Review Committee includes an Oral Health Advisory Panel that uses evidence-based literature to create a list of procedures considered a priority for coverage by Medicaid. Funding for the coverage of codes is determined by the Oregon Health Authority in conjunction with budgetary approval by the state legislature.

- Vermont employs several dentists to review evidence-based research and data from CMS, the health department and other organizations to make recommendations for coverage of dental procedures and to determine reimbursement rates for those services.

- In Wisconsin, the health department includes an oral health team informed of new codes by CMS. The oral health team, in collaboration with the state dental association, evaluates the efficacy of dental treatments according to evidence-based literature and input from the professional dental community. Reviews of requests to cover additional dental codes are done on an ongoing basis, with consideration for both budgetary constraints and the clinical significance of recommended procedures.

The frequency of code reviews and the groups supplying recommendations for coverage are different for each state. It is important that advocates for expanded oral health coverage understand and engage with their state's process for determining coverage.

Discussion

The results of this study show that the majority of Medicaid plans cover CDT code **D0145** (Oral Evaluation for Children Under Age Three), 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 3 and submit insurance claims with a separate medical procedure code. This coverage trend 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 further improve oral health for children.

Coverage for the other services discussed in this paper remains inconsistent across the country. Only four states currently allow code **D1310** (Nutritional Counseling) 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 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' attitudes toward and ability to provide nutritional counseling for infants and young children.[27] 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.

Restricted state coverage for code **D1320** (Tobacco Counseling) has placed similar limitations on dentists' attitudes toward and time available for tobacco cessation counseling. In a

semi-structured interview with 11 executives of dental insurance companies, all executives expressed belief that smoking cessation was part of routine care during dental visits.[28] Despite this perception that the dentist is a resource for tobacco cessation counseling, only one quarter of 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. In a national survey, 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.[29] If the disastrous health consequences and astronomical health care costs of treating chronic diseases associated with tobacco use are to be reduced across the country, tobacco counseling for prevention and cessation is a strategy that should be encouraged.

Interim treatment with silver diamine fluoride is gaining attention nationwide, yet fewer than half of states allow coverage for code **D1354** (Interim Caries Medicament). The option to delay or avoid general anesthesia with use of a caries-arresting medicament may be beneficial from both a safety and financial perspective. Although the more serious morbidities of dental rehabilitation under general anesthesia may be uncommon, this treatment modality is not without risks. Recent studies raised the possibility of long-term cognitive consequences of general anesthesia in young children. Additionally, hospital care comes at a significant financial cost.

SDF's advantages include ease of application and a relatively low cost. 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.

State plan inclusion of code D1354 may affect its use in pediatric dentistry training programs and subsequent use in private practice by graduates of those programs. A 2016 survey of pediatric dental residency program directors found that close to two-thirds of respondents felt a lack of coverage for SDF was a barrier to its use in residency training programs.[30]

Some states have developed incentive programs to encourage treatment of childhood caries with SDF. Georgia's Peach State Health Plan, for example, has partnered with Envolve Dental for the 2017 Silver Diamine Fluoride Quality Incentive Program. In addition to coverage for twice yearly SDF application, the program will provide a $250 incentive to providers for each case of SDF application when general anesthesia is avoided. California recently announced a pilot program in which dental professionals who enroll and complete a two-hour training course from the California Dental Association will be reimbursed $35 per patient for use of SDF on high-risk children. It would be prudent for advocates to suggest similar incentive programs in additional states to encourage more frequent use of SDF to address the high prevalence of early childhood caries among poor and medically compromised children.

Aside from SDF application, the volume of children in need of dental care under general anesthesia may be reduced by improved employment of behavior guidance techniques. Coverage of code **D9920** (Behavior Management) allows for extra time and customized strategies to help patients successfully comply with 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 10 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 publically funded health care.[31-32] This gap in reported use of behavior guidance strategies could be narrowed through workshops and courses to educate general dentists in the latest techniques. Expanded coverage for behavior guidance would allow for more dentists to feel confident in using these approaches and more positive dental experiences for children.

Several states have adopted code **D9311** (Consultation with Medical Professional) into their state plans for 2017. Coverage for medical consultations is essential to the AAPD's mission of promoting optimal oral health for all children, including those with complex health care needs. Many children with special health care needs can be safely treated in private office settings, but require clarity of medical history prior to making appropriate treatment recommendations. Dentists who have confirmation from medical providers as to the appropriateness of in-office therapies 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 more providers to treat many more children with complex health care needs confidently and comprehensively. A significant portion of children with special health care needs are treated by Medicaid providers,[33] and coverage for this code may encourage increased participation by dentists in Medicaid plans.

Four case management codes were adopted for CDT 2017 to address barriers to care for children enrolled in Medicaid dental services, particularly those affecting utilization of available benefits. Case management is a purposeful joint effort between providers and families to reduce potential limitations to health care utilization by addressing the particular logistical, financial and educational challenges facing individual patients.

Government supported case management programs have had positive effects on health literacy, treatment compliance and utilization.[34] The ability to navigate the process of finding eligible providers, arrange for dental visits and follow up, and to understand diagnoses and treatment recommendations is multifactorial and goes beyond traditional assumptions about access to care. While providers may be available to evaluate and treat Medicaid-enrolled children, successful utilization of dental services is complicated by socioeconomic, social and cultural factors.

Code **D9991** (Addressing Compliance Barriers) is designed to alleviate some of the hindrances to appointment compliance by going beyond appointment reminder mailings and offering coordinated involvement by social service agencies, community health care workers and family members. Coverage for these efforts is important to allow individual providers the time to arrange for special accommodations, such as subsidized public transportation or driver services. Further, the inclusion of such a code in electronic health records is important for documentation and an examination of the effects of such efforts on compliance rates. Additionally, reduction in the rates of failed appointments may encourage greater participation by dentists in Medicaid plans.

Code **D9992** (Care Coordination) allows providers to guide their patients through a complex health care system and helps to smooth the transition between providers, specialties and settings.

Code **D9993** (Motivational Interviewing) is meant to encourage the practice of motivational interviewing, an approach for helping patients acknowledge personal obstacles preventing them from achieving optimal oral health.

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

Perhaps surprisingly, Medicaid providers may be ambivalent about requesting coverage for such services as the application of silver diamine fluoride or transportation services. Questions have been raised regarding the likelihood that Medicaid will continue to cover dental treatment under general anesthesia if a less costly treatment option such as SDF is available as an alternative. While SDF may be an appropriate interim or permanent choice for many patients, it is not the best solution for all children with early childhood caries. Thus, advocates should argue for the inclusion of code D1354 as an *addition* to state dental plans rather than at the exclusion of other important services.

Concerns have been raised among public health providers regarding how coverage for code D9991, which addresses transportation issues, will affect designations for Health Professional Shortage Areas. Code D9994 (Oral Health Literacy) includes efforts to provide translators to non-English speaking families. The requirement to provide interpreters may be seen by many Medicaid providers as a financial and administrative burden. Advocates must work with policy makers to make coverage of important dental services more widely allowed by state plans and also address the concerns of providers regarding the employment of these procedures in practice to facilitate improved utilization and quality of dental care.

Research Limitations

This paper highlights more recent CDT codes and coverage for these procedures by individual states. Limitations to the information gathered include difficulties in accessing online fee schedules and verifying coverage by phone for some states. Occasionally, coverage for codes was confirmed or denied by a provider service representative when the code was not listed on the state's schedule of allowable services. In these cases, the information provided by phone was presented in this paper rather than the information found online. Additionally, some states issue memoranda to providers notifying them of coverage for a procedure even when the code has not been officially included in the most recent fee schedule or users manual. For this reason, there may be additional states not represented in this paper that are covering the discussed procedure codes. Another limitation to the information presented in this paper is the arrangement that many state Medicaid plans have with managed care organizations (MCOs). While MCOs may include some of the selected procedure codes in their fee schedules, the information provided in this paper attempted to represent coverage by state for Medicaid fee-for-service schedules.

Conclusion

The AAPD and its 10,000 members advocate for the continued and enhanced use of services that will lessen the disease burden of early childhood caries for those from socioeconomically disadvantaged backgrounds. Caries rates in children can be reduced through Medicaid coverage for diagnostic, preventive, restorative and administrative procedures. Further, comprehensive public insurance for children's oral health services can facilitate positive attitudes toward dentistry, mitigate the large demand for dental rehabilitation under general anesthesia, and improve utilization of dental services. 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

D0145: Oral Evaluation Patient Under 3
D1310: Nutritional Counseling
D1320: Tobacco Counseling
D1354: Caries Arresting Medication
D9920: Behavior Management
D9311: Consultation w/ Medical Provider

State	D0145	D1310	D1320	D1354	D9920	D9311
Alabama	Y					
Alaska	Y		Y		Y	
Arizona	Y			Y		
Arkansas			Y	Y	Y	
California				Limited Trial		
Colorado	Y					Y
Connecticut			Y		Y	
Delaware	Y				Y	
D.C.	Y					
Florida	Y			Y	Y	
Georgia				Y	Y	
Hawaii	Y					
Idaho	Y				Y	
Illinois				Y		
Indiana	Y			Y	Y	
Iowa	Y		Y	Y		
Kansas	Y				Y	
Kentucky	Y			Y		
Louisiana	Y				Y	
Maine	Y		Y		Y	
Maryland	Y					
Massachusetts	Y	Y	Y	Y	Y	Y
Michigan	Y			Y		
Minnesota	Y			Y	Y	

State	D0145	D1310	D1320	D1354	D9920	D9311
Mississippi						
Missouri	Y			Y		
Montana	Y	Y	Y	Y	Y	
Nebraska	Y					
Nevada	Y			Y		Y
New Hampshire	Y	Y		Y		
New Jersey	Y		Y	Y	Y	Y
New Mexico					Y	
New York	Y		Y		Y	
North Carolina	Y			Y		
North Dakota	Y				Y	
Ohio			Y	Y		
Oklahoma	Y		Y	Y		
Oregon	Y		Y	Y		
Pennsylvania	Y				Y	
Rhode Island					Y	
South Carolina	Y					
South Dakota	Y				Y	
Tennessee				Y	Y	
Texas	Y				Y	
Utah						
Vermont	Y			Y	Y	
Virginia	Y			Y	Y	
Washington				Y	Y	
West Virginia	Y		Y	Y		
Wisconsin						
Wyoming	Y	Y	Y		Y	

Case Management Codes are covered by Nevada.

Code Listing current as of September, 2018.

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