

**North Carolina Division of Medical Assistance
Oral Health Periodicity Schedule**

The North Carolina Division of Medical Assistance (DMA) Oral Health Periodicity Schedule follows a modified version of the American Academy of Pediatric Dentistry's (AAPD) *Periodicity of Examination, Preventive Dental Services, Anticipatory Guidance, and Oral Treatment for Children*. The DMA periodicity schedule has been developed in consultation with local authorities in the field of pediatric oral health care. This schedule is designed for the care of children who have no contributing medical conditions and are developing normally. Promotion of oral health care is considered a joint responsibility between oral health professionals and other health care professionals. This periodicity schedule recommends appropriate intervals of care which correspond to reasonable standards of dental practice. The schedule is not intended to prescribe by whom the services should be provided particularly for Medicaid eligible infants and toddlers under age 3. This will be determined by other factors including local community capacity to provide care to preschool Medicaid children. The DMA Oral Health Periodicity Schedule can be modified for children with special health care needs or if disease or trauma contributes to variations from the norm. All services rendered under DMA Dental Services Clinical Coverage Policy guidelines must be medically necessary.

RECOMMENDATION	AGE				
	Birth – 12 months	12 – 24 months	2 – 6 years	6 – 12 years	12 years & Older
Clinical oral evaluation ^{1,2}	*	*	*	*	*
Assess oral growth and development ³	*	*	*	*	*
Caries risk assessment ^{4,5}	*	*	*	*	*
Radiographic assessment ⁶			*	*	*
Prophylaxis and topical fluoride ^{5,6}	*	*	*	*	*
Fluoride supplementation ^{7,8}	*	*	*	*	*
Anticipatory guidance/counseling ⁹	*	*	*	*	*
Oral hygiene counseling ¹⁰	Parent/caregiver	Parent/caregiver	Patient and parent/caregiver	Patient and parent/caregiver	Patient
Dietary Counseling ¹¹	*	*	*	*	*
Injury prevention counseling ¹²	*	*	*	*	*
Counseling for non-nutritive habits ¹³	*	*	*	*	*
Assessment for substance abuse counseling referral				*	*
Periodontal assessment ^{5,6}				*	*
Assessment of developing malocclusion			*	*	*
Assessment for pit & fissure sealants ¹⁴			*	*	*
Assessment and/or removal of 3 rd molars					*
Transition to adult dental care					*
Referral to primary care physician, if needed	*	*	*	*	*

¹ The Primary Care Physician/Pediatrician/Dentist should perform the first/initial oral health screening following AAP/AAPD guidelines

² An oral evaluation should be done by the Primary Care Physician/Pediatrician/Dentist up to age 3. Every infant should receive an oral health risk assessment from his/her primary health care provider or qualified health care professional by 6 months of age that includes: (1) assessing the patient's risk of developing oral disease using an accepted caries-risk assessment tool; (2) providing education on infant oral health; and (3) evaluating and optimizing fluoride exposure. The evaluation should include an assessment of pathology and injuries.

³ By clinical examination

⁴ All children should be referred to a dentist for the establishment of a dental home no later than age 3 and by 12 months of age if possible. Children determined by the PCP/Pediatrician to be at risk for early childhood caries (ECC) should be referred to a dentist as early as 6 months, after the first tooth erupts, or 12 months of age (whichever comes first) for establishment of a dental home. Children at risk for ECC are defined as:

- Children with special health care needs
- Children of mothers with a high caries rate
- Children with demonstrable caries, heavy plaque, and demineralization ("white spot lesions")
- Children who sleep with a bottle or breastfeed throughout the night

Once dental care is established with a dental professional, it is recommended that every child enrolled in Medicaid see the dentist for routine care every six months.

⁵ Must be repeated at regular intervals to maximize effectiveness.

⁶ Timing, selection and frequency determined by child's history, clinical findings, susceptibility to oral disease and the child's ability to cooperate with the procedure.

⁷ Consider when systemic fluoride exposure is suboptimal.

⁸ Up to at least age 16.

⁹ Appropriate oral health discussion and counseling should be an integral part of each visit for care.

¹⁰ Initially, responsibility of parent; as child develops, joint responsibility with parent; then when indicated, responsibility lies with child

¹¹ At every appointment; initially discuss appropriate feeding practices, the role of refined carbohydrates and frequency of snacking in caries development and childhood obesity

¹² Initial discussions should include play objects, pacifiers, and car seats; when learning to walk, include injury prevention. For school-age children and adolescent patients, counsel regarding routine playing and sports, including the importance of mouthguards.

¹³ At first, discuss the need for additional sucking: digits vs. pacifiers; then the need to wean from the habit before malocclusion or skeletal dysplasia occurs. For school-aged children and adolescent patients, counsel regarding any existing parafunctional habits such as fingernail biting, clenching or bruxism.

¹⁴ For caries-susceptible primary and permanent molars; placed as soon as possible after eruption.

Note: Please refer to DMA Clinical Coverage Policy No. 4A -- Dental Services for covered services and limitations.

REFERENCES FOR ORAL HEALTH PERIODICITY SCHEDULE

1. American Academy of Pediatrics, “Policy Statement on Oral Health Risk Assessment Timing and Establishment of the Dental Home”, *Pediatrics*, 111(5):1113-16 (2003).
2. *Guide to Children’s Dental Care in Medicaid*, U.S. Department of Health & Human Services, Centers for Medicare and Medicaid Services (Oct. 2004), available at: <https://www.medicaid.gov/medicaid-chip-program-information/by-topics/benefits/downloads/child-dental-guide.pdf>
3. Cruz GG, Rozier RG, and Slade G, “Dental Screening and Referral of Young Children by Pediatric Primary Care Providers,” *Pediatrics*, 114(5):642-52 (Nov. 2004)
4. Scale NS and Casamassimo PS, “Access to Dental Care for Children in the United States: A Survey of General Practitioners,” *JADA*, 134:1630-1640 (Dec. 2003)
5. American Academy of Pediatric Dentistry, *Policy on Use of a Caries-risk Assessment Tool (CAT) for Infants, Children and Adolescents* Originating Council, Council on Clinical Affairs, Adopted 2002, Revised 2006, available at: http://www.aapd.org/media/Policies_Guidelines/P_CariesRiskAssess.pdf
6. American Academy of Pediatric Dentistry, *Guideline on Periodicity of Examination, Preventive Dental Services, Anticipatory Guidance/Counseling, and Oral Treatment for Infants, Children and Adolescents* Originating Council, Council on Clinical Affairs, Revised 2009, available at: http://www.aapd.org/media/Policies_Guidelines/G_Periodicity.pdf
7. Bright Futures/American Academy of Pediatrics, *Recommendations for Preventive Pediatric Health Care*, American Academy of Pediatrics (2008), available at: <http://brightfutures.aap.org/pdfs/AAP%20Bright%20Futures%20Periodicity%20Sched%20101107.pdf>