



Unique Considerations for Medicaid Audits of Pediatric Dental Practices

Introduction

The American Academy of Pediatric Dentistry (**AAPD**) supports the need to address waste, fraud and abuse in the Medicaid program. Further, the AAPD is opposed to the commission of fraud by dentists in their relationships with third-party payors. Fraud and abuse by dentists harm the patients we are sworn to serve and, by association, the reputation of our profession. Such unprofessional conduct can result in serious consequences from federal and state agencies and the possible loss of membership status in the AAPD.

Audits are necessary to identify improper payment and instances of fraud within Medicaid programs. Unfortunately, the quality and consistency of auditing practices vary greatly between contractors and by state. Although audits are a critical part of maintaining program integrity, they are most effective when they can make a clear distinction between truly fraudulent practices and honest mistakes. Auditing practices failing to make this distinction will have a substantial impact on children's access to oral health care through a large reduction in the number of dentists willing to participate in Medicaid.

After a brief review of AAPD Policy on Third-Party Audits, this report discusses three characteristics crucial to the effectiveness of Medicaid audits in pediatric dentistry: the demographics of patients, the services of pediatric dental practices and the special circumstances of treatment in a hospital or ambulatory setting. The important points in this discussion are highlighted by the case studies included in this report. Recommendations are presented to make audits work for providers and patients served under the Medicaid program.

AAPD Policy on Third-Party Audits

The AAPD Policy Statement on Third-Party Audits (Appendix 3) identifies several practices as potentially unfair and, ultimately, harmful to both the provider and to Medicaid recipients:

1. **A lack of peer review.** Auditors often lack the training or credentials necessary to conduct an objective review. An auditor should have sufficient knowledge of the appropriate clinical guidelines and standards of care in the subject area. For example, a pediatric dentist's audit findings should be reviewed by a dentist who specializes in pediatric dentistry.
2. **Contingency fees.** The potential for a conflict of interest exists when auditors receive compensation based on the amount of funds recuperated. While such a system was created as part of Recovery Audit Contractor (**RAC**) program for Medicare, and subsequently extended to Medicaid under the Affordable Care Act (**ACA**), the AAPD believes it is a problematic approach that should be repealed by Congress.
3. **Flawed methodology.** The methodology used for data mining is inconsistent and often opaque. In order to identify true outliers, audit methodology should consistently compare peers within the same specialty who practice in similar geographic areas and on similar patient populations.
4. **Inconsistency with AAPD Clinical Guidelines.** Auditing criteria should be consistent with AAPD Clinical Guidelines.

Characteristics Unique to the Pediatric Dental Medicaid Population

Children enrolled in Medicaid often experience different oral disease patterns, dietary habits, access to care, restorative needs and health literacy levels compared to children with private dental insurance. Reports have shown that significant disparities exist in oral health on the basis of socioeconomic status. Children from low-income families have twice as many dental caries as children from more affluent families.^{1,2} Utilization of dental services is also diminished among low-income families.³ Additionally, disease rates and treatments vary by geographic location. For example, 41 percent of pediatric patients in rural areas are on public assistance. Together, these characteristics put the pediatric Medicaid population at a higher risk for dental disease including Early Childhood Caries, the most common chronic disease of childhood.

Characteristics Unique to Pediatric Dental Practices

Pediatric dentists provide care for children at high risk for oral disease, those covered by Medicaid and those with special health needs at a higher rate than general dentists and thus have distinctively different practice patterns.

1. Close to 70 percent of pediatric dentists accept patients covered by public assistance programs (Medicaid and CHIP).
2. Pediatric dentists see almost 20 percent more public aid patients than general dentists. Also, more than half of pediatric dentists accept new Medicaid patients.⁴
3. More than 40 percent of pediatric dentists' patients are under five years of age. In contrast, 70 percent of general dentists report that fewer than 20 percent of their patients are children.⁵
4. A pediatric dentist's population may be skewed, caring for a large portion of Medicaid patients with complex treatment needs as a result of referrals from general dentists.
5. Almost all pediatric dentists (99.5 percent) report that they care for patients with special needs, compared to approximately 10 percent of general dentists.

A combination of patient and provider barriers has led to low utilization of dental care options, higher dental disease rates and higher treatment costs for publically insured pediatric patients. Despite these barriers, pediatric dentists are uniquely qualified to serve this at-risk population and currently provide care at higher rates than other dental providers. The barriers that exist will only increase if unfair audits result in pediatric dentists leaving or not enrolling in the Medicaid system.

Characteristics Unique to Oral Health Treatment in a Hospital or Ambulatory Care Setting

Pediatric dentists treat children with the most complex treatment needs, including children referred because of behavioral issues or multifaceted clinical needs. Providing this complex treatment in the dental office is often not possible. Therefore, alternative treatment is provided in a hospital or ambulatory care setting under sedation or general anesthesia.

For example, patients with special health care needs can have complex treatment conditions, acute situational anxiety, developmental or physical disabilities or medical conditions that require sedation or general anesthesia to undergo dental procedures in a safe and effective manner.⁶ Pediatric dentists also treat many infants and young children who have not yet developed effective skills to cope with invasive, potentially uncomfortable and psychologically threatening procedures. For many of these patients, treatment under general anesthesia represents the safest, most effective method to deliver the necessary oral health care.⁷

Pediatric dental services provided in a hospital or ambulatory care setting will often have a greater percentage of restorative and surgical procedures when compared to local general dentists or even other local pediatric dentists. The patient pool at these sites tends to be at higher risk for dental caries and more likely to be medically compromised. Although general anesthesia, on the surface, carries a higher cost than utilizing other methods of behavior guidance, it may lead to lower overall costs for extensive dental treatment due to the efficiency of combined care.⁸ In addition, patients at these sites will often only seek urgent care treatment and not return for preventive visits.⁹

These characteristics skew the parameters typically reviewed by auditors and potentially give the impression of a provider being an outlier. For example, most dentists treating very young children will provide maximum restorative care under sedation and general anesthesia, so the ratio of restorative claims compared to diagnostic and preventive claims will be higher compared to other providers.

Conclusion

It is clear that fraud and abuse can undermine the Medicaid program, and the AAPD supports the need to address these issues in an already underfunded system. It is equally clear that pediatric dentists are uniquely qualified to serve the population covered by Medicaid, and currently provide care at higher rates than other dental providers. However, unfair auditing practices will drive away good providers and discourage new dentists from enrolling in Medicaid. This in turn will have a substantial impact on children's access to oral health care, as well as the quality of life of the patients we serve.

Case Studies

Nebraska

In April of 2014, 300 dentists in Nebraska, nearly all the state's dental Medicaid providers, received certified audit letters from a RAC auditing agency on behalf of the Nebraska Department of Health and Human Services Medicaid Integrity Program. The audit pertained to potential overpayment of Medicaid claims on dental prophylaxis (cleaning of teeth) if the service was provided in less than a six-month interval. The auditors requested copies of all charts that fit these criteria, over 800 charts in the case of one pediatric dental practice. This indiscriminate audit was conducted despite a provision in the Nebraska Medicaid provider manual which allows for latitude in the six-month rule based on the dentist's clinical judgment:¹⁰ Dental prophylaxis will be "covered at the frequency determined appropriate by the treating dentist with a 6-month prophylaxis considered standard."

Connecticut

A 2014 initiative in Connecticut by the state's Department of Social Services (DSS) proposed an audit of Medicaid providers to recover overpayment or fraud. Apparently, all Medicaid dental providers with more than \$150,000 in claims for a year would be subject to such audits. The Connecticut State Dental Association met with DSS to discuss concerns over this approach and the lack of guidance on what standards will be used in the audits. For example, it appeared that no dentist would be involved in determining the medical necessity during chart reviews.

Maine

In June of 2013, Dr. Kristina Lake Harriman, clinical director of the Community Dental Center in Waterville, Maine, reported that a Medicaid RAC audit conducted on her facility felt "arbitrary and a bit unfair." The billing errors identified in the audit were due, in part, to a combination of computer errors that were subsequently corrected. Nevertheless, the overzealous use of an extrapolation method converted a \$186 overpayment for dental cleanings into a \$23,856 fine. This large fine was a serious financial burden on a non-profit community health center where 78 percent of the patients are Medicaid eligible and where there was no intent to defraud the government. (The issue was subsequently resolved, without a fine, by the Maine Department of Health and Human Services with valuable input from CMS.)

Recommendations

- 1. Engage dentists in program integrity.** Encourage state dental Medicaid agencies to engage state AAPD affiliates in developing fair and consistent audit policies and participate in provider education on those policies.
- 2. Utilize a fair, consistent audit methodology.** The U.S. Department of Health and Human Services Office of the Inspector General (OIG) methodology (see Appendix 2) used objective measures that were reasonable, clear and grounded in sound clinical practice. This methodology could serve as a model for other federal and state agencies when conducting audits for pediatric dental services. In developing their methodology, the OIG took great care to incorporate criteria and thresholds that took into account the variety of individual practice patterns and the distinction between potential fraud and simple honest mistakes.
- 3. Issue "Report Cards" to providers.** State Medicaid agencies should consider using their claims data to issue a quarterly or yearly report card that would show an individual dentist's metrics. For example, the report could include the top ten codes billed by volume or dollar amount compared to other pediatric dentists in the state.
- 4. Develop front-end software to "scrub" claims.** Pre-scrubbing algorithms exist that can be used to develop software to address fraud and abuse. This software could enhance the quality of dental claims submissions by ensuring that submissions are complete and accurate. It would identify potential denials before the claims reach the payor by reviewing proper coding and logical sequence of care. The uniform use of this type of scrubbing software could eliminate the need for the costly "pay and chase" system currently utilized by federal and state Medicaid agencies. (The ADA is currently investigating this approach.)



5. **Examine quality vs. quantity of care.** The proportion of children who receive only diagnostic and preventive services should be compared to the proportion of children who receive comprehensive care (diagnostic, preventive and treatment). Although the majority of children in the U.S. need primarily preventive and diagnostic services, there is still great need for treatment in a significant portion of Medicaid-enrolled children.
 - The proportion of prevention vs. treatment should be balanced with ensuring that providers are also fulfilling treatment needs. Ideally, the provider who completes the preventive and diagnostic services should also provide the treatment procedures when indicated.
 - Continuity of care should be evaluated by examining rates of recall visits and follow-up care. Further, this type of evaluation must consider program enrollment. The enrollment files provide information about enrollment spells for each child enrolled in Medicaid and will have an effect on continuity of care.
6. **Account for type and distribution of provider.** The distribution and type of local providers, such as general vs. pediatric dentists, can significantly affect a particular provider's treatment and billing patterns. Medicaid provider data systems should allow for mapping of dentist distribution. Additionally, audits should differentiate between general and pediatric dentists.
7. **Make policy changes that will enhance the audit process.**
 - Examine the Medicaid RAC programs that have been implemented across the states and assess the impact such audits have had on providers enrolled in the program and subsequent patient access to services.
 - Compile a list of state education and outreach efforts on Medicaid RAC audits to determine the depth of provider education needed to function well within the Medicaid program.
 - Issue guidelines to help ensure such education takes place consistent with the final federal rule on Medicaid RAC programs, published Sept. 16, 2011,¹¹ requiring states to provide education and outreach to providers. In the absence of fraud, clerical errors should be used as an opportunity to educate rather than penalize the provider.
 - Issue guidelines to establish a uniformly fair, transparent process concerning how and when extrapolation should be used to determine fines and to recommend the use of an in-state peer dentist to review clinical records where appropriate.

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Appendix 1: Definitions

The general definition of an **audit** is a “planned and documented activity performed by qualified personnel to determine by investigation, examination or evaluation of objective evidence, the adequacy and compliance with established procedures, or applicable documents and the effectiveness of implementation.”⁸ After receiving a notice of an impending audit from a third party payor, the dentist should ascertain the type and scope of audit to be conducted.⁹

A **third party payor** is “an organization other than the patient (which would be the first party) or health care provider (also known as the second party) involved in the financing of health care services.”⁹

Federal Medicaid regulations define **fraud** as “an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to him or some other person.”¹²

Abuse is defined as “provider practices that are inconsistent with sound fiscal, business, or medical practices, and result in an unnecessary cost to the Medicaid program, or reimbursement for services that are not medically necessary or that fail to meet the professionally recognized standards for health care. It also includes recipient practices that result in unnecessary cost to the Medicaid program.”¹²

The AAPD supports **medically necessary care (MNC)** and recognizes that dental care is medically necessary for the purpose of preventing and eliminating orofacial disease, infection, and pain, restoring the form and function of the dentition and correcting facial disfiguration or dysfunction.¹³

The Affordable Care Act (ACA) includes a “**Recovery Audit Contactor (RAC) Program**” in which private contactors are hired to review Medicaid provider activities including claims audits, identifying overpayments, fraud and abuse. The RAC auditors are paid on a contingency fee based on recovery amount.

Appendix 2: Methodology for identifying potentially fraudulent services

In recent years there have been a number of instances where individual dentists and dental practice chains have been prosecuted for providing unnecessary dental procedures to Medicaid children. In response, the U.S. Department of Health and Human Services (HHS) Office of Inspector General (OIG) conducted an analysis in several states. The methodology used objective measures that were reasonable, clear and grounded in sound clinical practice. This methodology could serve as a model for other federal and state agencies when conducting audits for pediatric dental services.

Medicaid fee-for-service paid claims were analyzed for general dentists, oral surgeons and orthodontists who provided services to 50 or more children in 2012.^{14,15,16} The OIG used the following billing measures to identify dental providers with questionable billing who were extreme outliers when compared to their peers.

Questionable Billing Measures for General Dentists

1. Average Medicaid payment per child served.
2. Average number of services provided per child per visit.
3. Average number of services provided per day.
4. Proportion of Medicaid children who received fillings.
5. Proportion of Medicaid children who received extractions.
6. Proportion of Medicaid children who received stainless steel crowns.
7. Proportion of Medicaid children who received pulp-tomies.
8. Proportion of Medicaid children who received advanced behavior management, e.g. restraints.

Questionable Billing Measures for Oral Surgeons

1. Average Medicaid payment per child served.
2. Average number of services provided per day.
3. Average number of services provided per child per visit.

Questionable Billing Measure for Orthodontists

1. Total number of children who received orthodontic services.

In developing their methodology, the OIG took great care to incorporate criteria and thresholds that took into account the variety of individual practice patterns and made a distinction between potential fraud and simple honest mistakes:

- **Compared similar peer groups and conducted separate analysis of general dentists and selected specialists.** In other words, general dentist billing patterns were compared to other general dentist billing patterns. Had pediatric dentists been a part of this study, pediatric dentist billing patterns would have been compared to other pediatric dentist billing patterns. This comparison is critical since pediatric dentists serve a much higher risk population with higher needs than do general dentists.
- **Established key for thresholds for each of these measures to identify dentists with patterns of questionable billing.** Of particular note, the study looked at proportions vs. simple volume. For example, they asked “what proportion of all treated children received extractions” as opposed to “how many extractions were performed.”
- **Established thresholds using the Tukey method, which calculates values greater than the 75th percentile plus three times the interquartile range.** This method identified billing practices that were more than two standard deviations from the mean and could be considered true outliers.
- **Avoided the often false assumption that identification of an outlier confirms that a particular provider is engaging in fraudulent or abusive practices.** This is an important point; once a “questionable billing practice” is identified, further research, such as chart reviews, is warranted.

Appendix 3: Policy on Third Party Payor Audits, Abuse, and Fraud

Purpose

One of the aims of the Deficit Reduction Act¹, approved by the US Congress in 2005, was to prevent Medicaid fraud and abuse through an audit process. Despite the good intentions of this law, experts predict health care providers will see more investigations, enforcement actions, and whistleblower cases, and will need to devote more resources toward compliance.² Pediatric dentists play a critical role in the Medicaid program, and there will be negative impact on access to care if honest providers are burdened with regulations and audits. The American Academy of Pediatric Dentistry (**AAPD**) supports efforts to eliminate Medicaid abuse. The AAPD cautions, however, against ill-informed or misguided investigations that may discourage dental provider participation in the program.² The AAPD is opposed to any of its dentist members committing abuse and fraud as it relates to their relationship with third party payors. Such behavior is unprofessional conduct and could result in loss of membership status in AAPD.³ This policy is intended to help AAPD members understand the audit process, both internal and external audits.

Methods

This policy is based upon a review of current dental and medical literature, including a literature search of the PubMed[®] electronic database with the following parameters: Terms: “dental audits”, “dental abuse and fraud”, “peer review”, “provider profiling”, “practice management”, “EPSDT”; Field: all; Limits: within the last 10 years; human; English. Nineteen articles match these criteria. Papers for review were chosen from this list as well as references within the selected articles. When data did not appear sufficient or were inconclusive, recommendations were based upon expert and/or consensus opinion by experienced researchers and clinicians.

Background

External audits are increasingly common for a full range of health care providers. AAPD members are no exception, as some of our members have experienced. If a provider requests payment from third party payors, the claims may be subject to review by a recovery audit contractor (RAC), a private entity that reviews paid claims and, in some cases, earns contingency fees for improper payments it retrieves. Private and public third party payors use audits as a mechanism to recoup over-payments, inspect for potential improper behavior, and possibly guide health care providers to control utilization and costs.⁴ Notably, there can be serious financial and even criminal penalties associated with billing errors.⁵

In 2012, an estimated \$19 billion, or seven percent, of the federal Medicaid funds were absorbed by improper payments, which include fraud and abuse as well as unintentional mistakes such as paper errors.⁶ Improper payments totaled an estimated \$11 billion, or nine percent of states’ Medicaid budgets in 2010, the most recent year for which data is available.⁷ Improper payments can occur when funds go to the wrong recipient, the recipient receives the incorrect amount of funds (either an underpayment or overpayment), documentation is not available to support a payment, or the recipient uses the funds in an improper manner.⁶

The AAPD recognizes the concern its members have regarding these external audits. The AAPD encourages its members to develop internal self-audit programs to address these challenges. Internal audits are used in order to preemptively detect discrepancies before the external authorities can discover them and impose penalties.⁴ Given the heightened concern for compliance to avoid an external audit, internal audits have taken on importance. A compliance program generally will incorporate a credible internal audit system, which means that it must be prepared to respond to an external audit by various authorities. In addition, some pediatric dentists have discovered that an internal audit system can be developed so that it not only addresses the external audit, but also serves other quality of care and performance improvement purposes.⁴

Definitions

Abuse: “provider practices that are inconsistent with sound fiscal, business, or medical practices, and result in an unnecessary cost to the Medicaid program, or reimbursement for services that are not medically necessary or that fail to meet the professionally recognized standards for healthcare. It also includes recipient practices that result in unnecessary cost to the Medicaid program.”⁸ The AAPD supports medically necessary care (**MNC**) and recognizes that dental care is medically necessary for the purpose of preventing and eliminating orofacial disease, infection, and pain, restoring the form and function of the dentition, and correcting facial disfigurement or dysfunction.⁹

Audit: “planned and documented activity performed by qualified personnel to determine by investigation, examination, or evaluation of objective evidence, the adequacy and compliance with established procedures, or applicable documents, and the effectiveness of implementation.”¹⁰ After receiving a notice of an impending audit from a third party payor, the dentist should ascertain the type and scope of audit to be conducted.¹¹

Fraud: “an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to him or some other person.”⁸

Third party payor: “an organization other than the patient (which would be the first party) or health care provider (also known as the second party) involved in the financing of health care services.”¹¹

Credentials of auditors

The Affordable Care Act required that each state Medicaid program use at least one RAC beginning in 2011.¹² Some states have started employing the RACs to aid in recovery of improper payments.¹³ The AAPD strongly believes that, while audits are a part of third party payment contracts and are necessary to protect the integrity of these programs, such audits must be completed by those who have credentials on par with the dental provider being audited. For example, pediatric dentists must be audited by a dentist who specializes in pediatric dentistry and who understands the clinical guidelines and standards of care which have been adopted and followed by their specialty. The AAPD is adamantly opposed to auditors receiving financial incentives for any money recuperated through these audits. This represents a conflict of interest.

Provider profiling

The AAPD is opposed to “provider profiling” and believes that dentist providers selected for audits should be chosen randomly or with compelling evidence that makes them an outlier compared to peers practicing in similar geographic areas, on similar populations of patients, and within the same specialty. Claims-based data used for provider profiling are not collected exclusively for performance assessment and, as a result, may be irrelevant or inadequate for profiling.¹⁴ Claims data may be unable to properly and fully characterize an episode of care and may fail to reveal a patient’s baseline status.¹⁴ In addition, codes contained in claims data do not articulate “patients’ compliance, their desire for care, or their socioeconomic status.”¹⁴

Peer review as part of audit outcomes

The AAPD supports peer review as a way to offer information and support to dentists who need to review best practices regarding chart documentation, coding, and billing practices related to third party payors. This should be offered in lieu of financial penalties when an audit shows that no intent to fraud was present, but that the dentists need education to improve their practice systems. It provides practicing dentists a means to preserve their reputation and good standing in the community.¹⁵ This model would be consistent with the peer review practices that occur when clinical decision making is in question. The intent of peer review is to resolve discrepancies between the dentists and third party payors expeditiously, fairly, and in a confidential manner.¹⁵

Best practices for chart documenting, coding, and billing

The AAPD supports the education of pediatric dentistry residents, pediatric dentists, and their staff to ensure good understanding of appropriate coding and billing practices. The AAPD, therefore, supports the creation of educational resources and programs that promote best practices, which may include:

- Programming at the AAPD’s Annual Session or other AAPD-sponsored continuing education course.
- Programs offered to pediatric dentistry state unit and district organizations.
- The creation of a web-based tutorial for dentists and their staff, including frequently asked questions regarding Medicaid.
- Partnering with other public/private organizations and agencies to distribute ‘Medicaid Updates’ that can be received via e-mail, and building open *Medicaid Compliance for the Dental Professional* webinars offered jointly by AAPD and Centers for Medicare and Medicaid Services (CMS)¹⁶.
- The development of a third party payor submission compliance program.

Medicaid policies that conflict with AAPD clinical practice guidelines

The AAPD is opposed to Medicaid programs that have policies which are in direct conflict with AAPD clinical practice guidelines and are of detriment to patient care. In several states, children are not receiving appropriate dental treatment covered by Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) because there is a refusal to reimburse providers for EPSDT-covered dental services.¹⁷ It is in the best interest of the public to have EPSDT dental periodicity schedules readily available on the Internet. Such availability would also improve compliance by health care professionals and EPSDT staff members with federal EPSDT requirements.¹⁷

In addition, according to CMS, “federal law also requires that states inform all families about EPSDT coverage.”¹⁸ The AAPD recommends that this requirement be followed to enable caregivers to seek necessary dental treatment for their children.

Policy statement

“Dental care is medically necessary to prevent and eliminate orofacial disease, infection, and pain, to restore the form and function of the dentition, and to correct facial disfigurement or dysfunction. MNC is based upon current preventive and therapeutic practice guidelines formulated by professional organizations with recognized clinical expertise. Expected benefits of MNC outweigh potential risks of treatment or no treatment. Early detection and management of oral conditions can improve a child’s oral health, general health and well-being, school readiness, and self-esteem. Early

recognition, prevention, and intervention could result in savings of health care dollars for individuals, community health care programs, and third party payors. Because a child's risk for developing dental disease can change over time, continual professional reevaluation and preventive maintenance are essential for good oral health. Value of services is an important consideration, and all stakeholders should recognize that cost-effective care is not necessarily the least expensive treatment."⁹

The AAPD:

- Encourages its members and all third party payors to support efforts to eliminate Medicaid abuse.
- Opposes any of its dentist members committing abuse and fraud as it relates to their relationship with third party payors.
- Recognizes the concern its members have regarding these external audits.
- Encourages its members to develop internal self-audit programs to address these challenges.
- Strongly believes that, while audits are a part of third party payment contracts and are necessary to protect the integrity of these programs, such audits must be completed by those who have credentials on par with the dental provider being audited.
- Adamantly opposes auditors receiving financial incentives for any money recuperated through audits.
- Opposes provider profiling and believes that dentist providers selected for audits should be chosen randomly or with compelling evidence that makes them an outlier as compared to their peers who practice in similar geographic areas, on similar populations of patients, and within the same specialty.
- Supports peer review in lieu of financial penalties when an audit shows that no intent to fraud was present, as a way to offer information and support to dentists who need to re-acquaint themselves on best practices regarding chart documentation, coding, and billing practices relating to third party payors.
- Supports the education of pediatric dentistry residents, pediatric dentists, and their staff to ensure a good understanding of appropriate coding and billing practices.
- Supports the creation of educational resources and programs that promote appropriate coding and billing practices.
- Opposes Medicaid programs that have policies in direct conflict with AAPD clinical practice guidelines and are of detriment to patient care.
- Endorses the enforcement of the "federal law that requires that states inform all families about EPSDT coverage"¹⁸ to enable caregivers to seek necessary dental treatment for their children.

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*Pertain only to Appendix 3

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