Policy on Model Dental Benefits for Infants, Children, Adolescents, and Individuals with Special Health Care Needs

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Purpose

The American Academy of Pediatric Dentistry (**AAPD**) believes that all infants, children, adolescents, and individuals with special health care needs must have access to comprehensive preventive and therapeutic oral health care benefits that contribute to their optimal health and well-being. This policy is intended to assist policy makers, third-party payors, and consumer groups/benefits purchasers to make informed decisions about the appropriateness of oral health care services for these patient populations.

Methods

This policy was developed by the Council on Dental Benefit Programs and Council on Clinical Affairs, adopted in 2008[1], and last revised in 2017[2]. This policy is based upon a review of the AAPD's oral health policies, best practices, and clinical practice guidelines as well as clinical practice guidelines that have been developed by other professional organizations and endorsed by the AAPD.

Background

The AAPD advocates optimal oral health and health care for all infants, children, adolescents, and individuals with special health care needs, regardless of race, ethnicity, religion, sexual or gender identity, medical status, disability, family structure, or financial circumstances.[3] Oral diseases are progressive and cumulative; ignoring oral health problems can lead to needless pain and suffering, infection, loss of function, increased health care costs, and lifelong consequences in educational, social, and occupational environments. A dental benefit plan should be actuarially sound and fiscally capable of delivering plan benefits without suppressing utilization rates or the delivery of services. When a benefits plan, whether for a commercial or government program, is not actuarially sound and adequately underwritten, access and appropriate care under the plan are placed at risk. When oral health care is not accessible, the health implications, effects on quality of life, and societal costs are enormous.[4] The AAPD's oral health policies, best practices, and clinical guidelines[5] encourage the highest possible level of care to children and patients with special health care needs. The AAPD also sponsors a national symposium each year on pediatric oral health care. Those sources as well as clinical practice guidelines from other organizations with recognized professional expertise and stature[6-13], serve as the basis for the recommendations below. Such recommendations ideally are evidence based but, in the absence of conclusive evidence, may rely on expert opinion and clinical observations.

Policy statement

The AAPD encourages all policy makers and third-party payors to consult the AAPD in the development of benefit plans that best serve the oral health interests of infants, children, adolescents, and individuals with special health care needs. These model services are predicated on establishment of a dental home, defined as the ongoing relationship between the dentist (ie, the primary oral health care provider) and the patient, inclusive of all aspects of oral health care, starting no later than 12 months of age.[14]

Value of services is an important consideration, and the AAPD encourages all stakeholders to recognize that a least expensive treatment is not necessarily the most beneficial or cost-effective plan in the long term for the patient's oral health.

The following services are essential components in health benefit plans.[5]

A. Preventive services including
   1. initial and periodic orofacial examination, including medical, dental, and social histories, furnished in accordance with the attached periodicity schedule or when oral screenings by other health care providers indicate a risk of caries or other dental or oral disease.
   2. education for the patient and the patient's family on measures that promote oral health as part of initial and periodic well-child assessment.

ABBREVIATION

AAPD: American Academy of Pediatric Dentistry.

3. age-appropriate anticipatory guidance and counseling on nonnutritive habits, injury prevention, intraoral/perioral piercing, human papilloma virus, and tobacco use/substance abuse.
4. application of topical fluoride at a frequency based upon caries risk factors.
5. prescription of a high-concentration fluoridated toothpaste for patients over 6 years old who are at moderate to high caries risk.
6. prescription of dietary fluoride supplement[13] based upon a child's age and caries risk as well as fluoride level of the water supply or supplies and other sources of dietary fluoride.
7. application of pit and fissure sealants on primary and permanent teeth based on caries risk factors, not patient age.[15]
8. dental prophylactic services at a frequency based on caries and periodontal risk factors.

B. Diagnostic procedures consistent with guidelines developed by organizations with recognized professional expertise and stature, including radiographs in accordance with recommendations by the American Academy of Oral and Maxillofacial Radiology, US Food and Drug Administration, and the American Dental Association.[8,9] When necessary and appropriate, teledentistry for orofacial evaluation may be used.

C. Restorative and endodontic services to relieve pain, resolve infection, restore teeth, and maintain dental function and oral health. This would include interim therapeutic restorations, a beneficial provisional technique in contemporary pediatric restorative dentistry.

D. Orthodontic services including space maintenance and services to diagnose, prevent, intercept, and treat malocclusions, including management of children with cleft lip/palate, congenital or developmental defects, and obstructive sleep apnea (OSA). These services include, but are not limited to, obturators, initial appliance construction, and replacement of appliances as the child grows.[17]

E. Dental and oral surgery including sedation/general anesthesia and related medical services performed in an office, hospital, or ambulatory surgical care setting.

F. Periodontal services to manage gingivitis, periodontitis, and other periodontal diseases or conditions in children.

G. Prosthodontic services, including implants with restorations to restore oral function as well as maxillofacial prosthetics/prosthodontics as recommended/supported by a craniofacial team.[17,18]

H. Diagnostic and therapeutic services related to the acute and long-term management of orofacial trauma. When the injury involves a primary tooth, benefits should cover complications for the developing succedaneous tooth. When the injury involves a permanent tooth, benefits should cover long-term complications to the involved and adjacent or opposing teeth including cosmetic/esthetic treatment that could impact social health.

I. Drug prescription for preventive services, relief of pain, or treatment of infection or other conditions within the dentist's scope of practice.

J. Medically-necessary services for preventive and therapeutic care in patients with medical, physical, or behavioral conditions. These services include, but are not limited to, the care of hospitalized patients, sedation, and general anesthesia in outpatient or inpatient hospital facilities.

K. Behavior guidance services necessary for the provision of optimal therapeutic and preventive oral care to patients with medical, physical, or behavioral conditions. These services may include both pharmacologic and nonpharmacologic management techniques.

L. Consultative services provided by a pediatric dentist when requested by a general practitioner or another dental specialist or medical care provider.

Recommended Dental Periodicity Schedule for Pediatric Oral Health Assessment, Preventive Services, and Anticipatory Guidance/Counseling

Since each child is unique, these recommendations are designed for the care of children who have no contributing medical conditions and are developing normally. These recommendations will need to be modified for children with special health care needs or if disease or trauma manifests variations from normal. The American Academy of Pediatric Dentistry emphasizes the importance of very early professional intervention and the continuity of care based on the individualized needs of the child. Refer to the text in *Periodicity of Examination, Preventive Dental Services, Anticipatory Guidance/Counseling, and Oral Treatment for Infants, Children, and Adolescents* (http://www.aapd.org/policies/) for supporting information and references.

AMERICA'S PEDIATRIC DENTISTS THE BIG AUTHORITY on little teeth®		AGE[19]				
		6 TO 12 MONTHS	12 TO 24 MONTHS	2 TO 6 YEARS	6 TO 12 YEARS	12 YEARS AND OLDER
Clinical oral examination	1	•	•	•	•	•
Assess oral growth and development	2	•	•	•	•	•
Caries-risk assessment	3	•	•	•	•	•
Radiographic assessment	4	•	•	•	•	•
Prophylaxis and topical fluoride	3,4	•	•	•	•	•
Fluoride supplementation	5	•	•	•	•	•
Anticipatory guidance/counseling	6	•	•	•	•	•
Oral hygiene counseling	3,7	Parent	Parent	Patient/parent	Patient/parent	Patient
Dietary counseling	3,8	•	•	•	•	•
Counseling for nonnutritive habits	9	•	•	•	•	•
Injury prevention and safety counseling	10	•	•	•	•	•
Assess speech/language development	11	•	•	•		
Assessment developing occlusion	12			•	•	•
Assessment for pit and fissure sealants	13			•	•	•
Periodontal-risk ssessment	3,14			•	•	•
Counseling for tobacco, vaping, and substance misuse					•	•
Counseling for human papilloma virus/ vaccine					•	•
Counseling for intraoral/perioral piercing					•	•
Assess third molars						•
Transition to adult dental care						•

1 First examination at the eruption of the first tooth and no later than 12 months. Repeat every 6 months or as indicated by child's risk status/susceptibility to disease. Includes assessment of pathology and injuries.

2 By clinical examination.

3 Must be repeated regularly and frequently to maximize effectiveness.

4 Timing, types, and frequency determined by child's history, clinical findings, and susceptibility to oral disease.

5 Consider when systemic fluoride exposure is suboptimal. Up to at least 16 years.

6 Appropriate discussion and counseling should be an integral part of each visit for care.

7 Initially, responsibility of parent; as child matures, jointly with parent; then, when indicated, only child.

8 At every appointment; initially discuss appropriate feeding practices, then the role of refined carbohydrates and frequency of snacking in caries development and childhood obesity. Monitor body mass index beginning at age 2.

9 At first, discuss the need for nonnutritive sucking: digits vs. pacifiers; then the need to wean from the habit before malocclusion or deleterious effect on the dentofacial complex occurs. For school-aged children and adolescent patients, counsel regarding any existing habits such as fingernail biting, clenching, or bruxism.

10 Initially pacifiers, car seats, play objects, electric cords; secondhand smoke; when learning to walk; with sports and routine playing; including the importance of mouthguards; then motor vehicles and high-speed activities.

11 Observation for age-appropriate speech articulation and fluency as well as achieving receptive and expressive language milestones.

12 Identify: transverse, vertical, and sagittal growth patterns; asymmetry; occlusal disharmonies; functional status including temporomandibular joint dysfunction; esthetic influences on self-image and emotional development.

13 For caries-susceptible primary molars, permanent molars, premolars, and anterior teeth with deep pits and fissures; placed as soon as possible after eruption.

14 Periodontal probing should be added to the risk-assessment process after the eruption of the first permanent molars.

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