Alabama Medicaid Agency

1st Look Program

Overview

• 1st Look Program goals
• Qualified Physicians
• Who qualifies for the program?
• Billing/Eligible Services
• Documentation Requirements
• Referrals
• Program Contacts

1st Look Program

• Developed by the agency in partnership with the state’s pediatric dentists and pediatricians.
• Scheduled to begin in January 2009

Program Goals

The 1st Look program is designed to:
• Improve awareness of early childhood caries.
• Increase early prevention education.
• Enlarge the dental provider referral base.
• Provide anticipatory guidance
• Apply fluoride varnishes
• Refer children to a dental home

Qualified Physicians

• Limited to Patient 1st PMPs and their professional staff
• Must complete and successfully pass the Medicaid approved training program to be reimbursed for these services.
• A score of 75% on the post test is required for successful completion.
• Physician has to be trained before other professional office staff members are eligible to be trained.
Who Qualifies?

- Children between the ages of 6 months and 36 months
- Children must have at least two high risk indicators using the AAPD Caries Risk Assessment Tool
- If a child has been seen by a dentist, the child does not qualify for the 1st Look program and the medical provider should not render services.

Who Qualifies?

- It is the responsibility of the provider to verify eligibility before service is rendered.
- It is recommended that provider review the benefits limits section of the eligibility verification of each patient to identify services already billed in order to avoid denial of payments.

Eligible Services/Billing

- 1st Look providers will be able to bill for initial oral assessment, once, under D0145 (oral exam < 3 years old, counseling)
- D0145 may be billed once by a medical provider and once by a dental provider for children age 6 months to 36 months.

Eligible Services

- Provider may also bill for the application of fluoride varnish for high caries risk children under D1206 (topical application).
- Varnish procedure will be limited to 3 per calendar year, regardless of provider, not to exceed a maximum of 6 applications between 6 months and 36 months of age. The allowed frequency will be no less than 90 days.

Documentation Requirements

Medical record must document:
- Content of anticipatory guidance
- Counseling given to parents/caregivers
- Results of Caries Assessment Tool
- Documentation that a referral has been made

Referrals

- Providers required to refer high risk patients (those with two or more indicators) to a Patient 1st Care Coordinator to assist in establishing a dental home.
- List of Care Coordinators can be found on Medicaid website www.medicaid.alabama.gov under “Contact Us”
Referrals

Once a child has been referred to a dental home:
- Information is to be kept on file with the medical provider.
- No further fluoride varnish application treatment by the medical provider will be permitted.

Program Contacts

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Child Health Professionals’ Role in Promoting Oral Health

- See children early and regularly.
- Become experts in oral health prevention strategies.
- Advocate for child health: Oral health is part of overall health!

AAP Recommendations for an Oral Health Risk Assessment

- Assess mother’s/caregiver’s oral health.
- Assess oral health risk of infants and children.
- Recognize signs and symptoms of caries.
- Assess child’s exposure to fluoride.
- Provide anticipatory guidance and oral hygiene instructions (brush/floss).
- Make timely referral to a dental home.

Learning Objectives

- Understand the role of the child health professional in assessing children’s oral health.
- Understand the pathogenesis of caries.
- Conduct an oral health risk assessment.
- Identify prevention strategies.
- Understand the need for establishing a dental home.
- Provide appropriate oral health education to families.
Course Outline

- Overview of Dental Caries and Early Childhood Caries
- Pathophysiology of Caries Process
- History: Determining Caries Risk
- Physical: Oral Health Assessment
- Anticipatory Guidance
- Treatment and Referral

Prevalence of Dental Caries

- 5 times more common than asthma
- 7 times more common than hay fever

Caries Rate

- 18% aged 2 to 4 years
- 52% aged 6 to 8 years
- 67% aged 12 to 17 years

Early Childhood Caries

- A severe, rapidly progressing form of tooth decay in infants and young children
- Affects teeth that erupt first, and are least protected by saliva

Early Childhood Caries Can Lead to...

- Extreme pain
- Spread of infection
- Difficulty chewing, poor weight gain
- Extensive and costly dental treatment
- Risk of dental decay in adult teeth
- Crooked bite (malocclusion)

Consequences of Dental Caries

- Missed school days
- Impaired speech development
- Inability to concentrate in school
- Reduced self-esteem
- Possible systemic illness for children with special health care needs

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Factors Necessary for Caries

Dental Caries: Etiology

TOOTH
- Age
- Fluorides
- Morphology
- Nutrition
- Trace Elements
- Carbonate Level

SUBSTRATE
- Oral Cleansing
- Oral Hygiene
- Salivary Stimulants
- Frequency of Eating
- Carbohydrate (type, concentration)

Strep mutans (Substrate)
Oral Hygiene
Fluoride in Plaque

Oral Flora

- Normal oral flora = billions of bacteria
- Site-specific and not colonized until the eruption of first tooth

Oral Flora: Pathogenesis of Caries

- An infectious process
- Initiated by pathogenic bacteria—Streptococcus mutans, Lactobacillus, and Streptococcus sobrinus

Oral Flora: How Does Infection Occur?

- Transmitted mainly from mother or primary caregiver to infant
- Window of infectivity is first 2 years of life
- Earlier child colonized, the higher the risk of caries
Fluoride’s Influence on Oral Flora

• Reduces enamel solubility
• Promotes remineralization of enamel, and may arrest or reverse early caries
• Inhibits the growth of cariogenic organisms, thus decreasing acid production
• Concentrated in dental plaque
• Primarily topical even when given systemically

Factors Necessary for Caries

• Strept mutans (Substrate)
• Oral Hygiene
• Fluoride in Plaque

Substrate: You Are What You Eat

• Promoted by carbohydrates, which break down to acid.
• Acid causes demineralization of enamel.

Substrate: Environmental Influences

• Saliva inhibits bacterial growth.
• Frequent snacking promotes growth of cariogenic bacteria.
• Unremoved plaque promotes the caries process.

Not Just What You Eat, But How Often

• Acids produced by bacteria after sugar intake persist for 20 to 40 minutes.
• Frequency of sugar ingestion is more important than quantity.

Breastfeeding

• The AAP and AAPD strongly endorse breastfeeding.
• Although breastmilk alone is not cariogenic, it may be when combined with other carbohydrate sources.
• For frequent nighttime feedings with anything but water after tooth eruption, consider an early dental home referral.
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High-Risk Groups for Caries

- Children with special health care needs
- Children from low socioeconomic and ethnocultural groups
- Children with suboptimal exposure to topical or systemic fluoride
- Children with poor dietary and feeding habits
- Children whose caregivers and/or siblings have caries
- Children with visible caries, white spots, plaque, or decay

Children With Special Health Care Needs (CSHCN)

Recommendations for Child Health Professionals

- Be aware of oral health problems/ complications associated with medical conditions.
- Monitor impact of oral medications and therapies.
- Choose non–sugar-containing medications if given repeatedly or for chronic conditions.
- Refer early for dental care (before or by age 1 year).
- Emphasize preventive measures.

Common Issues Among Children With Special Health Care Needs

- Children with asthma and allergies are often on medications that dry salivary secretions increasing risk of caries.
- Children who are preterm or low birth weight have a much higher rate of enamel defects and are at increased risk of caries.
- Children with congenital heart disease are at risk for systemic infection from untreated oral disease.

Socioeconomic Factors

- The rate of early childhood dental caries is near epidemic proportions in populations with low socioeconomic status.
  - No health insurance and/or dental insurance
  - Parental education level less than high school or GED
  - Families lacking usual source of dental care
  - Families living in rural areas

Ethnocultural Factors

- Increased rate of dental caries in certain ethnic groups
- Diet/feeding practices and child-rearing techniques influenced by culture
Fluoride Exposure

- Determine fluoride exposure: systemic versus topical
- Fluoridated water
  - 58% of total population
  - Optimal level is 0.7 to 1.2 ppm
  - Significant state variability
  - CDC fluoridation map

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Maternal/Primary Caregiver Screening

- Assess mother’s/caregiver’s oral history.
- Document involved quadrants.
- Refer to dental home if untreated oral health disease.

Child Oral Health Assessment

Prepare for the Examination

- Provide rationale.
- Describe caregiver role.
- Ensure adequate lighting.
- Assemble necessary equipment.

Positioning Child for Oral Examination

- Position the child in the caregiver’s lap facing the caregiver.
- Sit with knees touching the knees of caregiver.
- Lower the child’s head onto your lap.
- Lift the lip to inspect the teeth and soft tissue.

Primary Teeth Eruption

- Primary Dentition
  - Upper Teeth
    - Central incisor: 6-12 months (6-7 years)
    - Lateral incisor: 9-13 months (7-8 years)
    - Canine (upper): 16-22 months (10-12 years)
    - First molar: 15-19 months (6-11 years)
    - Second molar: 25-33 months (10-12 years)
  - Lower Teeth
    - Central incisor: 6-10 months (6-7 years)
    - Lateral incisor: 10-16 months (7-8 years)
    - Second molar: 14-18 months (9-11 years)
    - First molar: 17-23 months (9-12 years)
    - Canine (lower): 20-26 months (9-12 years)
What to Look For

• Lift the lip to inspect soft tissue and teeth.

• Assess for
  - Presence of plaque
  - Presence of white spots or dental decay
  - Presence of tooth defects (enamel)
  - Presence of dental crowding

• Provide education on brushing and diet during examination.

Check for Normal Healthy Teeth

Check for Early Signs of Decay: White Spots

Check for Later Signs of Decay: Brown Spots

Check for Advanced/Severe Decay

AAPD Caries Risk Assessment Tool (CAT)

General Health Conditions

- Children with special health care needs
- Conditions impairing saliva composition/flow

Environmental Characteristics

- Optimal systemic and topical fluoride exposure
- Consumption of simple sugars or foods strongly associated with caries initiation primarily at mealtimes
- High caregiver socioeconomic status
- Regular use of dental care in an established dental home

- Suboptimal systemic fluoride exposure with optimal topical exposure
- Occasional (ie, 1-2) between-meal exposures to simple sugars or foods strongly associated with caries
- Mid-level caregiver socioeconomic status (ie eligible for school lunch program or SCHIP)
- Irregular use of dental services

- Suboptimal topical fluoride exposure
- Frequent (ie, 3 or more) between-meal exposures to simple sugars or foods strongly associated with caries
- Low-level caregiver socioeconomic status (ie, eligible for Medicaid)
- No usual source of dental care
- Active caries present in the mother

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Anticipatory Guidance

- Minimize risk of infection.
- Optimize oral hygiene.
- Reduce dietary sugars.
- Remove existing dental decay.
- Administer fluorides judiciously.

Minimize Risk for Infection

- Address active oral health disease in mother/caregiver.
- Educate about the mechanism of cariogenic bacteria transmission.
- Model positive oral hygiene behaviors.
- Provide xylitol gum in certain cases.

Xylitol for Mothers

Xylitol gum or mints used 4 times a day may prevent transmission of cariogenic bacteria to infants.

- Helps reduce the development of dental caries
- A ‘sugar’ that bacteria can’t use easily
- Resists fermentation by mouth bacteria
- Reduces plaque formation
- Increases salivary formation to aid in the repair of damaged tooth enamel

Substrate: Contributing Dietary and Feeding Habits

- Frequent consumption of carbohydrates, especially sippy cups/bottles with fruit juice, soft drinks, powdered sweetened drinks, formula, or milk
- Sticky foods like raisins/fruit leather (roll-ups), and hard candies

Toothbrushing Recommendations

<table>
<thead>
<tr>
<th>Age</th>
<th>Toothbrushing Recommendations</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt; 1 year</td>
<td>Clean teeth with soft toothbrush</td>
</tr>
<tr>
<td>1-2 years</td>
<td>Parent performs brushing</td>
</tr>
<tr>
<td>2-6 years</td>
<td>Pea-sized amount of fluoride-containing toothpaste 2x/day</td>
</tr>
<tr>
<td>&gt; 6 years</td>
<td>Parent performs or supervises</td>
</tr>
<tr>
<td></td>
<td>Brush with fluoridated toothpaste 2x/day</td>
</tr>
</tbody>
</table>
Toothpaste and Children

- Children ingest substantial amounts of toothpaste because of immature swallowing reflex.
- Early use of fluoride toothpaste may be associated with increased risk of fluorosis.
- Once permanent teeth have mineralized (around 6-8 years of age), dental fluorosis is no longer a concern.

Toothpaste

A small pea-sized amount of toothpaste weighs 0.4 mg to 0.6 mg fluoride, which is equal to the daily recommended intake for children younger than 2 years.

Optimizing Oral Hygiene: Flossing

When to Use Floss

- Once a day (preferably at night)
- When 2 teeth touch

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Recommended Fluoride Supplement Schedule

<table>
<thead>
<tr>
<th>Age</th>
<th>Fluoride Concentration in Community Drinking Water</th>
</tr>
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<tbody>
<tr>
<td></td>
<td>&lt;0.3 ppm</td>
</tr>
<tr>
<td>0-6 mo</td>
<td>None</td>
</tr>
<tr>
<td>6 mo-3 yrs</td>
<td>0.25 mg/day</td>
</tr>
<tr>
<td>3 yrs-6 yrs</td>
<td>0.25 mg/day</td>
</tr>
<tr>
<td>6 yrs-16 yrs</td>
<td>1.0 mg/day</td>
</tr>
</tbody>
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MMWR: Recommendations for Using Fluoride to Prevent and Control Dental Caries in the US: http://www.cdc.gov/mmwr/preview/mmwrhtml/rr5014a1.htm

Example of Fluorosis
Fluoride Varnish

- 5% sodium fluoride or 2.26% fluoride in a viscous resinous base in an alcoholic suspension with flavoring agent (eg, bubble gum)
- Has not been associated with fluorosis
- Application does not replace the dental home nor is it equivalent to comprehensive dental care

Applying Fluoride Varnish

Remove Existing Dental Decay: Treating an Infection

Establishment of Dental Home

What is a dental home?
When to refer?
- Refer high-risk children by 6 months.
- Refer all children by 1 year.

Referral:

Community Systems of Care

- Identify dental care professionals in your community.
- Develop partnerships.

You Can Make a Difference!

- Institute oral health risk assessments into well-child visits.
- Provide patient education regarding oral health.
- Provide appropriate prevention interventions (eg, feeding practices, hygiene).
- Document findings and follow-up.
- Train office staff in oral health assessment.
- Identify dentists (pediatric/general) in your area who accept new patients/Medicaid patients.
- Take a dentist to lunch to establish a referral relationship.
- Investigate fluoride content in area water supply.