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 providedparticularly 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.

Table D.1
North Carolina Division of Medical Assistance Oral Health Periodicity Schedule

	AGE				
Recommendation	**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 3rd 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 schoolaged 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.

Recommendations for Preventive Pediatric Health Care

Bright Futures/American Academy of Pediatrics

Each child and family is unique; therefore, these **Recommendations for Preventive Pediatric Health Care** are designed for the care of children who are receiving competent parenting, have no manifestations of any important health problems, and are growing and developing in satisfactory fashion. **Additional visits may become necessary** if circumstances suggest variations from normal.

Developmental, psychosocial, and chronic disease issues for children and adolescents may require frequent counseling and treatment visits separate from preventive care visits.

These guidelines represent a consensus by the American Academy of Pediatrics (AAP) and Bright Futures. The AAP continues to emphasize the great importance of **continuity of care** in comprehensive health supervision and the need to avoid **fragmentation of care.**

The recommendations in this statement do not indicate an exclusive course of treatment or standard of medical care. Variations, taking into account individual circumstances, may be appropriate.

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	INFANCY								EARLY CHILDHOOD						
AGE[1]	PRENATAL[2]	NEWBORN[3]	3–5 d[4]	By 1 mo	2 mo	4 mo	6 mo	9 mo	12 m	15 mo	18 mo	24 mo	30 mo	3 y	4 y
HISTORY															
Initial/Interval	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
MEASUREMENTS															
Length/Height and Weight		●	●	●	●	●	●	●	●	●	●	●	●	●	●
Head Circumference		●	●	●	●	●	●	●	●	●	●	●			
Weight for Length		●	●	●	●	●	●	●	●	●	●				
Body Mass Index												●	●	●	●
Blood Pressure[5]		★	★	★	★	★	★	★	★	★	★	★	★	●	●
SENSORY SCREENING															
Vision		★	★	★	★	★	★	★	★	★	★	★	★	●[6]	●
Hearing		●[7]	★	★	★	★	★	★	★	★	★	★	★	★	●
DEVELOPMENTAL/BEHAVIORAL ASSESSMENT															
Developmental Screening[8]								●			●		●		
Autism Screening[9]											●	●			
Developmental Surveillance[8]		●	●	●	●	●	●		●	●		●		●	●
Psychosocial/Behavioral Assessment		●	●	●	●	●	●	●	●	●	●	●	●	●	●
Alcohol and Drug Use Assessment															
PHYSICAL EXAMINATION[10]		●	●	●	●	●	●	●	●	●	●	●	●	●	●
PROCEDURES[11]															
Newborn Metabolic/Hemoglobin Screening[12]		←——	●	——	——→										
Immunization[13]		●	●	●	●	●	●	●	●	●	●	●	●	●	●
Hematocrit or Hemoglobin[14]						★			●		★	★		★	★
Lead Screening[15]							★	★	● or ★[16]		★	● or ★[16]		★	★
Tuberculin Test[17]				★			★		★		★	★		★	★
Dyslipidemia Screening[18]												★			★
STI Screening[19]															
Cervical Dysplasia Screening[20]															
ORAL HEALTH[21]							★	★	● or ★[21]		● or ★[21]	● or ★[21]	● or ★[21]	●[22]	
ANTICIPATORY GUIDANCE[23]	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●

	MIDDLE CHILDHOOD						ADOLESCENCE										
AGE[1]	5 y	6 y	7 y	8 y	9 y	10 y	11 y	12 y	13 y	14 y	15 y	16 y	17 y	18 y	19 y	20 y	21 y
HISTORY																	
Initial/Interval	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
MEASUREMENTS																	
Length/Height and Weight	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
Head Circumference																	
Weight for Length																	
Body Mass Index	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
Blood Pressure[5]	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
SENSORY SCREENING																	
Vision	●	●	★	●	★	●	★	●	★	★	●	★	★	●	★	★	★
Hearing	●	●	★	●	★	●	★	★	★	★	★	★	★	★	★	★	★
DEVELOPMENTAL/BEHAVIORAL ASSESSMENT																	
Developmental Screening[8]																	
Autism Screening[9]																	
Developmental Surveillance[8]	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
Psychosocial/Behavioral Assessment	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
Alcohol and Drug Use Assessment							★	★	★	★	★	★	★	★	★	★	★
PHYSICAL EXAMINATION[10]	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
PROCEDURES[11]																	
Newborn Metabolic/Hemoglobin Screening[12]																	
Immunization[13]	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
Hematocrit or Hemoglobin[14]	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★
Lead Screening[15]	★	★															
Tuberculin Test[17]	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★
Dyslipidemia Screening[18]		★		★		★	★	★	★	★	★	★	★	←——	——	●	——→
STI Screening[19]							★	★	★	★	★	★	★	★	★	★	★
Cervical Dysplasia Screening[20]							★	★	★	★	★	★	★	★	★	★	★
ORAL HEALTH[21]		●[22]															
ANTICIPATORY GUIDANCE[23]	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●

1. If a child comes under care for the first time at any point on the schedule, or if any items are not accomplished at the suggested age, the schedule should be brought up to date at the earliest possible time.
2. A prenatal visit is recommended for parents who are at high risk, for first-time parents, and for those who request a conference. The prenatal visit should include anticipatory guidance, pertinent medical history, and a discussion of benefits of breastfeeding and planned method of feeding per AAP statement "The Prenatal Visit" (2001) [URL: http://aappolicy.aappublications.org/cgi/content/full/pediatrics;107/6/1456].
3. Every infant should have a newborn evaluation after birth, breastfeeding encouraged, and instruction and support offered.
4. Every infant should have an evaluation within 3 to 5 days of birth and within 48 to 72 hours after discharge from the hospital, to include evaluation for feeding and jaundice. Breastfeeding infants should receive formal breastfeeding evaluation, encouragement, and instruction as recommended in AAP statement "Breastfeeding and the Use of Human Milk" (2005) [URL: http://aappolicy.aappublications.org/cgi/content/full/pediatrics;115/2/496]. For newborns discharged in less than 48 hours after delivery, the infant must be examined within 48 hours of discharge per AAP statement "Hospital Stay for Healthy Term Newborns" (2004) [URL: http://aappolicy.aappublications.org/cgi/content/full/pediatrics;113/5/1434].
5. Blood pressure measurement in infants and children with specific risk conditions should be performed at visits before age 3 years.
6. If the patient is uncooperative, rescreen within 6 months per the AAP statement "Eye Examination in Infants, Children, and Young Adults by Pediatricians" (2007) [URL: http://aappolicy.aappublications.org/cgi/content/full/pediatrics;111/4/902].
7. All newborns should be screened per AAP statement "Year 2000 Position Statement: Principles and Guidelines for Early Hearing Detection and Intervention Programs " (2000) [URL: http://aappolicy.aappublications.org/cgi/content/full/pediatrics;106/4/798]. Joint Committee on Infant Hearing. Year 2007 position statement: principles and guidelines for early hearing detection and intervention programs. *Pediatrics.* 2007;120:898–921.
8. AAP Council on Children With Disabilities, AAP Section on Developmental Behavioral Pediatrics, AAP Bright Futures Steering Committee, AAP Medical Home Initiatives for Children With Special Needs Project Advisory Committee. Identifying infants and young children with developmental disorders in the medical home: an algorithm for developmental surveillance and screening. *Pediatrics.* 2006;118:405–420 [URL: http://aappolicy.aappublications.org/cgi/content/full/pediatrics;118/1/405].
9. Gupta VB, Hyman SL, Johnson CP, et al. Identifying children with autism early? *Pediatrics.* 2007;119:152–153 [URL: http://pediatrics.aappublications.org/cgi/content/full/119/1/152].
10. At each visit, age-appropriate physical examination is essential, with infant totally unclothed, older child undressed and suitably draped.
11. These may be modified, depending on entry point into schedule and individual need.
12. Newborn metabolic and hemoglobinopathy screening should be done according to state law. Results should be reviewed at visits and appropriate retesting or referral done as needed.
13. Schedules per the Committee on Infectious Diseases, published annually in the January issue of *Pediatrics.* Every visit should be an opportunity to update and complete a child's immunizations.
14. See AAP *Pediatric Nutrition Handbook,* 5th Edition (2003) for a discussion of universal and selective screening options. See also Recommendations to prevent and control iron deficiency in the United States. *MMWR.* 1998;47(RR-3):1–36.
15. For children at risk of lead exposure, consult the AAP statement "Lead Exposure in Children: Prevention, Detection, and Management" (2005) [URL: http://aappolicy.aappublications.org/cgi/content/full/pediatrics;116/4/1036]. Additionally, screening should be done in accordance with state law where applicable.
16. Perform risk assessments or screens as appropriate, based on universal screening requirements for patients with Medicaid or high prevalence areas.
17. Tuberculosis testing per recommendations of the Committee on Infectious Diseases, published in the current edition of *Red Book: Report of the Committee on Infectious Diseases.* Testing should be done on recognition of high-risk factors.
18. "Third Report of the National Cholesterol Education Program (NCEP) Expert Panel on Detection, Evaluation, and Treatment of High Blood Cholesterol in Adults (Adult Treatment Panel III) Final Report" (2002) [URL: http://circ.ahajournals.org/cgi/content/full/106/25/3143] and "The Expert Committee Recommendations on the Assessment, Prevention, and Treatment of Child and Adolescent Overweight and Obesity." Supplement to *Pediatrics.* In press.
19. All sexually active patients should be screened for sexually transmitted infections (STIs).
20. All sexually active girls should have screening for cervical dysplasia as part of a pelvic examination beginning within 3 years of onset of sexual activity or age 21 (whichever comes first).
21. Referral to dental home, if available. Otherwise, administer oral health risk assessment. If the primary water source is deficient in fluoride, consider oral fluoride supplementation.
22. At the visits for 3 years and 6 years of age, it should be determined whether the patient has a dental home. If the patient does not have a dental home, a referral should be made to one. If the primary water source is deficient in fluoride, consider oral fluoride supplementation.
23. Refer to the specific guidance by age as listed in Bright Futures Guidelines. (Hagan JF, Shaw JS, Duncan PM, eds. *Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents.* 3rd ed. Elk Grove Village, IL: American Academy of Pediatrics; 2008.)

KEY

● = to be performed ★ = risk assessment to be performed, with appropriate action to follow, if positive ←●→ = range during which a service may be provided, with the symbol indicating the preferred age