Take a 1st Look
A Healthy Smile = A Healthy Child

American Academy of Pediatrics
DEDICATED TO THE HEALTH OF ALL CHILDREN™
Alabama Chapter

Updated June 2018

Faculty

Richard Simpson, DMD
Fellow, American Academy of Pediatric Dentistry
Diplomate, American Board of Pediatric Dentistry
Immediate Past President
Alabama Academy of Pediatric Dentistry
Oral Health Committee Co-Chair
Alabama Chapter – AAP
North River Pediatric Dentistry
Tuscaloosa, Alabama

Faculty

Grant R. Allen, MD, FAAP
Alabama Chapter-
American Academy of Pediatrics
Oral Health Advocate

Faculty Disclosure

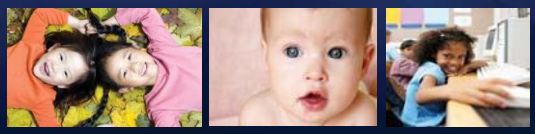
Please note that the speakers, Richard Simpson, DMD, and Grant R. Allen, MD, FAAP:

A. DO intend to discuss commercial products or services (fluoride varnish).

B. DO intend to discuss non-FDA approved uses of products/providers of services (fluoride varnish).

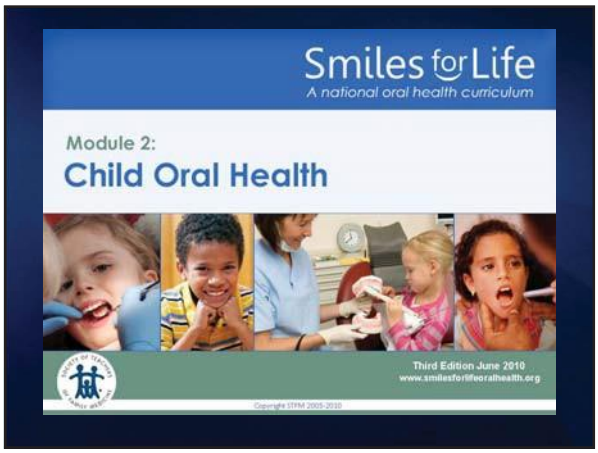
C. Do NOT have any relevant financial relationships or affiliations related to this topic.

Dental Fluoride Varnishing
and Oral Assessment Program
for Pediatricians



Module 2: Child Oral Health

- Course Steering Committee Editors
  - James Tysinger, Ph.D
  - Russell Maier, M.D.
- Dental Consultant
  - Joanna M. Douglass, B.D.S., D.D.S.
- Smiles for Life Editor
  - Alan B. Douglass, M.D.
- Funded by: DentaQuest Foundation



Oral Health Risk Assessment Training for Pediatricians and Other Child Health Professionals

- Developed by American Academy of Pediatrics Pediatrics Collaborative Care (PedCare) Program
- Supported by the Maternal and Child Health Bureau, Health Resources and Services Administration Department of Health and Human Services U93MC00184

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

AAP Recommendations for an Oral Health Risk Assessment

- Provide anticipatory guidance and oral hygiene instructions
  - Brush / floss
- Make timely referral to a dental home

Educational Objectives

- Discuss the prevalence, etiology, and consequences of Early Childhood Caries (ECC)
- Recognize the various stages of ECC on oral examination
- Assess a child's risk of developing ECC

Educational Objectives

- Implement prevention of ECC through use of fluoride, proper hygiene, diet, and appropriate dental referral
- Manage other oral conditions in pregnancy
- Understand the safety of common dental interventions in pregnancy
- Discuss common dental developmental issues in children and offer appropriate guidance to parents

Early Childhood Caries

- Chapter Objectives
  - Discuss the prevalence, etiology, and consequences of early childhood caries
  - Recognize the various stages of ECC during an oral examination

What is ECC?

- Etiology
  - Infectious, chronic disease that destroys tooth structure leading to loss of chewing function, pain, and infection
  - A variety of feeding habits beyond just nursing or bottle use are implicated
  - Affects 35% of 3 year olds from low income families

What is ECC?

- Progression
  - Upper front teeth that are least protected by saliva are affected first
  - Disease moves posteriorly as teeth erupt


Prevalence

- ECC is the most common chronic disease in children and is five times more common than asthma
- 30 - 50 % of low income children have ECC
- ECC prevalence in children 2 to 5 years old increased from 24% in 1988 – 1994 to 28% in 1999 – 2004

Prevalence

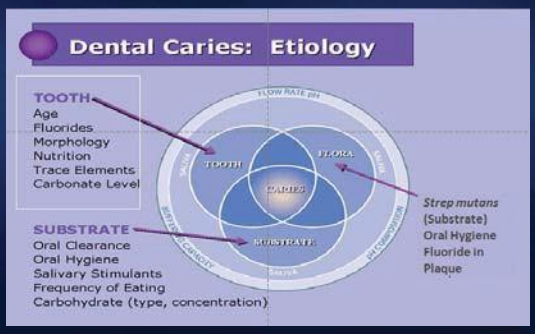
- 80 % of decay occurs in 20% of children
- Up to 70% of Native American children may have ECC



Children with Caries as Infants and Toddlers

- 80% of teeth go untreated if living in poverty
- Will continue to develop new caries at an annual rate at least twice that of preschoolers without caries
- Caries likely larger, more rapidly progressing, with higher potential for pain or other complications

Factors Necessary for Caries



Etiology: Bacteria

- Etiology
  - Mutans streptococci is vertically transmitted from the primary caregiver, typically the mother
  - Transfer is thought to occur via saliva contact
  - The higher the bacteria level in the caregiver's mouth, the more likely the child with become colonized

Etiology: Bacteria

- Caregivers can decrease the risk of passing bacteria to children by:
  - Receiving regular comprehensive dental care
  - Limiting the frequency of sugar in the diet
  - Maintaining excellent oral hygiene and using a fluoride containing toothpaste

Etiology: Bacteria

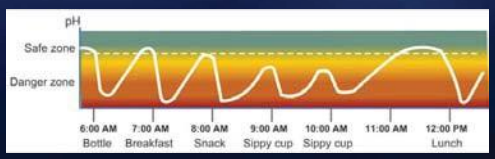
- Using preventive agents such as topical fluorides, antibacterial mouth rinses, and xylitol containing gums in appropriate age groups

Etiology: Sugars

- It is not just WHAT, but HOW children eat
  - Oral bacteria produce acids that persist for 20 – 40 minutes after sugar ingestion
  - Oral acids lead to enamel demineralization

Etiology: Sugars

- Remineralization occurs when acid is buffered by saliva
- If sugars are consumed frequently, there is insufficient time for remineralization to occur



Breastfeeding

- The AAP and AAPD strongly endorse breastfeeding
- Although breast milk alone is not cariogenic, it may be when combined with other carbohydrate sources
- For frequent night time feedings with anything but water after tooth eruption, consider an early dental home referral

Etiology: Teeth

- Nature of enamel defects
  - 20 to 40% of children have enamel defects
  - Defects may appear as changes in translucency, color, or texture
  - May be difficult to distinguish enamel defects from early clinical signs of caries (right photo)

Etiology: Teeth

- Diagnosis is immaterial as it does not affect management
- Enamel defects are associated with substantially increased risk of ECC

Healthy Teeth

- Nature of healthy teeth
  - Creamy white with no signs of deviation in color, roughness, or other irregularities
  - If the clinician cannot determine whether an abnormality in the tooth surface is a defect versus an early cavity, it does not matter

Healthy Teeth

- Any child with enamel abnormalities is at high risk for caries and should be referred to a dentist for further evaluation

White Spots

- Appearance and Symptoms
  - White spots and lines are the first clinical signs of demineralized enamel
  - Typically begins at the gingival margin
  - If the disease process is not managed, lesions will progress to cavities that are initially yellow

White Spots

- Treatment
  - Immediate dental referral
  - Dietary and oral hygiene counseling
  - Topical fluoride to reverse or arrest lesions

Brown Cavitations

- Appearance and Symptoms
  - Brown cavitations represent areas where loss of enamel has exposed underlying dentin
  - Lesions darken as they become stained with pigments from food
- Treatment
  - Immediate dental referral

Brown Cavitations

- Lesions are small enough that simplified restorative techniques that do not use high speed drills and local anesthesia can be used
- Dietary and oral hygiene counseling
- Topical fluoride to arrest lesions not requiring restorations

Early Aggressive ECC

- Appearance and Symptoms
  - Abscesses and fistulae may be present
  - Patient may experience pain, but children may be too young to accurately verbalize it

Early Aggressive ECC

- Treatment
  - Urgent dental referral for comprehensive treatment including extractions and / or silver crowns
  - Dietary and oral hygiene counseling
  - Topical fluoride to prevent development of new lesions

Advanced ECC

- Appearance and Symptoms
  - Multiple dark cavities appear in anterior and posterior teeth
  - Possible for abscesses and draining fistulae to be present
  - Patients may experience pain


Advanced ECC

- Treatment
  - Urgent dental referral for comprehensive treatment including extractions and / or silver crowns
  - Dietary and oral hygiene counseling
  - Use of fluoride to prevent development of new lesions

Caries Progression

- ECC affects the teeth that erupt early and are least protected by saliva
- Order of Progression
  - Upper incisors
    - Maxillary anterior teeth
  - First molars
    - Mandibular primary molars

Caries Progression

- Second molars
  - Maxillary primary molars



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

Why is it Important?

- 80% of ECC occurs in 20% of children
- Oral health risk assessment should begin around 4 to 6 months, just before the first tooth erupts
- A child's risk status determines
  - Age of first dental visit
  - Use of fluoride
  - Depth of nutritional and hygiene counseling provided

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

High-Risk Groups for Caries

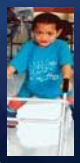
- Children whose caregivers and/or siblings have caries
- Children with visible caries, white spots, plaque, or decay

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

Children With Special Health Care Needs (CSHCN)

- 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

Common Issues Among Children With Special Health Care Needs

- 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

Socioeconomic Factors

- 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

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 the caregiver
- Lower the child's head onto your lap
- Lift the lip to inspect teeth and the soft tissue

Positioning Child for Oral Examination

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

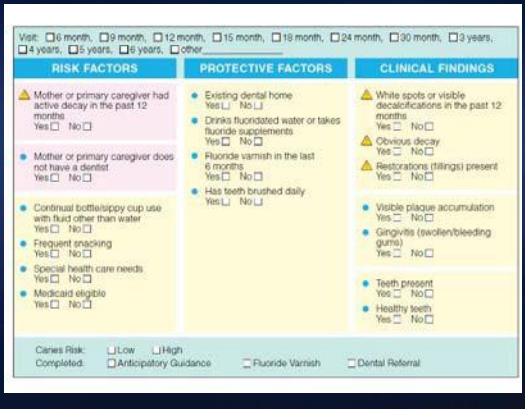
What To Look For

- Provide education on brushing and diet during examination

AAPD Caries Risk Assessment Tool (CAT)

Caries Risk Indicators		Low Risk	Moderate Risk	High Risk
	Clinical Conditions	•No carious teeth in past 24 months •No enamel demineralization (enamel caries "white spot lesions) •No visible plaque; no gingivitis	•Carious teeth in the past 24 months •1 area of enamel demineralization (enamel caries "white spot lesions) •Gingivitis	•Carious teeth in the past 12 months •More than 1 area of enamel demineralization (enamel caries "white –spot lesions" •Visible plaque on anterior (front) teeth •Radiographic enamel caries •High titers of mutans streptococci •Wearing dental or orthodontic appliances •Enamel hypoplasia
	Environmental Characteristics	•Optimal systemic and topical fluoride exposure •Consumption of simple sugars or foods strongly associated with caries initiation primarily atmealtimes •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
	General Health **Conditions**			•Children with special health care needs •Conditions impairing saliva composition/flow

Complete AAPD Policy Statement with CAT available at: http://www.aapd.org/pdf/policycariesriskassessmenttool.pdf



ECC Prevention

- Chapter Objective
  - Implement prevention of ECC through use of fluoride, proper hygiene, diet, and appropriate dental referral

Why Medical Clinicians?

- Medical clinicians are well positioned to promote oral health:
  - 89% of children have access to a usual source of primary medical care
  - Primary care clinicians have regular, consistent contact through well – child visits
  - 74% of poor children 19 – 35 months of age receive all their vaccines

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 four times a day may prevent transmissions of cariogenic bacteria to infants
  - Helps reduce the development of dental caries
  - A "sugar" that bacteria can not use easily

Xylitol for Mothers

- Resists fermentation by mouth bacteria
- Reduces plaque formation
- Increases salivary flow to aid in the repair of damaged tooth enamel

Effects and Sources of Fluoride

- Topical Mechanisms (main effect)
  - Inhibiting tooth demineralization
  - Enhancing remineralization
  - Inhibiting bacterial metabolism
- Systemic Mechanisms
  - Reducing enamel solubility through incorporation into its structure during tooth development

Effects and Sources of Fluoride

- Fluoride Sources
  - Topical: fluoride toothpastes, water fluoridation, fluoride varnish, gels, foams, mouthwashes (after age 6-8)
  - Dietary: water fluoridation, swallowed fluoride toothpaste (less than age 3), dietary fluoride supplements

Systemic Fluoride

- Guidelines
  - All children at high – caries risk should receive fluoride through systemic water fluoridation or dietary supplements
  - Children who drink optimally fluoridated water should NOT receive supplements
  - Optimal water fluoridation is 0.7 ppm

Systemic Fluoride

- Determine patient's water source and fluoride content
  - Public water supply
    - Local health department or water company can provide fluoridation levels
  - Bottled water (often contains fluoride)
  - Well water (variable fluoride levels, requires testing)

Fluoride Supplementation

- Guidelines
  - If fluoride content of water cannot be determined, do no prescribe
  - In optimally fluoridated communities where children drink bottled water, supplements should not be prescribed due to halo effect

Fluoride Supplementation

- Supplements are not recommended for infants until age six months
- All prescriptions for fluoride should specify a sugar - free prescription

Child's Age	Water Fluoride Concentration		
	< 0.3 ppm	0.3 – 0.6 ppm	> 0.6 ppm
6 mos – 3 yrs	0.25 mg	None	None
3 yrs – 6 yrs	0.50 mg	0.25 mg	None
> 6 years	1.00 mg	0.50 mg	None

Dosages are in milligrams F/day

Fluorosis

- Appearance and Significance
  - White mottling of teeth due to chronic excessive exposure to fluoride during tooth development
  - Cosmetic issue that does not affect systemic health

Fluorosis

- Risk Reduction
  - Determine fluoride content of drinking water before prescribing current dosage schedules
  - Avoid duplicating fluoride prescriptions
  - Use only a smear (< 2 years) or pea sized dab (> 2 years) of toothpaste
  - Fluoride varnish is not a risk factor for fluorosis

Hygiene: Tooth Brushing

- Guidelines
  - Brush teeth twice daily beginning as soon as teeth erupt
    - Bedtime is most critical due to increased salivary flow at night
  - Caregiver should brush child's teeth until age 6
    - Young children have difficulty brushing all areas

Hygiene: Tooth Brushing

- Caregiver should stand or sit behind child
- Lift lip and brush join between gum and teeth
- Child should spit out, not rinse, after brushing to increase topical fluoride exposure


How Much Toothpaste?

- Guidelines
  - Most preschool children swallow much of the toothpaste placed on the brush
  - These guidelines take this into account and these amounts are safe to swallow, but spitting out should always be encouraged

How Much Toothpaste?

- Parents should keep toothpaste tubes out of reach of small children

Less than 2 years: small smear

2 years and over: pea sized

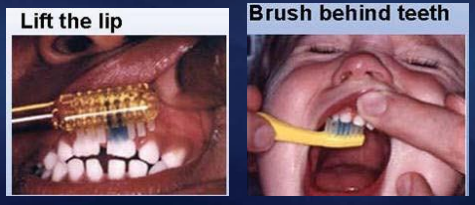
Brushing Techniques

- Guidelines
  - Caregiver should stand or sit behind the child
  - Lift lip to allow proper visualization
  - Brush the join between the gum and tooth, both on the outside (buccal) and inside (lingual) of tooth

Brushing Techniques

- Brush the top or chewing surface (occlusal)
- Use small backwards and forwards brushing movements or small circles
- Spit out toothpaste and do not rinse after brushing
- No food or drink after brushing

Brushing Techniques



Cariogenicity of Foods

Avoid High Risk Eating Patterns

- Follow these tips to lower caries risk
  - Avoid frequent snacking between meals, especially foods high in simple sugars
  - Avoid juices and other drinks between meals
    - Encourage water and white milk

Avoid High Risk Eating Patterns

- Refrain from eating sticky, retentive snacks
- Do not eat or drink before bed after tooth brushing
- Water only at night

Diet Advice: 0-12 Months

- Recommendations
  - Strongly encourage breast feeding
  - Hold infant for bottle feeding
  - Avoid giving bottles at bedtime or naptime
  - Do not use sweetened pacifiers
  - Introduce cup at 6 months

Diet Advice: 0-12 Months

- Wean bottle by 12 months
- Avoid ad lib use of sippy cup unless it contains water
- Snacks should contain no added sugar

Diet Advice: 1 - 5 Years

- Recommendations
  - Discontinue bottle by 12 months
  - Limit juice to 4 oz. and serve with meals only
  - Avoid carbonated beverages and juice drinks containing sweeteners
  - Choose fresh fruits, vegetables, or sugar free whole grain snacks

Diet Advice: 1 - 5 Years

- Only drink milk or water between meals
- Limit eating occasions to 3 meals a day with 1 snack in between
- Reserve soda, candy, and sweets for special occasions with meals

Establish a Dental Home

- The American Academy of Pediatric Dentistry and the American Academy of Pediatrics both recommend establishment of a dental home by the first birthday
- Dentist will provide
  - Enhanced preventative services
  - Comprehensive evaluation and diagnosis of oral disease

Establish a Dental Home

- Evaluation of growth and development
- Counseling on oral habits and interceptive orthodontic treatment as needed
- Fluoride varnish and cleanings
- Dental x - rays when indicated
- Sealants to permanent molars as child grows

Developmental Issues

- Chapter Objective:
  - Discuss common developmental issues in children and offer appropriate guidance to parents

Teething

- Concerns
  - Teething does not cause upper respiratory infection, ear infection, or diarrhea
  - Teething may cause fussiness
  - Drooling is developmentally common at this age

Teething

- Anticipatory Guidance
  - Apply cold teething ring or cloth to gums
  - Provide acetaminophen or ibuprofen if necessary
  - Avoid teething gels
  - Tooth eruption may be preceded by a hematoma

Teething

- No treatment is needed in primary definition

Nonnutritive Sucking

- Etiology
  - Satisfies a psychological need and decreases as the child ages
  - Increases risk of anterior open bite and delayed speech development if habit persists
- Anticipatory Guidance
  - Intervene to stop habit by 36 months, especially if changes to occlusion are noted

Nonnutritive Sucking

- Breaking the habit
  - Restrict to limited situations
  - Cover hands at night with mittens
  - Provide alternative comfort objects such as stuffed animal
- Pacifier use is preferable to digit sucking

Take Home Messages

- ECC develops through the interaction of bacteria, dietary sugars, and teeth
- Assess teeth and risk factors
- Prevention by medical clinicians targets:
  - Hygiene
  - Fluoride
  - Diet

Take Home Messages

- Establish a dental home by age one for all children where possible

Questions?

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
- Began 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

Qualified Physicians

- 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 max of 6 applications between 6 months and 36 months of age

Eligible Services

- The allowed frequency will be no less than 90 days

Billing Requirements

- 99381-EP 99392-EP
  - New Patient EPSDT Periodic Screening linked to V20.2 or appropriate diagnosis
- 99391-EP 99392-EP
  - Established Patient EPSDT Periodic Screening linked to V20.2 or appropriate diagnosis

Billing Requirements

- Billed on same day with dental codes
- *D0145 Dental Exam or D1206 Dental Varnishing linked only to V72.2

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
- A list of Care Coordinators can be found on Medicaid website www.medicaid.alabama.gov under Referrals

Referrals

- The list of Care Coordinators can be found under "Patient 1st > Information for Providers"
- 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

Dr. Danny Rush
Dental Director
Danny.Rush@medicaid.alabama.gov
334-242-5582

Bettye Blount
Dental Program Staff
Bettye.Blount@medicaid.alabama.gov
334-242-5625

Dental Fluoride Varnishing and Oral Assessment Program for Pediatricians Participating in ALLKids

Introduction

- The ALL Kids fluoride varnishing and oral assessment benefit for pediatricians, which was effective October 1, 2011, is modeled after Alabama Medicaid's 1st Look Program with some variations

Benefit Objectives

- Implement oral assessments and fluoride varnishes for children who do not have a dental home
- Provide preventive education for oral and dental care
- Promote oral health at an early age
- Refer children to a dental home

Qualified Providers

- Limited to BCBS AL PMD Pediatricians and their professional staff
- Pediatricians must be trained before their professional office staff members are eligible to be trained

Course Requirements

- Completion of the web based training and post test
- A score of at least 75% on the post test is required for successful completion
- Upon completion and certification, notify the dental program contact at ALL Kids with provider information

Benefit Guidelines

- Payment will be based on the BCBS AL Preferred Provider Organization (PPO) dental fee schedule for the procedure codes covered under this benefit
- The procedures must be done in conjunction with a routine visit

Benefit Guidelines

- Claims must be filed on a medical claim form for the following services provided: Oral Assessment, CDT code DO145 and Topical Fluoride Varnishing, CDT code D1206
- Encounter claims:
  - Claims will be bundled and paid as part of the encounter rate and will not be paid separately as fee for service

Reimbursement Guidelines

- Oral Assessment, CDT code D0145 limited to one assessment by a medical provider and one assessment by a dental provider for children six months to 36 months of age
- Topical Fluoride Varnishing, CDT code D1206 limited to three per calendar year, regardless of the provider

Reimbursement Guidelines

- Not to exceed a maximum of six applications between six months and 36 months of age with a frequency of no less than 90 days
- Once a child is referred to a dental home, no further fluoride varnish treatment is allowed by the medical provider

Eligibility

- If a child has been seen by a dentist, the child does not qualify for these services and the provider should not provide the services
- Payment for these procedures will be denied if the patient has previously seen a dentist

Thanks to

The American Academy of Pediatrics

and

Smiles for Life

To complete the process for both CME and 1st Look Certification,

please return to "POST TEST" and "EVALUATION" on the Chapter's Oral Health Risk Assessment Training page at:

http://tinyurl.com/mbjyqr8