701 Maternal and Child Oral Health Services

AUTHORITY: IOWA ADMINISTRATIVE CODE 641 IAC 76 (135), SOCIAL SECURITY ACT TITLE V SEC 506 [42 USC 706]; IOWA ADMINISTRATIVE CODE 641 IAC 50 (135)
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REPLACES: 701 – JANUARY 2012

Overview

Maternal and Child Health (MCH) contract agencies are responsible for ensuring access to oral health services, with an emphasis on early intervention and preventive oral health care beginning at or near the age of 12 months and into adulthood.

Through the core public health functions of assessment, policy development and assurance, contract agencies should work to develop comprehensive oral health service systems by:

- Building community infrastructure for oral health
- Providing population-based dental services
- Providing enabling services to assure access to dental care
- Providing gap-filling direct services

An MCH contract agency is required to provide these services based on the community needs assessment and as specified in the approved application plan on file with the Iowa Department of Public Health (IDPH).

Oral Health Center (OHC) staff within IDPH are available upon request to provide consultation and technical assistance for MCH contract agencies.

Iowa Administrative Code

The *Iowa Administrative Code* (IAC) 641 IAC 50 describes the purpose and responsibilities of the state oral health program and dental director. Chapter 641 IAC 50 rules can be found at https://www.legis.iowa.gov/docs/ACO/chapter/04-07-2010.641.50.pdf

702 MCH Oral Health Funding

AUTHORITY: IOWA ADMINISTRATIVE CODE 641 IAC 76 (135), SOCIAL SECURITY ACT
TITLE V SEC 506 [42 USC 706]
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Overview

Oral health program funding is available for CH contract agencies to use for the development of oral health service systems and should be allocated according to an agency needs assessment. Limited funding is also available for MH agencies. The types and allowable use of funds are listed below.

CH-Dental funding (CH)

CH contractors may use CH-Dental grant funds for the following:

- Costs associated with infrastructure building activities to provide support for the development and maintenance of comprehensive oral health service systems; and/or
- Costs associated with direct dental services provided by approved CH agency professional staff (dental hygienists, nurses, nurse practitioners, physician assistants) to Title V eligible children from birth through 21 years of age; and/or
- Reimbursement, at Title XIX approved rates, to local dentists providing a limited level of preventive and/or restorative dental care to Title V eligible children from birth through 21 years of age. (Funding may not be used to support direct care services provided within federally qualified health center (FQHC) dental clinics.)

I-Smile™ funding (CH)

CH contractors may use I-Smile™ grant funds for the following:

- Costs associated with infrastructure building, population-based, and non-billable enabling services to develop local systems to assure a dental home for Medicaid-enrolled children.

- Costs associated with maintaining a dental hygienist as the I-Smile™ coordinator. The coordinator will be responsible for implementing the agency's I-Smile™ project and will ensure integration and completion of I-Smile™ strategies within the oral health program plan.

I-Smile™ funds may not be used for any costs for the provision of direct care services, including salaries and supplies.

Maternal oral health funding (MH)

Although there is no Title V oral health-specific funding for MH contract agencies, Title V MH grant funds may be used for oral health-related infrastructure building, population-based, enabling and direct care services. In addition, some MH services may be available as part of the CH contract agency's I-Smile™ program.

Care coordination funding (fee-for-service) and Medicaid revenue (CH and MH)

MH and CH agencies must bill IDPH for allowable dental care coordination services provided to Medicaid-enrolled clients.

MH and CH agencies must bill Medicaid for allowable direct care oral health services from a qualified provider to Medicaid-enrolled CH and MH clients.

When billing for care coordination and direct care oral health services, agencies must bill their established costs, which are based on their annual cost analysis report. The MCH Cost Analysis Report, which includes maternal and child oral health services, must be submitted to IDPH annually.

Other funding sources (CH and MH)

MH and CH agencies are encouraged to seek other funds (e.g. foundation funding, Early Childhood Iowa (ECI), community grants) to enhance oral health service systems. Possible use of these supplemental funds may include: reimbursing dentists for treatment of eligible clients; contracting with an agency dental hygienist or nurse to provide oral screenings and fluoride varnish for clients; oral health promotion; and purchasing oral health supplies for clients.

703 The I-Smile™ Program

AUTHORITY: IOWA ADMINISTRATIVE CODE 441 IAC 84; 42CFR 441.B
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REPLACES: 703 – JANUARY 2012

Background

In 2005, the Iowa legislature mandated that all Medicaid-enrolled children age 12 and younger have a designated dental home and be provided with dental screenings and preventive, diagnostic, treatment and emergency services as identified in the oral health standards under the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) program. The I-Smile™ program was developed in response to this mandate and serves as the comprehensive program to improve the oral health of Iowa children.

Program overview

The basis of I-Smile™ is a conceptual dental home, with a focus on prevention and care coordination. The program relies on an integrated health system using different levels of care and different types of providers. Health professionals such as dental hygienists, physicians, advanced registered nurse practitioners, registered nurses, physician assistants and dietitians are part of a network providing oral screenings, education, anticipatory guidance and/or preventive services as needed. Through referrals, dentists provide definitive evaluation and treatment.

Due to their existing network of community partners and health related services for Medicaid-enrolled, uninsured and underinsured children, CH agencies are the center of the I-Smile™ dental home network.

Each CH service area must have one Iowa-licensed dental hygienist as I-Smile™ coordinator. The I-Smile™ coordinator, in conjunction with the CH project director and other applicable staff, is responsible for developing and implementing activities within the service region. These activities are included on an activity worksheet, developed each year through the Title V CH application process.

I-Smile™ activities must be based on the needs and assets of the service area. All counties served must be regularly assessed to determine available oral health resources as well as gaps in oral health services. Each county within the service area must be involved in the planning process and the plan must assure that children in all counties will be served.

Refer to the I-Smile™ Oral Health Coordinator Handbook for additional information.

I-Smile™ coordinator requirements

In addition to maintaining an Iowa license to practice dental hygiene, I-Smile™ coordinators are required to work a minimum of 20 hours a week and at least 20 hours a week must be spent on infrastructure building, population-based and enabling services. The I-Smile™ coordinator is the single point of contact for I-Smile™ activities.

I-Smile™ coordinators are required to participate in IDPH trainings and must also successfully complete the IDPH Public Health Training for Oral Health Professionals.

I-Smile™ strategies

The I-Smile™ coordinator is responsible for implementing the following I-Smile™ strategies to improve the dental support system for underserved children. Examples of activities are provided for each strategy.

Strategy: Partnerships and planning

Develop partnerships with local public health, dental and medical providers, local boards of health, schools, WIC, Head Start, migrant and community health centers, Iowa's hospital health systems, businesses, and civic and other organizations.

Participate in a local health or oral health coalition.

Establish an I-Smile™ referral network.

Participate in community health planning and needs assessments.

Conduct community oral health promotion (e.g. news articles, flyers, giveaways, social media)

Strategy: Local board of health

Provide I-Smile™ program updates to each local board of health.

Participate in local Community Health Needs Assessment and Health

linkage	Improvement Plan (CHNA-HIP) process. Coordinate the school screening audit process and report to the local board(s) of health.
Strategy: CH agency staff training	Provide training and oversight of agency staff involved with oral health services. Assure consistent oral health education and standardized direct care services for families.
Strategy: Agency oral health protocols	Work with CH contract agency staff, particularly EPSDT coordinators, to develop oral health protocols, including a plan for ongoing community needs assessment and program planning.
Strategy: Care coordination	Ensure appropriate dental care coordination is completed for children, pregnant women and families. Improve data tracking systems.
Strategy: Education for healthcare professionals	Train non-dental primary care providers, such as physicians and nurses, to provide oral screenings, fluoride varnish applications and education. Provide I-Smile™ referral information and patient education materials to hospitals, free clinics, and medical offices. Meet with dental office staff to promote age 1 dental visits and participation in Medicaid and ***hawk-i***, and to offer training on seeing very young children.
Strategy: Oral screening and risk assessment	Ensure completion of gap-filling oral screenings, risk assessments and referrals to dentists.
Strategy: Preventive oral health services	Ensure provision of fluoride varnish applications, prophylaxes, radiographs and/or sealants as gap-filling services.

704 Oral Health Infrastructure Building Services

AUTHORITY: IOWA ADMINISTRATIVE CODE 641 IAC 76 (135), SOCIAL SECURITY ACT TITLE V SEC 506 [42 USC 706]
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REPLACES: 704 – JANUARY 2012

Overview

Infrastructure building services are the foundation for assuring that children, pregnant women and families have access to oral health care.

Infrastructure building activities improve oral health status through the development and maintenance of comprehensive health services systems. These systems include community planning and assessment, policy development and support, training and data system development.

Examples

MCH contract agencies should provide infrastructure building services based on community needs assessments. Examples of infrastructure building activities include:

- Surveying dental offices to identify oral health care accessibility in the service area
- Establishing regular, personal contact with dentists to advocate for children, pregnant women and families
- Establishing referral tracking systems with local dental offices
- Educating and training physicians on oral health
- Conducting in-service staff trainings to develop oral health education, care coordination and referral protocols
- Establishing relationships with school health staff to assure oral health education and prevention services
- Developing and presenting oral health information for the board of health

- Participating in the local Community Health Needs Assessment and Health Improvement Plan (CHNA-HIP) process
- Conducting strategic planning with local oral health coalitions and other forums to assess community oral health needs
- Planning and implementing activities with community partners for “Give Kids a Smile Day”
- Sharing oral health information with local organizations that have interest in the health of women and children
- Meeting with child care providers to evaluate and implement oral health programs
- Coordinating the school dental screening requirement with local boards of health, schools and providers
- Promoting early oral health care through hospital delivery centers, pediatricians and/or obstetrician/gynecologists
- Organizing open mouth surveys

705 Oral Health Population-Based Services

AUTHORITY: IOWA ADMINISTRATIVE CODE 641 IAC 76 (135), SOCIAL SECURITY ACT TITLE V SEC 506 [42 USC 706]
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REPLACES: 705 – JANUARY 2012

Description

A population-based approach identifies groups within the community who share common health needs, especially low-income families or families with limited availability of health services.

Population-based services allow MCH contract agencies to provide preventive oral health services to an entire group rather than in a one-on-one setting. Programs and services meet the specific needs of these groups, benefiting many people at once. The client's payer source is not assessed and services for individuals are not billed.

Examples

Examples of population-based activities include:

- Oral health education classes for Head Start parents
- Group oral screenings at a community event (e.g. health fair)
- Oral screenings for open mouth surveys
- Group oral screenings for the school dental screening requirement
- Prenatal class education
- Oral health promotion

706 Oral Health Enabling Services

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REPLACES: 706 – JANUARY 2012

Overview

Enabling services include outreach, informing, and care coordination and provide the support families need to overcome barriers to oral health care. MCH contract agencies are responsible for providing enabling services to all child and maternal health clients regardless of payment source.

MH outreach

MH agencies must assess pregnant women regarding their access to oral health care and methods to pay for dental care. Medicaid presumptive eligibility determinations are provided for pregnant women who have no health insurance.

CH informing

Many families may not understand the importance of early and regular oral health care by age 1. As part of informing activities, CH contract agencies will: 1) promote the benefits of preventive oral health care, 2) provide the names and locations of participating dentists, 3) encourage families to establish dental homes, and 4) inform families about available payment sources for oral health care.

Dental care coordination

Care coordination links pregnant women, children and families to oral health care and requires personal contact (face-to-face, email, or telephone call or text) with families. Examples of dental care coordination activities include:

- Assisting clients with locating dentists
- Assisting with scheduling dentist appointments
- Reminding clients that periodic oral screenings or exams are due
- Counseling clients about the importance of keeping appointments

- Providing follow-up to assure that oral health care was received
- Arranging support services such as transportation, child care or translation/interpreter services
- Reinforcing anticipatory guidance
- Linking families to other community services (e.g., WIC)

MH "oral health only" enrollment for pregnant women

A woman may choose to opt out of full MH program services, yet need preventive dental services or assistance accessing dental care. In these instances, she can become enrolled in the MH program as an "oral health only" client.

Full enrollment in the MH program should always be encouraged, but in these situations described, it is not required.

"Oral health only" clients must be enrolled and also discharged on the same day, unless follow up services are needed.

707 Direct Care Oral Health Services Provided by Agency Staff

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Description

Based on local needs assessment, MCH contract agencies may provide direct care oral health services for families in their service areas. These services must be gap-filling and not duplicative of services provided by dentists. Examples include:

- Oral screenings
- Fluoride varnish applications
- Dental sealant applications
- Prophylaxes
- Radiographs

For the purposes of Medicaid billing, direct services may also include oral hygiene instruction and nutrition and tobacco counseling as it relates to oral health.

Note: An oral screening must always be done prior to the provision of fluoride varnish applications, dental sealants, prophylaxes or radiographs. Referrals for regular dental care and dental care coordination services must also be provided for women and children receiving direct care services by MCH contract agency staff.

Direct service providers

It is recommended that direct care oral health services be provided by a dental hygienist employed or contracted by the agency. However, based on an agency needs assessment and workforce availability, registered nurses, nurse practitioners and physician assistants who are employed or contracted by the agency may also provide direct oral health services.

Services must be provided according to IDPH protocols and scope of practice regulations.

Training for MH and CH agency non-dental health professionals must be provided by the CH contract agency I-Smile™ coordinator using IDPH-approved training materials. Documentation of the training, including a list of personnel trained, must be completed on approved forms and submitted to the IDPH Oral Health Center (OHC).

Refer to section 718 of this manual for information on dental hygienist supervision.

Consent for oral health services

MCH contract agencies must assure that consent is obtained prior to performing oral health services to maternal and child health clients according to the following criteria.

Active consent

Active consent is required for:

- Fluoride varnish applications
- Dental sealants
- Prophylaxes
- Radiographs

Active consent is also recommended for oral screenings. Active consent means that the client, or parent or guardian of a minor (child under age 18 and unmarried), must indicate consent for each service and must sign and date the form.

Consent forms are valid for one year. Standardized consent forms can be obtained from the OHC or agencies may develop agency-specific consent forms based on the OHC template. Consent forms that are modified must be pre-approved by the IDPH OHC staff.

Combined child health/oral health or maternal health/oral health consent forms may be used. Specific oral health services offered by the agency must be included on the combined consent forms. MCH contract agencies must assure that all information required on the OHC consent template is captured within the client chart.

Contract agencies may accept a consent form that has been faxed, but email or phone consent is not acceptable.

Passive consent

Passive (or "opt-out") consent is an acceptable form of permission for oral screenings, but **is not** acceptable for fluoride varnish applications, dental sealants, prophylaxes or radiographs. Passive consent is sometimes used (e.g. school settings) and allows a service to be provided, unless the parent has actively declined the service. Providers must assure that a parent or guardian has been notified about the service and did not decline the service in writing before performing an oral screening.

Note: Agencies are responsible for assuring that all required information is obtained for the purposes of data entry into CAReS or WHIS.

MCH contract agency staff or providers with questions about the necessity of obtaining consent, who is authorized to provide consent or the adequacy of a consent form, are encouraged to contact their private legal counsel to obtain advice on such issues.

Refer to sections 300 and 600 of this manual for additional detail on direct services and minor consent requirements.

Release of confidential information

Confidential information may not be shared without a *signed authorization for release*. All paper and electronic client records that include information on the identity, assessment, diagnosis, prognosis and services provided to specific individuals or families are considered confidential information.

Such records can be disclosed only under the circumstances expressly authorized under state or federal confidentiality laws, rules or regulations. MCH contract agencies must have policies and procedures that safeguard the confidentiality of records and may be liable civilly, contractually or criminally for unauthorized release of such information.

The authorized sharing of confidential information benefits the client as well as the MCH program for purposes such as case management, referral, program evaluation or sharing of demographic information.

A separate release of information form and consent form are required for all oral health services provided. However, when direct oral health services are provided in a school setting (parent/guardian not present), a combined consent/release of information form may be used. In this instance, two signatures must be obtained on the form – for consent and authorizing release of information.

Sample forms may be obtained from the IDPH Oral Health Center or agencies may develop agency-specific forms based on the OHC template.

708 Child Health: Oral Screening and Risk Assessment

AUTHORITY: MEDICAID SCREENING CENTER PROVIDER MANUAL
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REPLACES: 708 – JANUARY 2012

Descriptions

Oral screenings and risk assessments determine the level of care a child should receive through the I-Smile™ dental home. The oral screenings and risk assessments:

- Assist in educating families on the need for good oral health,
- Determine decay risk and prevention needs,
- Identify dental referral needs, and
- Provide a mechanism to inform dental offices of those needs when scheduling appointments for families.

CH contract agencies that provide complete well-child screens are required to do oral screenings for their clients at each well-child appointment.

CH contract agencies that do not provide complete well-child screens may provide oral screenings and risk assessments based on a local and/or state needs assessment. The screenings may occur at WIC clinics, Head Start classrooms or in other public health settings. The risk assessment should determine the plan of care for each client.

Oral screening components

The purpose of an oral screening is to identify oral health anomalies or diseases, such as dental caries, gum disease, soft tissue lesions or developmental problems and to help ensure individualized preventive oral health education. An oral screening includes a medical/dental history and an oral evaluation. Medical or dental history information that cannot be obtained through an interview with the parent or guardian should be collected through the consent form. Each component of the screening, listed below, must be documented in the client paper record and CAReS, as applicable.

Medical history

The medical history consists of:

- Name of child's primary care provider
- Pertinent medical conditions (e.g. heart murmur, special health needs, prematurity/low birth weight)
- Current medications used (e.g. those with sugar or those that cause dry mouth, enlarged gingiva, or bleeding)
- Allergies

Dental history

The dental history consists of:

- Name of child's dentist
- Current or recent oral health problems
- Parental concerns related to child's oral health
- Frequency of dental visits
- Home care (frequency of brushing, flossing or other oral hygiene practices)
- Feeding/snacking habits (exposure to sugar/carbohydrates)
- Use of fluoride by child (water source, use of fluoridated toothpaste or other fluoride products)
- Parent or sibling decay history (presence of untreated decay, fillings or crowns)

Soft tissue evaluation

The soft tissue evaluation consists of:

- Gum redness or bleeding
- Swelling or lumps
- Trauma or injury

Hard tissue evaluation

The hard tissue evaluation consists of:

- Suspected decay
- White spot lesions (demineralized areas) near the gumline
- Visible plaque
- Stained fissures
- Enamel defects
- Decay history (presence of fillings or crowns)
- Trauma or injury

Note: Documenting presence of "decayed", "filled", and/or "sealed" teeth must be done in the client paper record and CAReS.

Use of dental explorers

With the exception of school-based sealant programs, dental explorers cannot be used for oral screenings. A visual assessment is sufficient.

Using a dental explorer may transfer decay-causing bacteria from one tooth to another or cavitate a demineralized area.

School-based sealant programs may use dental explorers.

Education

If the parent/guardian is present, oral health education should be provided based on the finding of the oral screening and each client's individual need. If the parent/guardian is not present, education is recommended if a child is age-appropriate. Oral health education must be documented in the client paper chart and CAReS. Refer to policy 715 of this manual for additional information about education resources.

I-Smile™ risk assessment

As part of an oral screening, a risk assessment must be completed on each child. The risk assessment will establish a child's level of risk for tooth decay as low, moderate or high. Based on the level of risk, the CH contract agency staff will determine one of three appropriate care plans for education, preventive services and referrals to a dentist.

Documenting the risk level (low, moderate, or high) must be done in the client paper record and CAReS.

The I-Smile™ Risk Assessment, including the care plan levels, is in the Forms section of the I-Smile™ Oral Health Coordinator Handbook.

Dental referrals

All children that receive a dental screening must be referred to a dentist based on the I-Smile™ risk assessment.

Dental referrals should be documented as a dental service in CAReS according to agency protocol. Service notes about the referral must be entered in CAReS and the client chart as applicable. Follow-up should be provided to ensure that the client's oral health needs have been met.

NOTE: All children must be referred for a dental exam by age 1.

709 School Dental Screenings

AUTHORITY: IOWA ADMINISTRATIVE CODE 641 IAC 51 (135)
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REPLACES: 709 – JANUARY 2012

Overview

All children newly enrolling in an Iowa public or accredited non-public elementary or high school must show proof of a dental screening. This would include students entering kindergarten and ninth grade.

The purpose of the dental screening requirement is to improve the oral health of Iowa's children. The dental screenings will:

- Facilitate early detection and referral for treatment of dental disease
- Reduce the incidence, impact and cost of dental disease
- Inform parents and guardians of their children's dental problems
- Encourage the establishment of effective oral health practices early in life
- Promote the importance of oral health as an integral component of preparation for school and learning
- Contribute to statewide surveillance of oral health

The dental screenings enhance the I-Smile™ dental home concepts of prevention, education, care coordination and treatment and provide a critical step in closing the gap in access to dental care for underserved children.

CH contract agency responsibility

I-Smile™ coordinators within each CH contract agency will assist schools, families and local boards of health to assure compliance with the dental screening requirement. Activities include:

- Distributing forms and dental screening information to schools and dental offices and at community outreach events
- Building partnerships with area dentists and providing care coordination to help children who do not have a dentist
- Training non-dental health care professionals how to provide screenings
- Providing dental screenings in schools and other public health settings as a gap-filling service

- Working with schools and board of health to audit dental screening records

Additional information about the school dental screening requirement is available at http://www.idph.state.ia.us/OHDS/OralHealth.aspx?prog=OHC&pg=Screenings

710 Maternal Health: Oral Screening and Risk Assessment

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REPLACES: 710 – JANUARY 2012

Overview

A healthy mouth is essential for a healthy pregnancy. Diet and hormonal changes that occur during pregnancy may increase a woman's risk for developing tooth decay and gum disease. Oral infections can affect the health of the mother and her baby. Agency staff can have a positive impact on improving the health of maternal health clients and their babies by including oral screening services.

MH contract agencies that provide full prenatal care are required to include oral screening for their clients.

- At least one screening must be completed during the prenatal visit schedule.
- If a client has not seen a dentist following the initial screening, a second screening is required and can be completed postpartum, if needed.

MH contract agencies that do not provide full prenatal care are encouraged to provide oral screenings as a gap-filling service based on local needs assessment.

- Screenings should be considered for all pregnant and postpartum women, especially those who have indicated they have problems with their teeth or gums, or if a health history indicates that the woman is at risk for tooth decay or gum disease.
- Screenings may be provided to pregnant and postpartum women at WIC clinics or in other public health settings.

MH "oral health only" enrollment for pregnant women

A woman may choose to opt out of full MH program services, yet need preventive dental services or assistance accessing dental care. In these instances, she can become enrolled in the MH program as an "oral health only" client.

Full enrollment in the MH program should always be encouraged, but

in these situations described, it is not required.

"Oral health only" clients must be enrolled and also discharged on the same day, unless follow up services are needed.

Oral screening components

An oral screening includes a medical/dental history and a soft and hard tissue evaluation. The purpose of a screening is to identify dental anomalies or diseases, such as dental caries, gum disease or soft tissue lesions and to ensure that preventive dental education is provided. The screening service must be documented in WHIS and detailed in the client chart.

Medical history

The medical history consists of:

- Name of primary care provider
- Pertinent medical conditions (e.g. pregnancy due date, prenatal care, nausea/vomiting, gestational diabetes, heart murmur)
- Current medications used (e.g. those with sugar or those known to cause dry mouth, enlarged gingiva, or bleeding)
- Allergies
- Tobacco, alcohol or drug use

Dental history

The dental history consists of:

- Name of dentist
- Current or recent dental problems or injuries
- Length of time since last dental visit
- Home care (frequency of brushing, flossing or other oral hygiene practices)
- Snacking / eating habits (exposure to sugar/carbohydrates)
- Fluoride use (source of water, use of fluoridated toothpaste or other fluoride products)

Soft tissue evaluation

The soft tissue evaluation consists of:

- Gum redness, bleeding or exudate
- Swelling or lumps
- Trauma or injury
- Recession

Hard tissue evaluation

The hard tissue evaluation consists of:

- Suspected decay
- White spot lesions (demineralized areas) near the gumline

- Plaque, calculus (tartar) or stain
- Enamel defects
- Decay history (presence of fillings or crowns)
- Trauma or injury
- Loose or missing teeth

Note: Documenting the presence of “decayed” or “filled” teeth and/or “gingivitis” must be done in the client paper chart and WHIS.

Dental explorers

Dental explorers cannot be used for oral screenings. Visual assessment is sufficient. Dental explorers may transfer decay-causing bacteria from one tooth to another or cavitate a demineralized area.

Education

Oral health education should be provided and based on the findings of the oral screening and each MH client’s individual need. Education should include infant oral health care. Oral health education must be documented in the client paper chart and WHIS, as applicable. Refer to policy 715 of this manual for additional information about education resources.

Maternal oral health risk assessment

As part of an oral screening, a risk assessment must be completed on each woman. The risk assessment will establish the level of risk for dental disease as low, moderate or high. Based on the level of risk, the MH contract agency staff will determine one of three appropriate care plans for education, preventive services and referrals to a dentist.

Note: Documenting the risk level (low, moderate, or high) must be done in the client paper chart and WHIS.

The Maternal Oral Health Risk Assessment, including the care plan levels, is available from the Oral Health Center at IDPH.

Dental referrals

Following an oral screening, the provider should determine an appropriate care plan for preventive services and referrals to a dentist based on the Maternal Oral Health Risk Assessment. <u>At a minimum, a client should visit the dentist at least once during pregnancy.</u>

Dental referrals must be documented in WHIS and the client’s chart as applicable. Follow-up should be provided to ensure completion of the referral.

711 Dental Referrals

AUTHORITY: MEDICAID PROVIDER MANUALS (SCREENING CENTER AND MATERNAL HEALTH CENTER)
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REPLACES: 711 – JANUARY 2012

Child health referrals

An important goal of the I-Smile™ program is to assist families in obtaining necessary oral health care for their children. Visits to a dentist should begin by the age of 1 year and continue periodically as indicated by the client's I-Smile™ Risk Assessment and Care Plan.

These visits are important for prevention and early diagnosis of tooth decay and for anticipatory guidance for parents.

Maternal health referrals

Dental care is safe and effective during pregnancy. Ensuring that mothers have direct access to preventive care and treatment is significant for improving both the mother's and child's oral health and overall health.

Dental referrals for MH clients should be based on the Maternal Oral Health Risk Assessment and Care Plan. At a minimum, a MH client should visit the dentist at least once while pregnant. A dental visit should be scheduled as soon as possible if the client has any of the following conditions:

- No dental visit within the past year
- Suspected or obvious decay
- Gum inflammation or abscess
- Pain or injury
- Other abnormalities

Needed treatment can be provided throughout pregnancy.

Documenting referrals

Dental referrals should be documented in CAReS or WHIS and the client's chart as applicable. Follow-up should be provided to all clients to ensure completion of the referral.

712 Fluoride Varnish

AUTHORITY: NOT APPLICABLE
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REPLACES: 712 – JANUARY 2012

Overview

Fluoride varnish is highly effective in preventing decay and re-mineralizing white spot lesions. It is recommended for use on at-risk children as soon as teeth begin to erupt. It can also be highly effective for preventing tooth decay in pregnant women.

The benefits of fluoride varnish make it extremely useful within public health programs. When applied to teeth, fluoride varnish sets upon contact with saliva. The hardened layer of fluoride is then absorbed into enamel. If not brushed off the teeth, it will continue to be absorbed for several hours. The absorption time is much longer than for traditional fluoride gels and foams. Fluoride varnish application is recommended three to four times a year.

Because of the rapid hardening of the varnish and small amount used, the risk of ingestion and toxicity of fluoride varnish is extremely low, making it safe for very young children and pregnant women.

Criteria

The criteria for application of fluoride varnish include:

- Suspected tooth decay
- White spot lesions
- Visible plaque
- History of decay (fillings or crowns)
- Low socio-economic status

Fluoride varnish application must only be done in conjunction with an oral screening and must be provided according to the IDPH Fluoride Varnish protocol. Fluoride varnish application must be documented in CAReS or WHIS and the client record. The client paper record must include the product used and fluoride concentration.

Reference the IDPH website for fluoride varnish protocol: http://www.idph.state.ia.us/OHDS/OralHealth.aspx?prog=OHC&pg=Fluoride

713 Dental Sealants

AUTHORITY: IOWA ADMINISTRATIVE CODE 650 IAC 10
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REPLACES: 713 – JANUARY 2012

Overview

Dental sealants are an important preventive service for low-income, uninsured and/or underinsured children and adolescents. Based on community needs, a CH agency may provide dental sealant application as a gap-filling service.

Sealants are often applied in a school-based setting, offering an excellent opportunity for collaboration with local schools and dental providers. School settings allow for a large number of children to receive preventive care. IDPH recommends that sealant programs target those schools with a 40 percent or higher free and reduced lunch rate to reach students at highest risk.

The teeth most at risk of decay, and therefore most in need of sealants, are the first and second permanent molars. These teeth should be a priority on all children and adolescents and should be sealed as soon as possible after eruption. This would include children ages 6-8 years and 12-14 years. The permanent premolars may also benefit and sealant application on those teeth can be determined on an individual basis. Although sealing primary molars is a Medicaid-billable service, this should be limited to children whose age and behavior will allow an optimal application procedure to ensure sealant retention.

Clients who receive sealants provided by MCH contract agencies within direct care clinics and/or school-based settings must also be referred for regular dental care and may be eligible for dental care coordination services.

Information on school-based sealant programs can be found at: http://www.idph.state.ia.us/OHDS/OralHealth.aspx?prog=OHC&pg=Sealants

For specific programmatic guidelines, refer to the School-Based Dental

Sealant Program Manual at http://www.idph.state.ia.us/IDPHChannelsService/file.ashx?file=213E08F0-A5D8-4E2C-AAFC-6A47B6B544C7

Provider qualifications

A client must first have an exam or an oral screening to determine which teeth will benefit from the application of dental sealants. The following professionals are able to do this:

- Iowa-licensed dentist
- Iowa-licensed dental hygienist practicing under public health supervision, with a collaborative agreement that includes sealant screenings

Based on the findings from the exam or screening, a dentist or dental hygienist may apply dental sealants. A dental hygienist must practice under public health supervision, with a collaborative agreement that includes sealant application.

Dental assistants are recommended to be used to assist dentists and/or dental hygienists with sealant application. Dental assistants must be registered with the Iowa Dental Board. Other primary care providers (e.g. nurses) or laypersons (e.g. parent volunteer) are not eligible to serve in this role, per Iowa Dental Board rules.

Periodic retention checks are recommended for quality assurance, according to IDPH protocols.

Documenting services

Sealant application must be documented in CAReS or WHIS and the client record. The client paper record must include the sealant product used, tooth number and tooth surface.

Services and data for all school-based sealant programs must be submitted to IDPH using the department's Sealant Data Recording System.

714 Prophylaxes and Radiographs

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REPLACES: 714 – JANUARY 2012

Prophylaxes

Based on a community needs assessment, MCH contract agencies may choose to provide prophylaxes (professional cleanings that include scaling and polishing teeth) as a gap-filling service for clients. If a prophylaxis is provided, a periodontal assessment must be part of this service. The documentation for this assessment should include charting that details an evaluation of the teeth, gingiva and periodontium.

A prophylaxis may only be provided by a dentist or a dental hygienist. Dental hygienists must work under public health supervision and the collaborative agreement must include the guidelines for prophylaxis services.

Due to the threat of bleeding associated with prophylaxis, a detailed medical history must be completed to evaluate a client's risk for bacterial endocarditis or other blood-related conditions. This would include, but not be limited to, a client who has a heart murmur, takes anti-coagulant medications, or is immune-suppressed.

Contractors must document provision of prophylaxes in CAReS or WHIS and the client record.

Radiographs

In partnership with local dentists, MCH contract agencies may provide radiographs to assist with client referrals for dental treatment.

Radiographs may be provided by dental hygienists working under public health supervision. The public health supervision collaborative agreement must include guidelines for radiograph services.

Standing orders must be in place with a specific dentist who will read the client's radiographs, provide an exam and establish a treatment

plan.

Contractors must document radiographs in CAReS or WHIS and the client record. The client paper record must include the type of radiograph, number taken and tooth number, if applicable.

715 Guidelines for Oral Health Education

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Overview

Oral health education is an integral component of the services provided by MCH contract agencies. It is important that MCH clients understand that healthy teeth and gums impact overall health, proper nutrition, appearance and speech for both mother and child.

Child health guidelines

Parents/caregivers must be educated about a range of age-appropriate oral health topics such as:

- Importance of baby teeth
- First dental visit by age 1 and periodic visits based on client's risk assessment
- Proper daily cleaning and monthly "Lift the Lip" techniques
- Risks associated with certain foods and beverages, including bottle and sippy cup habits
- Importance of topical fluoride exposure
- Non-nutritive sucking (fingers or pacifier)
- Teething/eruption patterns
- Risks associated with certain medications (e.g. seizure medications, those that cause dry mouth, or sugary cough syrups used for an extended time)

Maternal health agency guidelines

Comprehensive services provided by a MH contract agency must include oral health education as an essential part of total health maintenance. Specific oral health issues that may require counseling include:

- Home care
- Dietary habits, including inappropriate snacking and soda pop consumption
- Pregnancy gingivitis
- Morning sickness

- Risks of periodontal disease and link to pre-term labor
- Systemic implications of oral diseases
- Fluoride
- Transfer of decay-causing bacteria from mother to child
- Infant oral health care

Educational resources

MCH contract agency staff providing education must be trained by the I-Smile™ coordinator to assure that a consistent message is given to all clients and families.

Agencies should provide anticipatory guidance and oral health education to individuals as well as groups to promote optimal oral health. Client education should be individualized and based on the findings of the oral screening and risk assessment. For child health clients, the parent or caregiver should be included in the education and demonstration of brushing and flossing.

The IDPH Oral Health Center provides educational brochures and the OHC website includes information to guide development of individual education plans, group curriculum or to provide background information.

The publication, *Bright Futures in Practice: Oral Health* also provides the tools and strategies needed to promote a lifelong foundation for oral health. It is published by the National Center for Education in Maternal and Child Health and may be ordered from: *www.brightfutures.org*.

For specific education guidelines, refer to the I-Smile™ Handbook on the Oral Health Center website at : http://www.idph.state.ia.us/OHDS/OralHealth.aspx?prog=OHC&pg=Resourcesor the I-Smile™ website at *www.ismiledentalhome.iowa.gov/*

716 Documentation of Oral Health Services

AUTHORITY: IOWA ADMINISTRATIVE CODE 441 IAC 84; 42CFR 441.B
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Documenting services

Direct care oral health services and care coordination must be documented in the client's health record, including CAReS or WHIS. Service documentation must include:

- Name of client
- Date of birth
- Medicaid number, if applicable
- Date of service
- Place of service
- Medical and dental history
- Findings from the oral screening
- Direct services provided
- Time in/time out for time-sensitive services (e.g. education, care coordination)
- Oral health education provided, including with whom you spoke
- Dental care coordination, including written and verbal dental referrals and referral follow-up
- Medicaments prescribed
- Client plan of care
- First and last name of provider and credentials
- Signature/signature log

CAReS and WHIS serve as both permanent dental health records and data systems. Information is analyzed and used to meet federal reporting requirements, for program planning and evaluation and quality assurance evaluation.

Additional records

A paper chart for each client may also be necessary to assure a comprehensive client health record. The IDPH Oral Health Center has developed template oral screening forms for MH and CH clients which MCH contract agencies may use as part of a paper chart.

All child health and maternal health records (hard copy and/or electronic) are the property of IDPH. Refer to section 600 of this manual for more information on record maintenance and storage.

For more specific information on CAReS refer to the CAReS User Manual:
www.idph.state.ia.us/hpcdp/common/pdf/CARES_manual.pdf

For more specific information on WHIS, refer to the WHIS User Manual:
www.idph.state.ia.us/hpcdp/common/pdf/family_health/womans_health_system_manual.pdf

717 Medicaid Billable Oral Health Services

AUTHORITY: IOWA ADMINISTRATIVE CODE 441 IAC 84; 42CFR 441.B
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REPLACES: 717 – JANUARY 2012

Billing Medicaid

MCH contract agencies must bill for oral health services provided to Medicaid-enrolled clients. All services except care coordination must be billed directly to Medicaid. (Dental care coordination services for Medicaid-enrolled clients are billed to IDPH as "fee-for-service".)

Oral health direct care services must be gap-filling. MCH contract agency staff providing direct care services must assure they are not duplicating services provided by dentists.

Note: For Medicaid clients, the Medicaid Eligibility Verification System (ELVS) is available to verify services and should be used when providing those services (e.g. prophylaxis) that have provider frequency restrictions.

Refer to sections 400 and 600 of this manual and the EPSDT Informing and Care Coordination Handbook for additional billing information.

Service providers

All services listed in the following tables may be provided by dental hygienists. With the exception of radiographs, prophylaxes and sealants, these services may also be provided by registered nurses, advanced registered nurse practitioners or physician assistants. Dietitians are eligible to provide nutritional counseling.

Refer to section 300 of this manual for information about eligible providers of care coordination.

All non-dental personnel must be trained using an IDPH-approved training before providing and billing for the listed direct care services. Training must be provided by the I-Smile™ coordinator in the service area or IDPH Oral Health Center (OHC) staff. Documentation of the training, including courses provided and names of the non-dental

providers trained, must be furnished to the OHC before services are provided and/or billed to Medicaid through an MCH contract agency.

Cost analysis

MCH contract agencies must bill their actual cost for providing oral health services. Reimbursement will be paid at the cost for services or at the maximum allowable Medicaid rate, whichever is lower. MCH cost analysis reports must be completed and provided to IDPH each year.

Questions regarding cost analysis reports, forms needed, or billing Medicaid for oral health services should be directed to the IDPH Oral Health Center at 1-866-528-4020.

Medicaid-billable oral health services table for Medicaid-enrolled

Code and Service Description	Modifier	Frequency
D0145 Oral evaluation and counseling with primary caregiver for patient younger than 3 years of age. Must include recording of the oral and physical health history, evaluation of caries susceptibility, development of an appropriate preventive oral health regimen and communication with and counseling of the child's parent, legal guardian and/or primary caregiver. (CH programs only)	**DA** Also add **TD** when provided by RN, ARNP, PA	Every 6 months Do not use for initial screening.
D0190 (with CC modifier) Initial oral screening by non-dentist	**CC** Also add **TD** when provided by RN, ARNP, PA	1 time per patient Also allowed when provider has not seen patient within a 3-year period.
D0190 Periodic oral screening by a non-dentist. Limited to those patients whose caretaker indicates they have not had a screening within the previous 6 months.	**TD** when provided by RN, ARNP, PA	Every 6 months
D0270 Bitewing radiograph – single film (RDH only)	none	1 time in 12-month period
D0272 Bitewing radiograph – two films (RDH only)	none	1 time in 12-month period
D0274 Bitewing radiograph – four films (RDH only)	none	1 time in a 12-month period
D1110 Prophylaxis – adult (age 13 and older) (RDH only)	none	Every 6 months
D1120 Prophylaxis – child (age 12 and younger) (RDH only)	none	Every 6 months

D1206 Topical fluoride varnish – therapeutic application for moderate to high caries risk patients. Risk determined using I-Smile™ Risk Assessment.	**TD** when provided by RN, ARNP, PA	4 times a year, at least 90 days apart
D1310 Nutritional counseling for the control and prevention of oral disease	**TD** when provided by RN, ARNP, PA	Every 6 months per 15 minutes, minimum of 8 minutes
D1320 Tobacco counseling for the control and prevention of oral disease (MH programs only)	**TD** when provided by RN, ARNP, PA	Every 6 months per 15 minutes, minimum of 8 minutes
D1330 Oral hygiene instruction. Hands-on demonstration of individualized home care techniques to age-appropriate client or parent/guardian.	**TD** when provided by RN, ARNP, PA	Every 6 months per 15 minutes, minimum of 8 minutes
D0601 Caries risk assessment and documentation using recognized assessment tool – finding of low risk	none	In conjunction with every screening
D0602 Caries risk assessment and documentation using recognized assessment tool – finding of moderate risk	none	In conjunction with every screening
D0603 Caries risk assessment and documentation using recognized assessment tool – finding of high risk	none	In conjunction with every screening
D0120 Dentist-provided periodic oral screening for school-based dental sealant programs. Limited to those patients whose caretaker indicates they have not seen a dentist within the previous 6 months.	none	Every 6 months
D0150 Dentist-provided initial oral screening for school-based dental sealant programs.	none	1 time per patient Also allowed when provider has not seen patient within a 3-year period.

IDPH-billable oral health services table for Medicaid-enrolled

Code and Service Description	Modifier	Frequency
T1016 Dental are coordination for Medicaid-enrolled clients	none	Based on documented time-in/time-out. Cannot be billed on the same day as a Medicaid-billable oral health service.

718 Supervision of Dental Hygienists

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Overview

Dental hygienists providing direct care services in Iowa must work under the supervision of a dentist.

Public health supervision

All dental hygienists providing direct services through MCH contract agencies must use public health supervision. This allows hygienists to provide services in designated public health settings without the patient first being examined by a dentist.

A hygienist must have an Iowa license and a minimum of three years of clinical experience to work under public health supervision. A collaborative agreement between a dentist and a hygienist is required. The agreement delegates what services can be provided, where services will be provided and standing orders for the services. Dentists providing public health supervision are not required to provide future dental treatment to patients served by the hygienist.

While the collaborative agreement allows the supervising dentist and hygienist to list the location of dental records, it is expected that all dental hygienists (employed or contracted) providing services through MCH contract agencies will maintain clinical records within the agency and not at a separate location. All records of patients receiving services associated with a MCH contract agency are the property of IDPH. Refer to section 600 of this manual for additional detail about client records.

A template and sample for a collaborative agreement is found on the IDPH website at http://www.idph.state.ia.us/OHDS/OralHealth.aspx?prog=OHC&pg=Resources

A copy of the collaborative agreement must be on file with the IDPH Oral Health Center (OHC). Each dental hygienist and dentist is responsible for reviewing the agreement biennially to assure that

information is current. If updates are needed, a revised agreement must be sent to the OHC. An addendum may be requested to add sites to the agreement on file.

A report of services provided under public health supervision for the calendar year must be filed at least annually with the IDPH Oral Health Center. OHC staff will provide instructions and a report form to be used each year.

719 Child Health: Dental Treatment Provided by Dentists

AUTHORITY: IOWA ADMINISTRATIVE CODE 641 IAC 76 (135), SOCIAL SECURITY ACT TITLE V SEC 506 [42 USC 706]
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REPLACES: 719 – OCTOBER 2012

Reimbursing dentists

CH-dental funds may be used to reimburse dentists for a limited number of basic preventive and restorative dental services, at Title XIX approved rates, for CH clients. (Funding may not be used to support direct care services provided within FQHC dental clinics.)

Client eligibility

Criteria for eligibility are that

- Child is age 0 – 21 years
- Child is not eligible for the Title XIX Program
- Child is uninsured or underinsured for dental coverage
- Child's family meets income guidelines as established by Iowa's Title XXI program

Dental provider agreements

Child Health contract agencies that use CH-dental funds to reimburse dentists for services are required to have a written agreement with those providers.

Recommended information to include in the agreement includes:

- List of the dental procedures that Title V will reimburse and the reimbursement amounts for those procedures
- Maximum amount allowed per child without prior authorization
- Information on how a dental office may request an "exception" to pay for procedures not currently on the list
- Clarification that reimbursement from Title V is accepted as payment in full and the family is not responsible for additional costs
- I-Smile™ Coordinator contact information

Dental vouchers

CH contract agencies may create a "dental voucher" system for eligible clients. The family can be given a voucher to provide to a participating dental office. The voucher will indicate that the CH contract agency will reimburse the dental office for allowable treatment costs (using CH-Dental funds).

Dental vouchers may **not** be used to pay for direct care services provided within FQHC dental clinics.

For any client receiving oral health services by a dentist reimbursed with CH-dental funds, "dental voucher" must be indicated as a service in CAReS.

Dental treatment coverage

The IDPH Oral Health Center (OHC) provides CH contract agencies an updated list of pre-authorized codes and reimbursement levels annually. Reimbursement for services is based on the most current Title XIX fee schedule.

Payment frequency for examinations, prophylaxes, fluoride varnish applications, and sealants should be made according to Medicaid guidelines and agency protocol. Refer to Section 717 for details about Medicaid billable oral health services.

Exceptions to use CH-Dental funds for dental services that are not on the pre-authorized list of codes must be requested in writing to the OHC for consideration. Policy 205 of this manual contains directions for requesting an exception to policy.

Quarterly reporting

CH contract agencies are required to submit quarterly Dental Data Reports to the Oral Health Center at the end of each fiscal quarter (January 30, April 30, July 30 and October 30). Information collected includes the number of children who saw a dentist using CH-dental funds, the number of dental procedures provided and the total amount of treatment dollars reimbursed to dentists per quarter. The Dental Data Report is completed through iowagrants.gov.