PEDIATRIC PRIMARY CARE AND ORAL HEALTH

Most Medicaid children are not receiving recommended oral health assessments and treatments

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As evidence regarding the link between oral health and systemic health continues to grow, there has been an increasing emphasis on integrating oral health care into the pediatric primary care setting and improving the coordination of care within interprofessional health teams.[1-4] The American Academy of Pediatrics and the American Academy of Pediatric Dentistry recommend that primary care providers perform oral health assessments, that medical care teams administer topical fluoride varnish, especially in the absence of a dental home, and that primary care providers refer patients to a dental home by one year of age or at first tooth eruption. Additionally, the benefits of oral health interprofessional practice with achieving the triple or quadruple aim have been expressed in prior research.[1-2,5-10] Given the importance of oral health during primary care, this research brief is provided evaluating well-child medical visits and oral health services.

Data from the IBM Watson Medicaid MarketScan© database of medical and dental claims from 13 de-identified states, was utilized for the analysis. In 2017, 7 percent of the approximately 1.5 million children ages 5 and younger who had a well-child visit (WCVs) received an oral health assessment during a well-child visit. As seen in Figure 1, this is an increase from 6 percent in 2013.

Oral health assessments at a well-child visit are important because children that receive an oral health assessment are also likely to get other oral health care or utilize a dental preventive encounter.[6] In 2017, 97% of those who had an oral health assessment during a well-child visit also had fluoride applied at that visit; and 25% were identified with a non-traumatic dental condition that was previously undiagnosed. These are increases from 95% and 16%, respectively, in 2013 (Figure 2). The benefits of fluoride varnish administration have been evaluated in peer-reviewed literature with caries inhibiting effectiveness being reported.[11-12] Additionally, earlier diagnosis or findings of dental disease have resulted in children having more preventive visits as they age, experience less dental surgical intervention and lower dentally related costs, as well as, results in better quality of life.[9,13-16]

Figure 1: Medicaid Enrolled Children, Ages 0-5,
Receiving a Oral Health Assessment During a Well-Child Visit

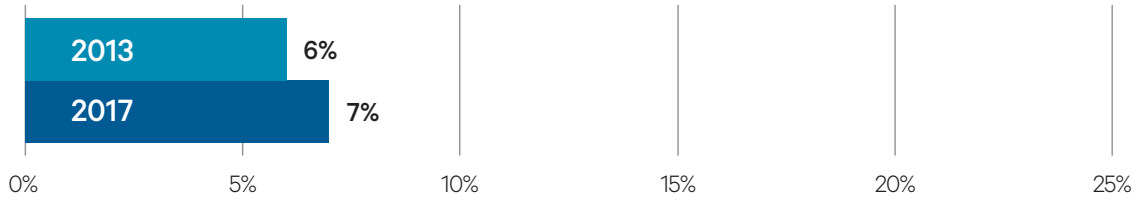
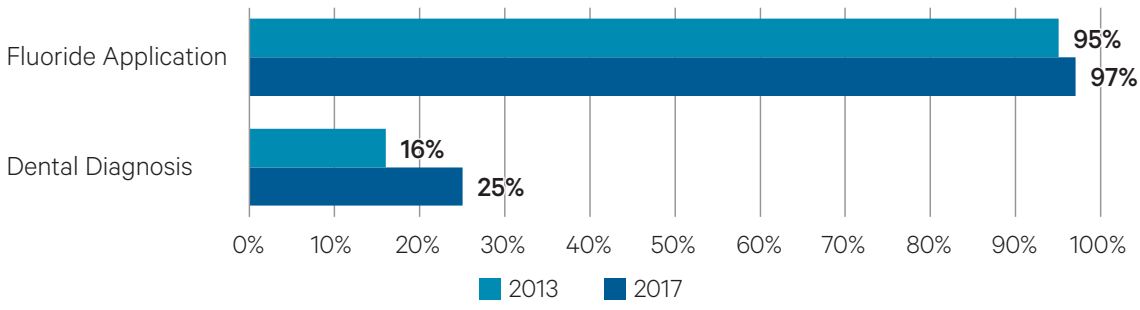


Figure 2: Medicaid Enrolled Children, Ages 0-5,
Receiving Dental Treatment During a Oral Health Assessment at a Well-Child Visit



EVALUATION

The available research, including this brief, observes that WCVs that integrate oral health can expand preventive care and result in earlier intervention, uncover oral health disease, and increase topical fluoride varnish opportunities. However, the overall prevalence of WCVs that include oral health assessments during early well-child medical visits is low. The lower occurrence of integrated appointments can relate to several factors that fragment and stagnate interprofessional practice and the delivery of holistic care. The most common barriers reported include:[2,4,7,17-25]

- lack of interoperable health information technology,
- limited primary medical care curriculum within dental education,
- the capacity of primary and dental care teams,
- limited oral health education during medical and behavioral health training,
- poorly established dental referral and consultative networks for medical teams,
- and a dichotomized financial reimbursement structure between medicine and dentistry.

While challenges persist in bringing together the different disciplines of U.S. healthcare, successful oral health integration and coordination has been reported. Effective interprofessional programs indicate a higher level of functionality and ease of use for electronic health records, dependable referral networks, a data and quality-driven approach to care delivery, understood and shared proprietorship, as well as a policy and financial environment that allows for expanded scope of practice and payment or savings for those preventions and interventions.[1-3,7-9] The limited use of oral health prevention during well-child visits found in this analysis paired with the demonstrated success of interprofessional programs designed to overcome challenges cited in the evidence, emphasize the opportunity for expanded interprofessional efforts. These efforts can lead to better outcomes for all, with better well-being for children and decreased costs for public insurance programs.

METHODOLOGY

Data used in this brief comes from an analysis of the IBM Watson Medicaid Marketscan© database, 2013 and 2017, a representative Medicaid claims database. Well-child visits are coded using ICD-9 codes V202-V203, V700, V705-706, and V708; ICD-10 codes Z00121, Z00129, Z00110-Z00111, Z005, Z0070-Z0071, Z008, Z020-Z026, Z0282, Z0289; and CPT codes 99381-99385, 99391-99395, 99432 99461.

Oral health assessments are captured using ICD-9 codes V722-V732, ICD-10 Codes Z0120-Z0121, and CDT codes D0120-D0160. Fluoride Application is captured using CDT codes D1206 and D1208. Dental diagnoses are captured using ICD-9 codes 5200-5299, 78492, 7924, V523, V534, V585 and ICD-10 codes A690, K000-K149, M260-M279, R6884, R859, Z463-Z464.

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