DEPARTMENT OF HEALTH & SOCIAL SERVICES

PROPOSED CHANGES TO REGULATIONS

MEDICAID DENTAL SERVICES COVERAGE AND PAYMENT

- **7 AAC 110. Medicaid Coverage; Professional Services.**
- **7 AAC 140. Medicaid Coverage; Facility and Facility-Based Services.**
- **7 AAC 145. Medicaid Payment Rates.**
- **7 AAC 160. Medicaid Program; General Provisions.**

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SUPPLEMENTAL NOTICE PUBLIC REVIEW DRAFT
December 21, 2021.

COMMENT PERIOD ENDS: February 7, 2022.

Please see the public notice for details about how to comment on these proposed changes.

7 AAC 110.145 is repealed and readopted to read:

7 AAC 110.145. Dental services for adults. (a) Payment for emergent dental services covered under this subsection does not reduce a recipient's annual limit under (b) and (c) of this section. Except as specifically excluded under (g) of this section, the department will pay for the following emergent dental services identified in the *Fee Schedule: Emergent Adult Dental Services,* adopted by reference in 7 AAC 160.900, for recipients 21 years of age or older, as follows:

(1) the following dental services for the immediate relief of pain or acute infection:

(A) limited oral evaluation not more than two times per fiscal year;

(B) extractions; under this subparagraph,

(i) a claim submitted for up to two extractions in a single day must be accompanied by medical justification; and

(ii) a provider must obtain prior authorization from the department for three or more extractions in a single day or four or more extractions in a 12-month period;

(C) one intraoral periapical radiograph to determine if an extraction is necessary;

(D) anesthesia or sedation in accordance with 7 AAC 110.155 and necessary for dental services covered under this section; a claim submitted to the department for payment of costs for general anesthesia must be accompanied by written medical justification for the service;

(2) a dental service that exceeds a limit established in (b) and (c) of this section if the department determines, based on medical justification submitted with a prior authorization request, that a delay in the provision of the service will endanger the life of the recipient.

(b) Subject to appropriation under AS 47.07.067 and except as specifically excluded under (g) of this section, the department will pay up to $1,150 per state fiscal year for the dental services identified in the *Fee Schedule: Enhanced Adult Dental Services*, adopted by reference in 7 AAC 160.900 and provided to a recipient 21 years of age or older, as follows:

(1) periodic or comprehensive oral evaluation not more than one time per fiscal year, panoramic radiographs not more than one time per a fiscal year and other dental radiographs necessary for dental care;

(2) preventive care, including

(A) prophylaxis, including necessary scaling, polishing, and instructions on oral hygiene and diet, not more than two times per fiscal year; and

(B) topical application of fluoride not more than four times per fiscal year, or topical fluoride varnish not more than four times per fiscal year, or a combination of topical application of fluoride and fluoride varnish not more than four times per fiscal year;

(3) restorative care for the treatment of decayed or fractured teeth, including amalgams and resins, and crowns if the tooth cannot be restored with amalgams or resin; under this paragraph

(A) a claim submitted for up to two crowns in a single day must be accompanied by medical justification;

(B) a provider must obtain prior authorization from the department for three or more crowns in a single day or four or more crowns in a 12-month period;

(C) all surfaces restored on a single tooth on the same day are considered connected therefore payment is limited to one single or multi-surface restoration code per tooth per day;

(D) final restorations are limited to not more than five surfaces per tooth; tooth preparation, temporary restorations, sedative and cement bases, and local anesthesia are considered components of a complete restorative procedure and may not be billed separately; and

(E) the department will provide payment for crowns only upon seatment of the permanent crown, and for partials and dentures only upon seatment of the appliance; the department will not provide partial payment for incomplete or in-progress dental services;

(4) endodontics, with the following limitations:

(A) palliative and sedative treatments may not exceed two times per tooth before a definitive treatment;

(B) as to root canal therapy, tooth preparation, temporary filling of the root canal, and follow-up care are considered components of a complete root canal and may not be billed separately;

(C) a separate claim in addition to a root canal claim may be made for pin retention and restoration, and may not exceed five surfaces per tooth;

(5) periodontics, including treatment of pain or acute infection of supporting tissues of the teeth, including gingivitis, periodontitis, and periodontal abscess;

(6) oral surgery; under this paragraph

(A) prior authorization from the department is required for extractions; and

(B) local anesthesia, materials, and routine postoperative care are considered components of a complete surgical procedure and may not be billed separately;

(7) professional consultation, if medically necessary or if requested by the department.

(c) Prior authorization from the department is required for prosthodontic services. Except as specifically excluded under (g) of this section, the department will pay up to $1,150 per state fiscal year for prosthodontic services provided to a recipient 21 years of age or older, and up to twice the annual limit if one annual limit is not adequate to cover the cost of the provision of upper and lower dentures at the same time. If the department authorizes use of up to twice the annual limit for dentures, the maximum amount authorized is the remaining amount from the current fiscal year and the entire amount allotted for the succeeding fiscal year limit. In the succeeding fiscal year, the department will not authorize a new or additional annual limit. The department will pay for prosthodontic services identified in *Fee Schedule: Prosthodontic Adult Dental* Services, adopted by reference in 7 AAC 160.900, as follows:

(1) a complete denture, maxillary;

(2) a complete denture, mandibular;

(3) a partial denture, maxillary;

(4) a partial denture; mandibular;

(5) replacement of a complete or partial dentures only if the existing denture is unusable and only once per five years, unless the department determines, based on medical justification submitted with the prior authorization request, that a delay will endanger the life of the recipient;

(6) replacement of a partial denture with a complete denture not earlier than five years after payment for the partial denture, unless the department determines, based on medical justification submitted with the prior authorization request, that a delay will endanger the life of the recipient;

(7) a denture within the same dental arch no more than three times per lifetime, unless the department determines, based on medical justification submitted with the prior authorization request, that a delay will endanger the life of the recipient;

(8) adjustments to complete or partial dentures not earlier than six months following the seatment date of the denture and not more than four times per fiscal year;

(9) rebase and reline procedures of a complete or partial denture not earlier than six months following the seatment date of the denture and not more than once per three fiscal years.

(d) The cost of anesthesia or sedation in accordance with 7 AAC 110.155 and necessary for dental services covered under this section does not reduce the recipient’s annual limit described in (b) and (c) of this section.

(e) A dental service provided after a recipient's annual limit under (b) and (c) of this section has been exhausted is considered a noncovered service and the department will not provide payment. Notwithstanding 7 AAC 145.015, a provider may bill a recipient for the difference under (c) of this section if the unused portion of a recipient’s annual limit is less than

the allowable Medicaid payment rate, or under (b) and (c) of this section if the unused portion of the recipient's combined annual limit is less than the allowable Medicaid payment rate. A provider shall inform a recipient in advance of the recipient's obligation to pay for the difference. The provider shall document in the recipient's records that the recipient was informed of and agreed to pay for any balance above the annual limit for the service provided.

(f) The department will assist a provider and recipient to the extent possible in monitoring the recipient's annual limit. However, the department will not assume financial responsibility for dental services provided that exceed the recipient's annual limit.

(g) The department will not pay for the following dental services provided to a recipient 21 years of age or older:

(1) dental services not identified in the *Fee Schedule: Emergent Adult Dental Services*, the *Fee Schedule: Enhanced Adult Dental Services*, and the *Fee Schedule: Prosthodontic Adult Dental Services*, adopted by reference in 7 AAC 160.900;

(2) behavior management;

(3) indirect pulp capping;

(4) endodontic apical surgery and retrograde fillings;

(5) immediate, interim, and temporary dentures;

(6) dental implant and implant-related dental services;

(7) inlays, overlays, and three-fourth crowns;

(8) restoration of etched enamel or deep grooves without obvious dentin involvement;

(9) space maintainers;

(10) tobacco counseling, which is considered a component of periodic and comprehensive evaluations and may not be billed separately;

(11) denture characterization and personalization, and precision attachments;

(12) experimental dental procedures;

(13) local anesthesia, which is considered a component of covered dental procedures and may not be billed separately

(14) anesthesia or sedation in conjunction with a noncovered service or a service for which service limits have been exhausted;

(15) dental sealants;

(16) orthodontic services. (Eff. 2/1/2010, Register 193; am 8/25/2010, Register 195; am 11/1/2010, Register 196; am 5/1/2016, Register 218; am____/____/____, Register____)

Authority: AS 47.05.010 AS 47.07.040 AS 47.07.067

AS 47.07.030

7 AAC 110.150 is repealed and readopted to read:

7 AAC 110.150. Dental services for recipients under 21 years of age. (a) Except as provided in 7 AAC 110.200(3), the department will pay for the services identified in the *Fee Schedule: Dental Services for Children*, adopted by reference in 7 AAC 160.900, as follows, provided to a recipient under 21 years of age:

(1) periodic oral evaluation not more than two times per calendar year, limited oral evaluation not more than two times per calendar year, and comprehensive oral evaluation not more than two times per calendar year; panoramic radiographs not more than one time per calendar year and other dental radiographs as necessary for dental care;

(2) preventive care, as follows:

(A) prophylaxis, limited to necessary scaling, polishing, and instructions on oral hygiene and diet, not more than two times per calendar year;

(B) topical application of fluoride not more than four times per calendar year, or topical fluoride varnish not more than four times per calendar year, or a combination of topical application of fluoride and fluoride varnish not more than four times per calendar year;

(C) sealants, limited to one time per tooth per calendar year; and

(D) space management therapy restricted to posterior teeth; the department will pay for a primary teeth space maintainer only if a significant risk exists of detrimental drifting occurring before the permanent tooth erupts and for a permanent teeth space maintainer only if prosthodontic treatment is not applicable;

(3) restorative care for the treatment of decayed or fractured teeth, including amalgams and resins, and crowns if the tooth cannot be restored with amalgams or resin; under this paragraph

(A) a claim submitted for up to two crowns in a single day must be accompanied by medical justification;

(B) a provider must obtain prior authorization from the department for three or more crowns in a single day or four or more crowns in a 12-month period;

(C) all surfaces restored on a single tooth on the same day are considered connected therefore payment is limited to one single or multi surface restoration code per tooth per day;

(D) final restorations are limited to not more than five surfaces per tooth; tooth preparation, temporary restorations, sedative and cement bases, and local anesthesia are considered components of a complete restorative procedure and may not be billed separately; and

(E) the department will provide payment for crowns only upon seatment of the permanent crown, and for partials and dentures only upon seatment of the appliance; the department will not provide partial payment for incomplete or in-progress dental services;

(4) endodontics, with the following limitations:

(A) palliative and sedative treatments may not exceed two times per tooth before a definitive treatment;

(B) root canal therapy; tooth preparation, filling of the root canal, and follow-up are considered components of a complete root canal and may not be billed separately; and

(C) a separate claim may be made for pin retention and restoration, and may not exceed five surfaces per tooth;

(5) periodontics, including treatment of pain or acute infection of supporting tissues of the teeth, including gingivitis, periodontitis, and periodontal abscess;

(6) prosthodontics including replacement of a complete or partial denture only if the existing denture is unusable and only once per five calendar years;

(7) oral surgery; under this paragraph, the following services are covered:

(A) extractions; under this subparagraph,

(i) a claim submitted for up to two extractions in a single day to alleviate immediate pain or infection must be accompanied by medical justification;

(ii) a provider must obtain prior authorization from the department for three or more extractions in a single day or four or more extractions in a 12-month period to alleviate immediate pain or infection; and

(iii) a provider must obtain prior authorization from the department for an extraction that is required for a reason other than to alleviate immediate pain or infection;

(B) local anesthesia, materials, and routine postoperative care are considered components of a complete surgical procedure and may not be billed separately;

(8) anesthesia and sedation in accordance with 7 AAC 110.155 and necessary for dental services covered under this section;

(9) professional consultation, if medically necessary or if requested by the department.

(b) Except as provided in 7 AAC 110.200(3), the department will not pay for the following dental services for recipients under 21 years of age:

(1) dental services not identified in the *Fee Schedule: Dental Services for Children*, adopted by reference in 7 AAC 160.900;

(2) behavior management in conjunction with any services covered under 7 AAC 110.155;

(3) indirect pulp capping;

(4) endodontic apical surgery and retrograde fillings;

(5) immediate, interim, and temporary dentures;

(6) dental implant and implant-related dental services;

(7) inlays, overlays, and three-fourth crowns;

(8) restoration of etched enamel or deep grooves without obvious dentin involvement;

(9) space maintainers for anterior teeth;

(10) tobacco counseling, which is considered a component of periodic and comprehensive evaluations and may not be billed separately;

(11) denture characterization and personalization, and precision attachments;

(12) experimental dental procedures;

(13) local anesthesia, which is considered a component of covered dental procedures and may not be billed separately;

(14) anesthesia or sedation in conjunction with a noncovered service. (Eff. 2/1/2010, Register 193; am 8/25/2010, Register 195; am 11/1/2010, Register 196; am 5/11/2012, Register 202; am 5/1/2016, Register 218; am____/____/____, Register____)

Authority: AS 47.05.010 AS 47.07.030 AS 47.07.040

7 AAC 110.153 is repealed and readopted to read:

7 AAC 110.153. Orthodontic services. (a) The department will pay a provider for only those orthodontic dental services identified in the *Fee Schedule: Dental Services for Children*, adopted by reference in 7 AAC 160.900, and that have prior authorization form the department.

The department will pay for orthodontic services rendered by an orthodontist who is enrolled in accordance with 7 AAC 110.140, as follows:

(1) limited orthodontic treatment of the primary dentition for a malocclusion that does not involve the entire dentition; the department will pay for limited orthodontic treatment for recipients under 21 years of age; treatment may be directed at the existing problem or at one or more aspects of a larger problem when the decision is made to defer or forego more comprehensive therapy; the prior authorization request must be submitted by the orthodontist and must include

(A) a description of the condition;

(B) a description of the orthodontic appliance;

(C) a scored *Handicapping Labiolingual Deviation (HLD) Index Report*, adopted by reference in 7 AAC 160.900, completed and signed by the orthodontist;

(D) a treatment plan for correcting the condition;

(E) panoramic radiograph;

(F) other medical or dental information to support the requested orthodontic treatment, including required extractions or orthognathic surgery; and

(G) an *Orthodontic Referral Oral Health and Hygiene Assessment*, adopted by reference in 7 AAC 160.900, completed and signed by the referring dentist;

(2) interceptive orthodontic treatment of the primary or transitional dentition to redirect ectopically erupting teeth, correct isolated dental crossbite, or recover minor space loss where overall space for erupting teeth is adequate; the department will pay for interceptive orthodontic treatment for recipients under 13 years of age; the prior authorization request must be submitted by the orthodontist and must include

(A) a description of the condition;

(B) a description of the orthodontic appliance;

(C) a scored *Handicapping Labiolingual Deviation (HLD) Index Report*, adopted by reference in 7 AAC 160.900, completed and signed by the orthodontist;

(D) a treatment plan for correcting the condition;

(E) panoramic radiograph;

(F) other medical or dental information to support the requested orthodontic treatment, including required extractions or orthognathic surgery; and

(G) an *Orthodontic Referral Oral Health and Hygiene Assessment*, adopted by reference in 7 AAC 160.900, completed and signed by the referring dentist;

(3) comprehensive orthodontic procedures for treatment of cleft palate for treatment in conjunction with orthognathic surgery for a class III skeletal malocclusion, for treatment based on medical necessity due to functional impairment, or based on a score of 28 or greater on the *Handicapping Labiolingual Deviation (HLD) Index Report*, adopted by reference in 7 AAC 160.900, and completed by an orthodontist; the department will pay for interceptive orthodontic treatment for recipients under 13 years of age; when requesting approval for orthodontic treatment the provider should consider the recipient's willingness and ability to attend scheduled appointments and ability to maintain an acceptable level of oral hygiene, which is vital to the success of orthodontic treatment; the prior authorization request must be submitted by the orthodontist and must include

(A) a description of the condition including medical information to determine functional impairment;

(B) a description of the orthodontic appliance;

(C) a scored *Handicapping Labiolingual Deviation (HLD) Index Report*, adopted by reference in 7 AAC 160.900, completed and signed by the orthodontist;

(D) a treatment plan for correcting the condition;

(E) panoramic radiographs;

(F) study models, if requested in the process of reviewing the prior authorization; and

(G) an *Orthodontic Referral Oral Health and Hygiene Assessment*, adopted by reference in 7 AAC 160.900, completed and signed by the referring dentist.

(b) If comprehensive orthodontic treatment commences earlier than 18 months after the most recent limited or interceptive orthodontic treatment, reimbursement for the comprehensive orthodontic treatment will be reduced by the amount reimbursed for limited or interceptive orthodontic treatment.

(c) If a recipient's eligibility ends or if the recipient reaches the maximum age for the service before the conclusion of treatment, payment for remaining services is the responsibility of the recipient, or the parent or guardian if the recipient is a minor.

(d) The orthodontist may terminate treatment under (a) of this section prior to completion if the recipient is uncooperative or noncompliant, or if the recipient is no longer eligible for Medicaid. Upon early termination of treatment, the orthodontist shall

(1) report early termination of treatment to the department within 30 days of termination of treatment; and

(2) remove the brackets and, if needed, replace with orthodontic retention.

(e) Except for orthodontic treatment of cleft palate, the department will not pay for services under (a) of this section if the recipient has a history of caries during the six months

before treatment or if the recipient demonstrates oral hygiene inadequate to successfully complete orthodontic services.

(f) Except for orthodontic treatment of cleft palate, the department will not pay for orthodontic treatment under (a)(3) of this section more than one time during the recipient's lifetime. (Eff. 12/1/2010, Register 196; am 5/1/2016, Register 218; am____/____/____, Register____)

Authority: AS 47.05.010 AS 47.07.030 AS 47.07.040

7 AAC 110.155 is repealed and readopted to read:

7 AAC 110.155. Dentist-administered anesthesia and sedation. (a) The department will pay for nitrous oxide sedation, intramuscular sedation, or nonintravenous conscious sedation required for dental services covered under 7 AAC 110.145 – 7 AAC 110.155 if the dental services provider justifies, in writing, that local anesthesia is inadequate to control pain.

(b) The department will pay for general anesthesia or intravenous sedation required for dental services covered under 7 AAC 110.145 – 7 AAC 110.155 if a provider obtains prior authorization from the department. A claim submitted to the department for payment of costs for general anesthesia must be accompanied by written medical justification for the service. Medical justification and prior authorization requests must include documentation substantiating that local anesthesia and sedation under (a) of this section are inadequate to control pain and that the service is required for a patient who meets one of the following conditions:

(1) severe intellectual or developmental disability;

(2) severe physical disability or medically compromised condition;

(3) a prolonged or difficult surgical procedure.

(c) The cost of the supplies necessary for the administration of anesthesia and sedation, including drugs, nitrous oxide masks, tubing, and syringes, are included in the payment made under (a) and (b) of this section. (Eff. 2/1/2010, Register 193; am____/____/____, Register____)

Authority: AS 47.05.010 AS 47.07.030 AS 47.07.040

7 AAC 110.160 is repealed.

7 AAC 110.160. Diagnostic x-ray. Repealed. (Eff. 2/1/2010, Register 193; repealed____/____/____, Register____)

7 AAC 140.105(b) is amended to read:

(b) The department will pay for use of the ambulatory surgical center to perform dental services covered by the department under **7 AAC 110.145 - 7 AAC 110.155** [7 AAC 110.140 - 7 AAC 110.160], if use of the center is medically necessary.

Eff. 2/1/2010, Register 193; am 8/25/2010, Register 195; am____/____/____, Register____)

Authority: AS 47.05.010 AS 47.07.030 AS 47.07.040

7 AAC 140.215(d) is amended to read:

(d) The department will separately pay a health clinic for dental services covered under **7 AAC 110.145 - 7 AAC 110.155** [7 AAC 110.145 - 7 AAC 110.160] provided by a dentist who is enrolled separately under 7 AAC 110.140.

(Eff. 2/1/2010, Register 193; am 10/1/2011, Register 199; am 4/24/2020, Register 234; am____/____/____, Register____)

Authority: AS 47.05.010 AS 47.07.040 AS 47.07.073

AS 47.07.030 AS 47.07.070

7 AAC 145.120 is repealed and readopted to read:

(a) The department will pay a dentist for dental services provided to a recipient 21 years of age or older in accordance with 7 AAC 110.145 and the *Fee Schedule: Emergent Adult Dental Services, Fee Schedule: Prosthodontic Adult Dental Services,* and *Fee Schedule: Enhanced Adult Dental Services*, adopted by reference in 7 AAC 160.900.

(b) Except for orthodontic services, the department will pay a dentist for dental services provided to a recipient under 21 years of age in accordance with 7 AAC 110.150 and the *Fee Schedule: Dental Services for Children,* adopted by reference in 7 AAC 160.900.

(c) The department will pay for orthodontic services in accordance with 7 AAC 110.153 and the *Fee Schedule: Dental Services for Children*, adopted by reference in 7 AAC 160.900.

(d) The department will review dental payment rates at the beginning of each fiscal year and may adjust the rates to reflect changes in the United States Department of Labor consumer price index and after reviewing fee profiles from the most recent calendar year's Medicaid dental claims to determine the need for adjusting payment rates. For state fiscal year 2020, payment rates will not be adjusted by the consumer price index. (Eff. 2/1/2010, Register 193; am 11/1/2010, Register 196; am 1/15/2011, Register 197; am 3/22/2014, Register 209; am 5/1/2016, Register 218; am 7/1/2019, Register 231; am____/____/____, Register____)

Authority: AS 47.05.010 AS 47.07.030 AS 47.07.040

7 AAC 160.900(a)(25) is repealed and readopted to read:

(25) the American Academy of Pediatric Dentistry's *Recommendations for Pediatric Oral Health Assessment, Preventive Services, and Anticipatory Guidance/Counseling*, revised as of 2018;

7 AAC 160.900(a)(26) is repealed and readopted to read:

(26) the American Academy of Pediatric Dentistry's guideline on *Periodicity of Examination, Preventive Dental Services, Anticipatory Guidance/Counseling, and Oral Treatment for Infants, Children, and Adolescents*, revised as of 2018;

7 AAC 160.900(d)(23) is repealed:

(23) repealed____/____/____;

7 AAC 160.900(e)(2) is repealed and readopted to read:

(2) *State Fiscal Year 2022 Fee Schedule: Dental Services for Children*, revised as of July 1, 2021, *State Fiscal Year 2022 Fee Schedule: Emergent Adult Dental Services*, revised as of July 1, 2021, *State Fiscal Year 2022 Fee Schedule: Prosthodontic Adult Dental Services*, revised as of July 1, 2021, and *State Fiscal Year 2022 Fee Schedule: Enhanced Adult Dental Services*, revised as of July 1, 2021;

(Eff. 2/1/2010, Register 193; am 8/25/2010, Register 195; am 12/1/2010, Register 196; am 1/1/2011, Register 196; am 1/15/2011, Register 197; am 2/9/2011, Register 197; am 3/1/2011, Register 197; am 10/1/2011, Register 199; am 12/1/2011, Register 200; am 1/26/2012, Register

201; am 3/8/2012, Register 201; am 4/1/2012, Register 201; add'l am 4/1/2012, Register 201; am 5/11/2012, Register 202; am 10/16/2012, Register 204; am 11/3/2012, Register 204; am 12/1/2012, Register 204; am 12/2/2012, Register 204; am 1/1/2013, Register 204; am 1/16/2013, Register 205; am 7/1/2013, Register 206; add'l am 7/1/2013, Register 206; am 11/3/2013, Register 208; am 1/1/2014, Register 208; am 2/2/2014, Register 209; am 3/19/2014, Register 209; am 3/22/2014, Register 209; am 5/18/2014, Register 210; am 2/26/2015, Register 213; am 3/15/2015, Register 213; am 7/1/2015, Register 214; am 5/1/2016, Register 218; am 6/16/2016, Register 218; am 6/16/2016, Register 218; am 7/22/2017, Register 223; am 11/5/2017, Register 224; am 3/1/2018, Register 225; am 10/1/2018, Register 227; am 1/1/2019, Register 228; am 3/24/2019, Register 229; am 6/2/2019, Register 230; am 6/13/2019, Register 230; am 7/1/2019, Register 231; am 10/25/2019, Register 232; am 11/10/2019, Register 232; am 4/24/2020, Register 234; am 6/25/2020, Register 234; am 10/1/2020, Register 235; am 10/4/2020, Register 236; add'l am 1/1/2021, Register 236 (this regulation originally was filed as an emergency regulation on May 21, 2020; it was adopted as a permanent regulation on September 4, 2020); am____/____/____, Register____)

Authority: AS 47.05.010 AS 47.07.030 AS 47.07.040
AS 47.05.012

Editor's note: The American Academy of Pediatric Dentistry's *Oral Health Policies & Recommendations for Pediatric Oral Health Assessment, Preventive Services, and Anticipatory Guidance/Counseling* can be accessed on the American Academy of Pediatric Dentistry's website at https://www.aapd.org/globalassets/media/policies_guidelines/bp_chart.pdf.

The American Academy of Pediatric Dentistry's guideline on *Periodicity of Examination, Preventive Dental Services, Anticipatory Guidance/Counseling, and Oral Treatment for Infants,*

Children, and Adolescents can be accessed on the American Academy of Pediatric Dentistry's website at https://www.aapd.org/globalassets/media/policies_guidelines/bp_periodicity.pdf .