Commonwealth of Massachusetts
Executive Office of Health and Human Services
Office of Medicaid
www.mass.gov/masshealth

MassHealth
Transmittal Letter ALL-233
December 2020

TO: All Providers Participating in MassHealth

FROM: Daniel Tsai, Assistant Secretary for MassHealth

RE: All Provider Manuals (Updates to Appendix W – Behavioral Health, Medical Schedule, and Dental Schedule)

This letter transmits revisions to Appendix W for MassHealth all provider manuals. The revisions in Appendix W become effective on December 2, 2020.

The Medical and Dental Schedules

With this transmittal letter, MassHealth is highlighting changes to the Medical Schedule and the Dental Schedule in Appendix W. These revisions further align the Medical Schedule with the Bright Futures *Guidelines* and *Periodicity Schedule,* and the Massachusetts Health Quality Partners *Pediatric Preventive Care Guidelines*. The changes also update the Dental Schedule consistent with the *Recommendation for Pediatric Oral Health Assessment, Preventive Services, and Anticipatory Guidance/Counseling* from the American Academy of Pediatric Dentistry.

Behavioral Health Screening

MassHealth includes developmental and behavioral health (mental health and substance use disorder) screens in its list of Early Periodic Screening, Diagnostic, and Treatment (EPSDT) services and Preventive Pediatric Healthcare Screening and Diagnosis (PPHSD) services, in accordance with 130 CMR 450.140 through 450.150.

MassHealth has revised Appendix W (EPSDT Services Medical and Dental Protocols and Periodicity Schedules), which requires providers to choose a clinically appropriate behavioral health screening tool from a menu of approved, standardized tools when conducting a behavioral health screen at a periodic or interperiodic visit.

MassHealth has added three more tools to its list of approved, standardized behavioral health screening tools for children younger than age 21. These tools are

- Ages and Stages Questionnaires, Second Edition (ASQ:SE-2)
- Car, Relax, Alone, Forget, Friends, Trouble 2.1 (CRAFFT 2.1)
- Patient Health Questionnaire-9 Modified for Adolescents (PHQ-9 Modified)

For dates of service through December 2, 2021, providers may use either the ASQ:SE (original) or the ASQ:SE-2 (second edition). For dates of service on or after December 3, 2021, providers should use only the ASQ:SE-2 (second edition).

For dates of service through December 2, 2021, providers may use either the CRAFFT (original) or the CRAFFT 2.1 (updated). For dates of service on or after December 3, 2021, providers should use only the CRAFFT 2.1 (updated).

In addition, due to recent updates to the Survey of Well-being of Young Children (SWYC) that were previously only included in the Survey of Well-being of Young Children-MA (SWYC-MA), MassHealth will be removing the SWYC-MA from the list of approved tools as of December 2, 2021.

For dates of service through December 2, 2021, providers may use either the SWYC or the SWYC-MA. For dates of service on or after December 3, 2021, providers should use only the SWYC.

For more information about the standardized behavioral health screening tools, go to www.mass.gov/masshealth-childrens-behavioral-health-initiative and click "Screening for Behavioral Health Conditions."

Modifiers to CPT Code 96110

Providers who administer behavioral health screenings using one of the tools from the menu of approved behavioral health screening tools must submit a claim using the CPT Code 96110 and the appropriate modifier (U1 or U2).

When the provider submits a claim for 96110 for the administration of the Edinburgh Postnatal Depression Scale (EPDS), the provider must include an additional (second) modifier to the claim. This second modifier is UD.

MassHealth Website

This transmittal letter and attached pages are available on the MassHealth website at www.mass.gov/masshealth-transmittal-letters.
To sign up to receive email alerts when MassHealth issues new transmittal letters and provider bulletins, send a blank email to join-masshealth-provider-pubs@listserv.state.ma.us. No text in the body or subject line is needed.

Questions

If you have questions about the information in this transmittal letter, please contact the MassHealth Customer Service Center at (800) 841-2900, e-mail your inquiry to providersupport@mahealth.net, or fax your inquiry to (617) 988-8974.

NEW MATERIAL
(The pages listed here contain new or revised language.)

All Provider Manuals

Pages W-1 through W-11

OBSOLETE MATERIAL
(The pages listed here are no longer in effect.)

Pages W-1 through W-8 — transmitted by Transmittal Letter ALL-219

Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Medical Protocol and Periodicity Schedule (the Medical Schedule) and EPSDT Dental Protocol and Periodicity Schedule (the Dental Schedule)

I. The Medical Schedule

The EPSDT Medical Protocol and Periodicity Schedule (the Medical Schedule) consists of screening procedures arranged according to the intervals or age levels at which each procedure should be provided. See 130 CMR 450.140 through 450.150 for more information about Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services and Preventive Pediatric Healthcare Screening and Diagnosis (PPHSD) services. This schedule reflects recommended well and preventive child healthcare screening services. If the clinical needs of a child justify deviation from this schedule, the provider must document this fact in the member's medical record, including the provider's clinical judgment and justification for that deviation.

The Medical Schedule reflects guidance from several sources, including, but not limited to:

- The United States **Centers for Disease Control and Prevention** (CDC).
- The **Bright Futures Guidelines** (https://brightfutures.aap.org/materials-and-tools/guidelines-and-pocket-guide/Pages/default.aspx) and the **Bright Futures/American Academy of Pediatrics (AAP) Periodicity Schedule** (https://brightfutures.aap.org/materials-and-tools/Pages/default.aspx).

  The Periodicity Schedule presents recommendations for each age-related visit in the Bright Futures Guidelines, including recommendations for screenings, assessments, physical examinations, and procedures. The Periodicity Schedule is updated between editions of the Bright Futures Guidelines.
- **The Massachusetts Health Quality Partners (MHQP) Pediatric Preventive Care Guidelines** (www.mhqp.org/resources-professionals/clinical-guidelines/pediatric-preventive-care-guidelines/). MHQP is an independent, nonprofit organization that includes healthcare providers, payers, and patients in Massachusetts with the goal of improving patient care in the state of Massachusetts.

I.A. Frequency of Pediatric Preventive Healthcare Visits

Pediatric preventive healthcare visits should contain the components explained in the descriptions in the Medical Schedule and, at a minimum, occur at the following ages:

- newborn;
- three to five days;
  - newborns discharged from the hospital *fewer than 48 hours after delivery* should be evaluated within 48 hours of discharge;
  - newborns discharged from the hospital *48 hours or more after delivery* should be evaluated within 48 to 72 hours after discharge;
- one, two, four, six, and nine months;
- 12, 15, 18, 24, and 30 months; and
- annually from three to 21 years.

I.B. Components of Pediatric Preventive Healthcare Visits

i. HISTORY

Health histories should be taken at each preventive healthcare visit. An initial health history that is taken at a member's first visit with a provider typically is more comprehensive than health histories taken during interval preventive healthcare visits.

Interval history may be obtained according to the concerns of the family and the health care professional's preference or style of practice. History that is relevant to the age-specific health supervision encounter is gathered to assess strengths, accomplish surveillance, and enhance the health care professional's understanding of the child and family and to guide their work together. Past medical history and pertinent family history are important elements of the initial and interval history. Some visits also include relevant social history questions.

Health histories should include age-appropriate history regarding the member, including but not limited to

(a) family history;
(b) birth, growth, and nutrition, and developmental history;
(c) immunization history;
(d) current and past medications, including any alternative or complementary medicine;
(e) medication allergies and other allergies;
(f) medical history, including previous diagnoses, surgeries, and hospitalizations;
(g) review of systems;
(h) risk-taking behaviors, including alcohol, marijuana, tobacco, opiate, and other substance use;
(i) sexual health and development, including sexual activity; and
(j) other medical, psychosocial, and behavioral health concerns.

ii. MEASUREMENTS

- **Length/Height and Weight -** Length/height and weight measurements should be obtained for children aged birth to 21 years at every preventive healthcare visit and plotted using appropriate, standard growth charts such as those available through the CDC.

- **Head Circumference -** Head circumference measurements should be obtained at every preventive healthcare visit from newborn to 24 months and plotted using appropriate, standard growth charts such as those available through the CDC.

c) Weight for Length - Weight for length should be plotted using appropriate, standard growth charts such as those available through the CDC at every preventive healthcare visit from newborn to 18 months.

d) Body Mass Index (BMI) Screen for Obesity - BMI should be plotted using appropriate, standard growth charts such as those available through the CDC or calculated at every preventive healthcare
visit from 24 months to 20 years. Use the WHO Growth Charts for monitoring weight in children ages one to two years.

e) Blood Pressure - Blood pressure measurement should be done at every preventive visit starting at age three. For infants and children with certain chronic conditions (including obesity, sleep-disordered breathing, and those born preterm), blood pressure measurement should be done at preventive visits before age three.

iii. SENSORY SCREENING

a) Vision Screening

For ages 0 to one years old:

- Assess newborn before discharge or at least by age two weeks using red reflex.
- Evaluate fixation preference, alignment, and eye disease by age six months.

For ages one to 17 years old:

- Perform visual acuity test at ages three, four, five, six, eight, 10, 12, 15, and 18 years. Document in medical record if test is performed in another setting such as a school.
- Screen for strabismus between ages three and five years.
- Perform vision screening at entry to kindergarten if not screened during the prior year, as recommended by the Massachusetts Preschool Vision Screening Protocol (www.mass.gov/eohhs/docs/dph/com-health/school/preschool-vision-protocols.pdf).

b) Hearing Screening

For newborns: Confirm initial screen was completed, verify results, and follow up, as appropriate.

For ages three to five days to three months: Verify results of newborn hearing screening, and follow up, as appropriate.

For ages four months to three years: Perform risk assessment for hearing problems at each preventive visit.

For ages four to 10 years: Perform hearing screening at ages four, five, six, eight, and 10 years.

For ages 11 to 21 years: Screen with audiometry including 6,000 and 8,000 Hz high frequencies once between 11 and 14 years, once between 15 and 17 years, and once between 18 and 21 years.

iv. DEVELOPMENTAL / BEHAVIORAL HEALTH

a) Developmental Screening

Ongoing surveillance is supplemented and strengthened by standardized developmental screening tests that may be used at certain visits (i.e., nine months, 18 months, and 30 months) and at other times at which concerns are identified.

If concerns are identified, refer the child to the local Early Intervention Program of the Massachusetts Department of Public Health if they are age 0 to 30 months, and to the local public school system if they are above age 30 months. The Early Intervention Program, the local public school, or both will conduct assessments to determine eligibility and service needs.

b) Autism Spectrum Disorder Screening

Screening using an autism-specific tool should occur at the 18-month and 24-month preventive healthcare visits.

c) Developmental Surveillance

Developmental surveillance should occur at each preventive healthcare visit from newborn to age 21 except at visits when developmental screening is being done. Comprehensive child development surveillance may include

- Eliciting and attending to the parents' concerns;
- Maintaining a developmental history;
- Making accurate and informed observations of the child;
- Identifying the presence of risk and protective factors;
- Periodically using screening tests; and
- Documenting the process and findings.

d) Psychosocial and Behavioral Assessment

Psychosocial and behavioral health assessment should occur at every preventive healthcare visit, including initial and periodic visits, from newborn to 21 years, with standardized behavioral health screening performed if there are concerns. In performing behavioral health screening, providers should use one of the clinically appropriate tools from the following list of standardized behavioral health screening tools:

i. Ages and Stages Questionnaires (ASQ: SE) and the Ages and Stages Questionnaires, Second Edition (ASQ: SE-2);

ii. Brief Infant-Toddler Social and Emotional Assessment (BITSEA);

iii. Car, Relax, Alone, Forget, Friends, Trouble (CRAFFT) and the Car, Relax, Alone, Forget, Friends, Trouble 2.1 (CRAFFT 2.1);

iv. Early Childhood Screening Assessment (ECSA);

v. Edinburgh Postnatal Depression Scale (EPDS);

vi. Modified Checklist for Autism in Toddlers - Revised (M-CHAT-R);

vii. Modified Checklist for Autism in Toddlers - Revised with Follow-up (M-CHAT-R/F);

viii. Parents' Evaluation of Developmental Status (PEDS);

ix. Patient Health Questionnaire-9 (PHQ-9);

x. Patient Health Questionnaire-9 Modified for Adolescents (PHQ-9 Modified);

xi. Pediatric Symptom Checklist (PSC-35), Pediatric Symptom Checklist (PSC-17), and Pediatric Symptom Checklist-Youth Report (PSC-Y);

xii. Strengths and Difficulties Questionnaire (SDQ); and

xiii. Survey of Well-being of Young Children (SWYC) and Survey of Well-being of Young Children–MA (SWYC-MA).

If there is evidence of a psychosocial or behavioral health concern or need for further assessment, the provider should offer the necessary behavioral health services or make a referral to another provider who can provide them. To determine which providers may be available to provide the needed behavioral health services and how to use out-of-network providers, if necessary, contact the MassHealth Customer Service Center at (800) 841-2900 (TTY: (800) 497-4648) or the member's health plan.

Psychosocial and behavioral health assessments should include issues such as food insecurity, domestic violence, substance use, housing situations, and other matters that impact child and family health.

e) Tobacco, Alcohol, and Drug Use Assessment

Risk assessment for tobacco, alcohol, and drug use should be performed at every preventive healthcare visit from 11 years to 21 years.

f) Depression Screening

Screening specifically for depression should occur at every preventive healthcare visit from 12 to 21 years using an appropriate depression screen such as the Patient Health Questionnaire Modified for Adolescents (PHQ-9 Modified), or other tools available in the Guidelines for Adolescent Depression in Primary Care (GLAD-PC) toolkit.

g) Maternal and Caregiver Depression Screening

Screening for maternal and caregiver postpartum depression should occur at one-month, two-month, four-month, and six-month preventive healthcare visits.

v. PHYSICAL EXAMINATION

A physical examination should be performed at every preventive healthcare visit, including initial visits and periodic visits. The components of the physical examination should be age-appropriate. Infants should be completely unclothed and other children undressed, draped, and chaperoned, as indicated. The use of a chaperone should be a shared decision between the patient, the patient's parent or guardian, and physician.

vi. PROCEDURES

a) Newborn Blood Screening

Verify at the newborn or the three- to five- day preventive healthcare visit that all required newborn screenings were performed, especially if the newborn was not born in a hospital setting or was born outside Massachusetts. Verify results and follow up as appropriate. Additional information about the Massachusetts newborn screening program is available from the New England Newborn Screening Program (https://nensp.umassmed.edu/).

b) Newborn Bilirubin Screening

Confirm at the newborn preventive healthcare visit that the initial screening was completed, verify results, and follow up as appropriate.

c) Critical Congenital Heart Defect Screening

Screening for critical congenital heart defect or disease using pulse oximetry should be performed in newborns, after 24 hours of age, before discharge from the hospital. Confirm at the newborn preventive healthcare visit that the screening has been done.

d) Immunization Assessment and Administration

Immunize according to the Massachusetts Department of Public Health's Immunization Program. Immunization status should be assessed at every preventive healthcare visit from newborn to 21 years.

e) Anemia Screening

For ages 0 to one years old: Screen once between age nine and 12 months. At clinician discretion, conduct assessment of infants at high risk for iron deficiency. Consider screening at 15 and 30 months, based on risk factors.

For ages one to 10 years old: Conduct risk assessment or screening, including dietary iron sufficiency, at clinician discretion. Screen those with risk factors annually from ages two to five.

For ages 11 to 21: Conduct risk assessment or screening. Screen all non-pregnant female adolescents for anemia every five to 10 years during well visits starting at age 12. Screen those with known risk factors (i.e., excessive menstrual blood loss, low iron intake, or previous diagnosis of iron deficiency anemia) annually.

f) Lead Exposure Screening

Screen for lead exposure according to the guidance set forth by the Massachusetts Childhood Lead Poisoning Prevention Program (MCLPPP). As described in the MCLPPP's *Changes to the Lead Regulation for Pediatric Healthcare Providers* updated in October 2017 (www.mass.gov/doc/lead-fact-sheet-for-providers-111417-0/download), initial screening is recommended between nine and 12 months and again at two and three years of age. Screen at four years of age if a child lives in a city or town with a high risk for childhood lead exposure. Screen at entry to daycare, preschool, or kindergarten if not screened before.

A list of high-risk communities can be found at www.mass.gov/lists/view-annual-screening-and-blood-lead-level-reports-and-high-risk-community-list and additional information about screening may be found at www.mass.gov/dph/clppp.

Pursuant to M.G.L. c. 111,§ 191 (https://malegislature.gov/Laws/GeneralLaws/PartI/TitleXVI/Chapter111/Section191), physicians, other healthcare providers, and private laboratories must report all cases of childhood lead poisoning known to them to the agency director within three working days of identification, unless previously reported. If a child suffers multiple episodes of lead poisoning, the provider must report each episode.

g) Tuberculosis Assessment and Testing

Risk for tuberculosis should be assessed at the one-month, six-month, 12-month, and 24-month preventive healthcare visit and then annually from three years to 21 years of age. Testing should be performed as indicated by the results of the risk assessment.

h) Dyslipidemia Assessment and Testing

Assess for dyslipidemia risk factors every two years at age two, four, six, and eight, and then annually from age 12 to 16. Screen for dyslipidemia once between age nine and 11, and once between age 17 and 21.

i) Sexually Transmitted Infections (STIs) Assessment and Testing

Assess for risk of sexually transmitted infections annually starting at the 11-year preventive healthcare visit, with screening as indicated by the risk assessment.

j) Human Immunodeficiency Virus (HIV) Assessment and Testing

Assess for risk of human immunodeficiency virus annually starting at the 11-year preventive healthcare visit, and test as indicated by the results of the risk assessment. Adolescents should be tested as least once between the ages of 15 and 18. Those at increased risk of HIV infection, including those who are sexually active, participate in injection drug use, or are being tested for other STIs, should be tested for HIV and reassessed annually.

k) Cervical Dysplasia Screening
Cytology screening for cervical cancer should begin at the 21st year preventive healthcare visit. In compliance with guidance from the U.S. Preventive Services Task Force, human papillomavirus (HPV) testing is not recommended at age 21 (www.uspreventiveservicestaskforce.org/uspstf/recommendation/cervical-cancer-screening).

vii. ORAL HEALTH

By one year of age, it is recommended that every child have a dental home. A dental home is the ongoing relationship between a dentist and a child, inclusive of all aspects of oral health care delivered in a comprehensive, continuously accessible, coordinated, and family-centered way.

More details regarding oral health appear in Section II of this Appendix W, regarding the Dental Schedule. Fluoride varnish and fluoride supplementation are two aspects of oral health that are addressed by both primary care providers and dental providers.

a) Fluoride Varnish
Assess the need for fluoride varnish at all preventive visits from six months to five years old. Once teeth are present, fluoride varnish may be applied to all children every three to six months in the primary care or dental office.

b) Fluoride Supplementation
Assess the need for dietary fluoride supplementation at six months, nine months, 12 months, and then at all preventive visits from 18 months to 16 years old. Dietary fluoride supplements should be considered for children if their primary water source is deficient in fluoride.

viii. ANTICIPATORY GUIDANCE

Anticipatory guidance should be provided at every preventive healthcare visit with discussion topics including, but not be limited to

a) developmental expectations and sound parenting practices;

b) behavioral risks, such as avoidance of the use of alcohol, drugs, tobacco, e-cigarettes (also known as vaping), opiates, cannabis, and other substances;

c) safe environments at home, in school, and in the community, which are free of violence, toxic stress, bullying, and ostracism;

d) mental health, including depression and anxiety, based on risk factors and individual patient presentation in adolescence;

e) academic or behavioral problems that may be signs of attention deficit hyperactivity disorder (ADHD);

f) safe and healthy sexual behaviors, including abstinence and contraception, with sensitivity to sexual orientation and gender identity;

g) benefits and components of a healthy diet and safe weight management, ways to maintain adequate calcium and vitamin D, and counseling against sugar-sweetened and caffeinated drinks;

h) benefits of daily physical activity, opportunities for daily physical activity, and parents as role models;

i) healthy sleep habits and encouraging proper sleep amounts and safe sleep practices, including placing infants on their backs when putting them to sleep, avoiding co-sleeping, and use of a firm sleep surface without soft bedding or toys;

j) impact of electronic media as a risk factor for being overweight, low school performance, and violent behavior. Encourage limiting of screen time. Discourage placement of computers and TVs in bedrooms;

k) safety related to online activity, social networking, and use of smartphones and other handheld devices;

l) chronic and communicable disease prevention;

m) safety measures and injury prevention, including childproofing, car seats and seat belts, bike and motorcycle helmets, poison prevention, firearm safety, and other age-appropriate counseling;

n) skin protection, including using sunscreen, minimizing exposure to the sun, and discouraging use of indoor tanning;

o) potential risks of body piercing and tattooing;

p) nutrition, which primary care providers may assess and promote by doing the following:

i. Ask about dietary habits;

ii. Promote breastfeeding as the best form of infant nutrition and assess breastfed infants between two and five days of age;

iii. Starting in middle childhood, screen annually for eating disorders and ask about body image and dieting patters; and

iv. Make every effort to inform a potentially eligible member or the parent or guardian about the Women, Infants, and Children (WIC) nutrition program. A referral to WIC should be made using the WIC Medical Referral Form (MRF) from the Massachusetts WIC Program. In addition, the member, parent, or guardian may also be referred to the Supplemental Nutrition Assistance Program (SNAP), which is administered by the Department of Transitional Assistance.

II. The Dental Schedule

The EPSDT Dental Protocol and Periodicity Schedule (the Dental Schedule) consists of procedures arranged according to the intervals or age levels at which each procedure is to be provided. The Dental Schedule is based on the *Recommendations for Pediatric Oral Health Assessment, Preventive Services, and Anticipatory Guidance/Counseling* from the American Academy of Pediatric Dentistry (AAPD) Reference Manual 2019-2020. See 130 CMR 450.140 through 450.150 for more information about Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services and Preventive Pediatric Healthcare Screening and Diagnosis (PPHSD) services. This schedule reflects recommended well and preventive child healthcare screening services. If the clinical needs of a child justify deviation from this schedule, the provider must document this fact in the member's dental record, including the provider's clinical judgment and justification for that deviation.

II.A. Dental Schedule Table

The Dental Schedule is included in the following table. Explanations of each component are included in section II.B.

	6 – 12 Months	12 -24 Months	2 - 6 Years	6 - 12 Years	12 - 20 Years
Clinical oral examination (1)	x	x	x	x	x
Assessment of oral growth and development (2)	x	x	x	x	x
Caries-risk assessment (3)	x	x	x	x	x
Radiograph assessment (4)			x	x	x
Prophylaxis and topical fluoride (5)	x	x	x	x	x
Fluoride supplementation (6)	x	x	x	x	x
Fluoride varnish (7)	x	x	x	x	x
Anticipatory guidance/ counseling (8)	x	x	x	x	x
Oral hygiene counseling (9)	Parent	Parent	Patient/parent	Patient/parent	Patient
Dietary counseling (10)	Parent	Parent	Patient/Parent	Patient/Parent	Patient
Injury prevention counseling (11)	x	x	x	x	x
Counseling for nonnutritive habits (12)	x	x	x	x	x
Pit and fissure sealants (13)			x	x	x
Counseling for speech/language development (14)	x	x	x		
Tobacco control education Substance abuse screening (15)				x	x
Screening for intraoral/perioral piercing (16)				x	x
Assessment and treatment of developing malocclusion (17)			x	x	x
Assessment and/or removal of third molars (18)					x
Transition to adult dental care (19)					x

II.B. Explanations of the Dental Schedule Table

The explanations in this section are numbered and align with the numbers that appear in the Dental Schedule Table in section II.A.

1. The first clinical oral examination should occur at the eruption of the first tooth and no later than 12 months of age. Clinical examinations should take place every six months or as indicated by the child's risk status and susceptibility to disease. The clinical examination includes assessment of all hard and soft tissues, as well as pathology and injuries.
2. Oral growth and development are assessed by clinical examination.
3. Caries risk assessment should be repeated during each clinical examination to monitor changes in risk status.
4. Radiographic assessments are an important component of the clinical assessment. Timing, selection, and frequency are determined by child's history, clinical findings, and susceptibility to oral disease and in compliance with FDA guidance (www.fda.gov/radiation-emitting-products/medical-x-ray-imaging/selection-patients-dental-radiographic-examinations).
5. Prophylaxis and fluoride treatments are important preventive measures. Prophylaxis and fluoride treatments should be a component of the periodic examination and assessment process.
6. Evaluate when systemic fluoride exposure is suboptimal or fluoride supplementation is otherwise indicated by guidance of the American Academy of Pediatric Dentistry and the Bright Futures Periodicity schedule. See list of Massachusetts fluoridated communities at www.mass.gov/files/documents/2016/07/xv/fluoride-census.pdf.
7. Fluoride Varnish - Once teeth are present, fluoride varnish may be applied every three to six months in the dental office or primary care setting (https://pediatrics.aappublications.org/content/pediatrics/134/3/626.full.pdf).
8. Anticipatory guidance is an integral component of the initial comprehensive exam and each subsequent exam.
9. Oral hygiene instruction should be provided to parents of young children. Age-appropriate instruction should be provided to the child throughout childhood and adolescence.
10. Dietary counseling is an integral component of each dental visit. For very young children, this should include a discussion of appropriate feeding practices and prevention of early childhood caries. By age one, the counseling should include the role of refined carbohydrates and frequency of snacking in caries development and childhood obesity.
11. Injury prevention counseling should initially include information about play objects, pacifiers, and car seats for infants. As the child nears age one, counseling should include learning to walk, sports, and routine playing, and the importance of mouth guards.
12. Counseling related to non-nutritive sucking habits should include information about the need for additional sucking (e.g. pacifiers). As the child grows, counseling should include the need to wean from the sucking habit before malocclusion or skeletal dysplasia occurs. For school-aged children and adolescent patients, counseling should include any existing habits such as fingernail biting, clenching, or bruxism.

13. For caries-susceptible primary molars, permanent molars, premolars, and anterior teeth with deep pits and fissures; dental sealants should be placed as soon as possible after eruption. Sealants are an essential component of preventive dental care.
14. Appropriate referrals for speech and language development should be made at age-appropriate intervals.
15. Education regarding prevention of tobacco use and substance abuse should begin as early as age six according to the National Cancer Institute and American Dental Association.
16. The oral health consequences of oral piercings should be discussed with pre-adolescents and adolescents.
17. Assessment and treatment of developing malocclusion should begin in the two- to six-year age range and referrals made to an orthodontist as indicated by the patient's needs.
18. Third molars erupt between ages 17-20. Clinical and radiographic evaluation of eruption pattern of third molars should begin at age 16 and assessments made for impactions and interference with periodontal health of adjacent teeth. A decision regarding extraction of third molars should occur after all four third molars are erupted, or radiographic assessment indicates impaction.
19. Transition to adult dental care should occur before the 21st birthday of the child.