

# Policy on Medically-Necessary Care

## Review Council

Council on Clinical Affairs

## Latest Revision

2015

### Purpose

The American Academy of Pediatric Dentistry (AAPD) recognizes that dental care is medically-necessary for the purpose of preventing and eliminating orofacial disease, infection, and pain, restoring the form and function of the dentition, and correcting facial disfiguration or dysfunction.

### Methods

This document was developed by the Council on Clinical Affairs and adopted in 2007. This document is an update from the last revision in 2014. It includes an electronic search with Scopus® and PubMed®/MEDLINE using the terms: medically-necessary care, systemic disease and oral disease, dentistry as medically-necessary care, periodontal disease and cardiovascular disease, oral health and pregnancy, oral health and respiratory illness, pediatric dentistry general anesthesia, and nutritional deficiency cognitive development; fields: all; limits: within the last 15 years, human, English. The reviewers agreed upon the inclusion of 59 articles that met the defined criteria. When data did not appear sufficient or were inconclusive, recommendations were based upon expert and/or consensus opinion by experienced researchers and clinicians.

### Background

The AAPD defines medically-necessary care (MNC) as “the reasonable and essential diagnostic, preventive, and treatment services (including supplies, appliances, and devices) and follow-up care as determined by qualified health care providers in treating any condition, disease, injury, or congenital or developmental malformation to promote optimal health, growth, and development. MNC includes all supportive health care services that, in the judgment of the attending dentist, are necessary for the provision of optimal quality therapeutic and preventive oral care. These services include, but are not limited to, sedation, general anesthesia, and utilization of surgical facilities. MNC must take into account the patient’s age, developmental status, and psychosocial well-being, in addition to the clinical setting appropriate to meet the needs of the patient and family.”<sup>1</sup>

MNC is based upon current preventive and therapeutic practice guidelines formulated by professional organizations with recognized clinical expertise. Such recommendations ideally are evidence based but, in the absence of conclusive evidence, may rely on expert opinion and clinical observations.

Expected benefits of care should outweigh potential risks. MNC increases the probability of good health and well-being and decreases the likelihood of an unfavorable outcome. Value of services is an important consideration, and all stakeholders should recognize that cost-effective care is not necessarily the least expensive treatment.<sup>2</sup>

Dental care is medically-necessary to prevent and eliminate orofacial disease, infection, and pain, to restore the form and function of the dentition, and to correct facial disfiguration or dysfunction. Following the U.S. Surgeon General’s report<sup>3</sup> emphasizing that oral health is integral to general health, the U.S. Department of Health and Human Services recommended changing perceptions of the public, policy makers, and healthcare providers so that oral health becomes an accepted component of general health.<sup>4,5</sup> Oral diseases can have a direct and devastating impact on overall health, especially for those with certain systemic health problems or conditions.

Caries is the most common chronic disease of childhood.<sup>3</sup> Approximately 60 percent of children experience caries in their primary teeth by age five.<sup>6</sup> Between 1988-1994 and 1999-2004, prevalence of caries in primary teeth increased for youths aged two to 11 years, with a significant increase noted for those in the two to five year age range.<sup>7</sup> By 17 years of age, 78 percent of children in the U.S. have experienced caries.<sup>5</sup> As much as 90 percent of all caries in school-aged children occurs in pits and fissures. Caries, periodontal diseases, and other oral conditions, if left untreated, can lead to pain, infection, and loss of function. These undesirable outcomes can adversely affect learning, communication, nutrition, and other activities necessary for normal growth and development.<sup>8</sup> Rampant caries is associated with insufficient development in children who have no other medical problems.<sup>9</sup> Children with early childhood caries (ECC) may be severely underweight because of the associated pain and disinclination to eat. Nutritional deficiencies during childhood can impact cognitive development.<sup>10</sup>

Other oral conditions also can impact general health and well-being. Gingivitis is nearly universal in children and

#### ABBREVIATIONS

**AAPD:** American Academy Pediatric Dentistry. **CC:** Chronic condition. **ECC:** Early childhood caries. **MNC:** Medically-necessary care.

adolescents, and children can develop severe forms of periodontitis.<sup>11</sup> There exists a relationship between periodontal disease and cardiovascular disease<sup>12,13</sup> as well as periodontal disease and adverse pregnancy outcomes.<sup>14,15</sup> An association between oral health and respiratory diseases has been recognized.<sup>16,17</sup> Oral health, oral microflora, and bacterial pneumonia, especially in populations at high risk for respiratory disease, have been linked. The mouth can harbor respiratory pathogens that may be aspirated, resulting in airway infections.<sup>17</sup> Problems of esthetics, form, and function can affect the developing psyche of children, with life-long consequences in social, educational, and occupational environments.<sup>18</sup> Self-image, self-esteem, and self-confidence are unavoidable issues in society, and an acceptable orofacial presentation is a necessary component of these psychological concepts.<sup>19</sup>

Congenital or acquired orofacial anomalies (e.g., ectodermal dysplasia, cleft defects, cysts, tumors) and malformed or missing teeth can have significant negative functional, esthetic, and psychological effects on individuals and their families.<sup>20,21</sup> Patients with craniofacial anomalies often require specialized oral health care as a direct result of their craniofacial condition. These services are an integral part of the rehabilitative process.<sup>20</sup> Young children benefit from esthetic and functional restorative or surgical techniques and readily adapt to appliances that replace missing teeth and improve function, appearance, and self-image. During the period of facial and oral growth, appliances require frequent adjustment and have to be remade as the individual grows.

Professional care is necessary to maintain oral health,<sup>3,4</sup> and risk assessment is an integral element of contemporary preventive care for infants, children, adolescents, and persons with special health care needs.<sup>22</sup> The goal of caries risk assessment is to prevent disease by identifying and minimizing causative factors (e.g., microbial burden, dietary habits, dental morphology) and optimizing protective factors (e.g., fluoride exposure, personal oral hygiene, sealants).<sup>23,24</sup> Ideally, risk assessment and implementation of preventive strategies would occur before the disease process has been initiated.

Infants and young children have unique caries-risk factors such as ongoing establishment of oral flora and host defense systems, susceptibility of newly erupted teeth, and development of dietary habits and childhood food preferences. Children are most likely to develop caries if mutans streptococci is acquired at an early age.<sup>25</sup> High-risk dietary practices appear to be established early, probably by 12 months of age, and are maintained throughout early childhood.<sup>26</sup> Adolescence can be a time of heightened caries activity and periodontal disease due to an increased intake of cariogenic substances and inattention to oral hygiene procedures.<sup>27-29</sup>

An analysis of caries risk includes determination of protective factors, such as fluoride exposure. More than one-third of the U.S. population does not benefit from community water fluoridation.<sup>3</sup> Fluoride contributes to the prevention, inhibition, and reversal of caries.<sup>30</sup> Therefore, early determination of a child's systemic and topical fluoride exposure is important. Children experiencing caries as infants and toddlers have a

much greater probability of subsequent caries in both the primary and permanent dentitions.<sup>10</sup> An individualized preventive plan based on a caries risk assessment is the key component of caries prevention. Because any risk assessment tool may fail to identify all infants at risk for developing ECC, early establishment of the dental home is the ideal approach for disease prevention.<sup>31</sup> Early diagnosis and timely intervention, including necessary referrals, can prevent the need for more extensive and expensive care often required when problems have gone unrecognized and/or untreated.<sup>32</sup>

When very young children have not been the beneficiaries of adequate preventive care and subsequently develop ECC, therapeutic intervention should be provided by a practitioner with the training, experience, and expertise to manage both the child and the disease process. Because of the aggressive nature of ECC, restorative treatment should be definitive yet specific for each individual patient. Conventional restorative approaches may not arrest the disease.<sup>33</sup> Areas of demineralization and hypoplasia can cavitate rapidly. The placement of stainless steel crowns may be necessary to decrease the number of tooth surfaces at risk for new or secondary caries. Stainless steel crowns are less likely than other restorations to require retreatment.<sup>34,35</sup> Low levels of compliance with follow-up care and a high recidivism rate of children requiring additional treatment also can influence a practitioner's decisions for management of ECC.<sup>36</sup>

Sealants are particularly effective in preventing pit and fissure caries and providing cost savings if placed on the teeth of patients during periods of greatest risk.<sup>37</sup> Children with multiple risk factors and tooth morphology predisposed to plaque retention (i.e., developmental defects, pits and fissures) benefit from having such teeth sealed prophylactically. A child who receives sealants is 72 percent less likely to receive restorative services over the next three years than children who do not.<sup>38</sup> Sealants placement on primary molars in young children is a cost-effective strategy for children at risk for caries, including those insured by state Medicaid programs.<sup>39</sup> Although sealant retention rates initially are high, sealant loss does occur.<sup>40</sup> It is in the patient's interest to receive periodic evaluation of sealants. With follow-up care, the success rate of sealants may be 80 to 90 percent, even after a decade.<sup>40</sup>

Sealants are safe and effective, yet their use continues to be low.<sup>40</sup> Initial insurance coverage for sealants often is denied, and insurance coverage for repair and/or replacement may be limited.<sup>41,42</sup> While all Medicaid programs reimburse dentists for placement of sealants on permanent teeth, only one in three reimburses for primary molar sealants.<sup>43</sup> While some third party carriers restrict reimbursement for sealants to patients of certain ages, it is important to consider that timing of dental eruption can vary widely. Furthermore, caries risk may increase at any time during a patient's life due to changes in habits (e.g., dietary, home care), oral microflora, or physical condition, and previously unsealed teeth subsequently might benefit from sealant application.<sup>40</sup>

The extent of the disease process, as well as the patient's developmental level and comprehension skills, affect the

practitioner's behavior guidance approaches. The success of restorations may be influenced by the child's response to the chosen behavior guidance technique. To perform treatment safely, effectively, and efficiently, the practitioner caring for a pediatric patient may employ advanced behavior guidance techniques such as protective stabilization and/or sedation or general anesthesia.<sup>44</sup> The patient's age, dental needs, disabilities, medical conditions, and/or acute situational anxiety may preclude the patient's being treated safely in a traditional outpatient setting.<sup>45</sup> For some infants, children, adolescents, and persons with special health care needs, treatment under sedation or general anesthesia in a hospital, outpatient facility, or dental office or clinic represents the only appropriate method to deliver necessary oral health care.<sup>44,46</sup> The impact of chronic conditions (CC) status and CC severity increases the odds of receiving dental treatment under general anesthesia.<sup>47</sup> Although general anesthesia may provide optimal conditions to perform restorative procedures, it can add significantly to the cost of care. General anesthesia, under certain circumstances, may offer a cost-saving alternative to sedation for children with ECC.<sup>48,49</sup>

Reimbursement issues defined by the concept of MNC have been a complicated topic for dentistry. Pediatric dental patients may be denied access to oral health care when insurance companies refuse to provide reimbursement for sedation/general anesthesia and related facility services. Most denials cite the procedure as "not medically-necessary". This determination appears to be based on arbitrary and inconsistent criteria.<sup>50-55</sup> For instance, medical policies often provide reimbursement for sedation/general anesthesia or facility fees related to myringotomy for a three-year-old child, but deny these benefits when related to treatment of dental disease and/or dental infection for the same patient. American Dental Association Resolution 1989-546 states that insurance companies should not deny benefits that would otherwise be payable "solely on the basis of the professional degree and licensure of the dentist or physician providing treatment, if that treatment is provided by a legally qualified dentist or physician operating within the scope of his or her training and licensure."<sup>55</sup>

Patients with craniofacial anomalies often are denied third party coverage for initial appliance construction and, more frequently, replacement of appliances as the child grows. The distinction between congenital anomalies involving the orofacial complex and those involving other parts of the body is often arbitrary and unfair. For instance, health care policies may provide reimbursement for the prosthesis required for a congenitally missing extremity and its replacement as the individual grows, but deny benefits for the initial prosthesis and necessary periodic replacement for congenitally missing teeth. Third-party payors frequently will refuse to pay for oral health care services even when they clearly are associated with the complete rehabilitation of the craniofacial condition.<sup>56,57</sup>

## Policy statement

Dental care is medically-necessary to prevent and eliminate

orofacial disease, infection, and pain, to restore the form and function of the dentition, and to correct facial disfiguration or dysfunction. MNC is based upon current preventive and therapeutic practice guidelines formulated by professional organizations with recognized clinical expertise. Expected benefits of MNC outweigh potential risks of treatment or no treatment. Early detection and management of oral conditions can improve a child's oral health, general health and well-being, school readiness, and self-esteem. Early recognition, prevention, and intervention could result in savings of health care dollars for individuals, community health care programs, and third party payors. Because a child's risk for developing dental disease can change over time, continual professional reevaluation and preventive maintenance are essential for good oral health. Value of services is an important consideration, and all stakeholders should recognize that cost-effective care is not necessarily the least expensive treatment.

The AAPD encourages:

1. Oral health care to be included in the design and provision of individual and community-based health care programs to achieve comprehensive health care.
2. Establishment of a dental home for all children by 12 months of age in order to institute an individualized preventive oral health program based upon each patient's unique caries risk assessment.
3. Healthcare providers who diagnose oral disease to either provide therapy or refer the patient to a primary care dentist or dental/medical specialist as dictated by the nature and complexity of the condition. Immediate intervention is necessary to prevent further dental destruction, as well as more widespread health problems.
4. Evaluation and care provided for an infant, child, or adolescent by a cleft lip/palate, orofacial, or craniofacial deformities team as the optimal way to coordinate and deliver such complex services.
5. The dentist providing oral health care for a patient to determine the medical indication and justification for treatment. The dental care provider must assess the patient's developmental level and comprehension skills, as well as the extent of the disease process, to determine the need for advanced behavior guidance techniques such as sedation or general anesthesia.

Furthermore, the AAPD encourages third party payors to:

1. Recognize malformed and missing teeth are resultant anomalies of facial development seen in orofacial anomalies and may be from congenital defects. Just as the congenital absence of other body parts requires care over the lifetime of the patient, so will these.
2. Include oral health care services related to these facial and dental anomalies as benefits of health insurance without discrimination between the medical and dental nature of the congenital defect. These services, optimally provided by the craniofacial team, include, but are not limited to, initial appliance construction, periodic examinations, and replacement of appliances.

3. End arbitrary and unfair refusal of compensation for oral health care services related to orofacial and dental anomalies.
4. Recognize the oral health benefits of dental sealants and not base coverage for sealants on permanent and primary teeth on a patient's age.
5. Ensure that all children have access to the full range of oral health delivery systems. If sedation or general anesthesia and related facility fees are payable benefits of a health care plan, these same benefits shall apply for the delivery of oral health services.
6. Regularly consult the AAPD with respect to the development of benefit plans that best serve the oral health interests of infants, children, adolescents, and persons with special health care needs, especially those with craniofacial or acquired orofacial anomalies.

## References

1. American Academy of Pediatric Dentistry. Definition of medically-necessary care. *Pediatr Dent* 2015;37(special issue):15.
2. American Academy of Pediatrics. Policy statement: Model contractual language for medical necessity for children. *Pediatrics* 2005;116(1):261-2.
3. U.S. Department of Health and Human Services. Oral Health in America: A Report of the Surgeon General. Rockville, Md.: U.S. Department of Health and Human Services, National Institute of Dental and Craniofacial Research, National Institutes of Health; 2000.
4. Institute of Medicine, National Research Council. Improving Access to Oral Health Care for Vulnerable and Underserved Populations. Washington, D.C.: The National Academies Press; 2011. Available at: "[http://books.nap.edu/openbook.php?record\\_id=13116](http://books.nap.edu/openbook.php?record_id=13116)". Accessed June 12, 2015.
5. U.S. Department of Health and Human Services. National Call to Action to Promote Oral Health. Rockville, Md.: U.S. Department of Health and Human Services, Public Health Service, National Institute of Health, National Institute of Dental and Craniofacial Research; NIH Publication No. 03-5303, May, 2003.
6. Crall JJ. Development and integration of oral health services for preschool-age children. *Pediatr Dent* 2005; 27(4):323-30.
7. Dye BA, Tan S, Smith V, et al. Trends in oral health status: United States, 1988-1994 and 1999-2004. *National Center for Health Statistics. Vital Health Stat* 11(248). Hyattsville, Md.; 2007.
8. American Academy of Pediatric Dentistry. Definition of dental neglect. *Pediatr Dent* 2015;37(special issue):13.
9. Acs G, Lodolini G, Kaminsky S, Cisneros GJ. Effect of nursing caries on body weight in a pediatric population. *Pediatr Dent* 1992;14(5):302-5.
10. Nyaradi A, Li J, Hickling S, Foster J, Oddy WH. The role of nutrition in children's neurocognitive development, from pregnancy through childhood. *Front Hum Neurosci* 2013;7:97. Available at: "<http://ncbi.nlm.nih.gov/pmc/articles/PMC3607807>". Accessed June 12, 2015.
11. American Academy of Periodontology. Periodontal diseases of children and adolescents. *J Periodontol* 2003; 74(11):1696-704.
12. Geismar K, Stoltze K, Sigurd B, Gyntelberg F, Holmstrup P. Periodontal disease and coronary heart disease. *J Periodontol* 2006;77(9):1547-54.
13. Demmer RT, Desvarieux M. Periodontal infections and cardiovascular disease: The heart of the matter. *J Am Dent Assoc* 2006;137(suppl):14-20.
14. Bobetsis YA, Barros SP, Offenbacher S. Exploring the relationship between periodontal disease and pregnancy complications. *J Am Dent Assoc* 2006;137(suppl):7-13.
15. Muerman JH, Furuholm J, Kaaja R, Rintamaki H, Tikkanen U. Oral health in women with pregnancy and delivery complications. *Clin Oral Investig* 2006;10(2):96-101.
16. Azarpazhooh A, Leake JL. Systematic review of the association between respiratory diseases and oral health. *J Periodontol* 2006;77(9):1465-82.
17. Scannapieco FA. Pneumonia in non-ambulatory patients: The role of oral bacteria and oral hygiene. *J Am Dent Assoc* 2006;137(suppl):21-5.
18. de Paula DF, Santos NC, daSilva ET, Nunes MF, Leles CR. Psychosocial impact of dental esthetics on quality of life in adolescents. *Angle Orthod* 2009;79(6):1188-93.
19. Zhang M, McGrath C, Hägg U. Impact of malocclusion and its treatment on quality of life: A literature review. *Int J Paediatr Dent* 2006;16(6):381-7.
20. American Cleft Palate-Craniofacial Association. Parameters for evaluation and treatment of patients with cleft lip/palate or other craniofacial anomalies. Revised ed. Chapel Hill, N.C.: American Cleft Palate-Craniofacial Association; November 2007.
21. National Foundation for Ectodermal Dysplasias. Parameters of oral health care for individuals affected by ectodermal dysplasias. National Foundation for Ectodermal Dysplasias. Mascoutah, Ill.; 2003:9.
22. American Academy of Pediatric Dentistry. Guideline on caries risk assessment and management for infants, children, and adolescents. *Pediatr Dent* 2015;37(special issue):132-9.
23. Fontana M, Zero DT. Assessing patients' caries risk. *J Am Dent Assoc* 2006;37(9):1231-9.
24. Milgrom P, Chi DL. Prevention-centered caries management strategies during critical periods in early childhood. *J Calif Dent Assoc* 2011;39(10):735-41.
25. Harris R, Nicoll AD, Adair PM, Pine CM. Risk factors for dental caries in young children: A systematic review of the literature. *Community Dent Health* 2004;21 (suppl 1):71-85.
26. Douglass JM. Response to Tinanoff and Palmer: Dietary determinants of dental caries and dietary recommendations for preschool children. *J Public Health Dent* 2000; 60(3):207-9.

27. American Psychological Association. *Developing adolescents: A reference for professionals*. Washington, D.C.: American Psychological Association; 2002.
28. Kawamura M, Takase N, Sasahara H, Okada M. Teenagers oral health attitudes and behavior in Japan: Comparison by sex and age group. *J Oral Science* 2008;50(2):167-74.
29. Källestål C, Dahlgren L, Stenlund H. Oral health behavior and self esteem in Swedish adolescents over four years. *J Adolesc Health* 2006;38(5):583-90.
30. CDC. Recommendations for using fluoride to prevent and control dental caries in the United States. *MMWR Recomm Rep* 2001;50(RR14):1-42.
31. American Academy of Pediatric Dentistry. Guideline on infant oral health care. *Pediatr Dent* 2015;37(special issue):146-50.
32. Lee LJ, Bouwens TJ, Savage MF, Vann WF Jr. Examining the cost-effectiveness of early dental visits. *Pediatr Dent* 2006;28(2):102-5, discussion 192-8.
33. Randall RC, Vrijhoef MMA, Wilson NHF. Efficacy of preformed metal crowns vs amalgam restorations in primary molars: A systematic review. *J Am Dent Assoc* 2000;131(3):337-43.
34. Foster T, Perinpanayagam H, Pfaffenbach A, Certo M. Recurrence of early childhood caries after comprehensive treatment with general anesthesia and follow-up. *J Dent Child* 2006;73(1):25-30.
35. Eidelman E, Faibis S, Peretz B. A comparison of restorations for children with early childhood caries treated under general anesthesia or conscious sedation. *Pediatr Dent* 2000;22(1):33-7.
36. Almeida AG, Roseman MM, Sheff M, Huntington N, Hughes CV. Future caries susceptibility in children with early childhood caries following treatment under general anesthesia. *Pediatr Dent* 2000;22(4):302-6.
37. Weintraub JA. Pit and fissure sealants in high-caries risk individuals. *J Dent Educ* 2001;65(10):1084-90.
38. Anderson M. Risk assessment and epidemiology of dental caries: Review of the literature. *Pediatr Dent* 2002;24(5):377-85.
39. Chi DL, van der Goes D, Ney JP. Cost-effectiveness of pit-and-fissure sealants on primary molars in Medicaid-enrolled children. *Am J Public Health* 2014;104(3):555-61.
40. Feigl RJ. The use of pit and fissure sealants. *Pediatr Dent* 2002;24(5):415-22.
41. American Dental Association. Statement on preventive coverage in dental benefits plans (1992:602; 1994:656; 2013:XXX). In: *ADA Current Policies*, 2013. Chicago, Ill.; 2014. Available at: "<http://www.ada.org/-/media/ADA/Member%20Center/Files/2013%20Current%20Policies%20Final.ashx>". Accessed August 9, 2015.
42. American Dental Association Council on Access, Prevention, and Interprofessional Relations, American Dental Association Council on Scientific Affairs. Dental sealants. *J Am Dent Assoc* 1997;128(4):485-8.
43. Singh JA, Chi DL. Primary tooth pit and fissure sealant reimbursement rates within state Medicaid programs. *J Dent Res* 2013;92(Special issue A):741.
44. U.S. Department of Health and Human Services. *Healthy people 2010*. Rockville, Md.: U.S. Department of Health and Human Services, National Institutes of Health; 2000.
45. American Academy of Pediatric Dentistry. Guideline on behavior guidance for the pediatric dental patient. *Pediatr Dent* 2015;37(special issue):180-93.
46. Nelson T, Nelson G. The role of sedation in contemporary pediatric dentistry. *Dent Clin North Am* 2013;57(1):145-61.
47. Chi DL, Momany ET, Neff J, et al. Impact of chronic condition status and severity on dental treatment under general anesthesia for Medicaid-enrolled children in Iowa state. *Paediatr Anaesth* 2010;20(9):856-65.
48. Lee JY, Vann WF, Roberts MW. A cost analysis of treating pediatric dental patients using general anesthesia vs conscious sedation. *Pediatr Dent* 2000;22(1):27-32.
49. Prabhu NT, Nunn JH, Evans DJ. A comparison of costs in providing dental care for special needs patients under sedation or general anesthesia in the North East of England. *Prim Dent Care* 2006;13(4):125-8.
50. Patton LL, White BA, Field MJ. State of the evidence base for medically-necessary oral health care. *Oral Surg Oral Med Oral Pathol Oral Radiol Endod* 2001;92(3):272-5.
51. Flick WG, Claybold S. Who should determine the medical necessity of dental sedation and general anesthesia? A clinical commentary supported by Illinois patient and practitioner surveys. *Anesth Prog* 1998;45(2):57-61.
52. Conway TE. What is currently available in terms of medically-necessary oral care? *Spec Care Dentist* 1995;15(5):187-91.
53. White BA. The costs and consequences of neglected medically-necessary oral care [Review]. *Spec Care Dentist* 1995;15(5):180-6.
54. Cameron CA, Litch CS, Liggert M, Heimburg S. National Alliance for Oral Health consensus conference on medically necessary oral health care: Legal issues. *Spec Care Dentist* 1995;15(5):192-200.
55. American Dental Association. *Dental Benefit Programs—Organization and Operations. Benefits for services by qualified practitioners* (1989:546). In: *ADA Current Policies*, 2013. Chicago, Ill.; 2014. Available at: "<http://www.ada.org/-/media/ADA/Member%20Center/Files/2013%20Current%20Policies%20Final.ashx>". Accessed August 9, 2015.
56. Strauss RP. The organization and delivery of craniofacial services: The state of the art. *Cleft Palate Craniofac J* 1999;36(3):189-95.
57. Strauss RP, Cassell CH. Critical issues in craniofacial care: Quality of life, costs of care, and implications of prenatal diagnosis. *Acad Pediatr* 2009;9(6):427-3.