

Appendix: Supplemental Materials
Measure: Oral Evaluation, Dental Services
NQF Measure Number 2517

Table of Contents

Measure Specifications for Oral Evaluation, Dental Services	1
Letter from Centers for Medicare and Medicaid Services	7

****Please read the DQA Measures User Guide prior to implementing this measure.****

DQA Measure Technical Specifications: Administrative Claims-Based Measures

Oral Evaluation, Dental Services

Description: Percentage of enrolled children under age 21 who received a comprehensive or periodic oral evaluation within the reporting year
Numerator: Unduplicated number of children who received a comprehensive or periodic oral evaluation as a dental service
Denominator: Unduplicated number of enrolled children under age 21
Rate: NUM/DEN

Rationale: Dental caries is the most common chronic disease in children in the United States (1). In 2009–2010, 14% of children aged 3–5 years had untreated dental caries. Among children aged 6–9 years, 17% had untreated dental caries, and among adolescents aged 13–15, 11% had untreated dental caries (2). Identifying caries early is important to reverse the disease process, prevent progression of caries, and reduce incidence of future lesions. Approximately three quarters of children younger than age 6 years did not have at least one visit to a dentist in the previous year (3).

(1) Centers for Disease Control and Prevention. Hygiene-related diseases: dental caries. Available at:

http://www.cdc.gov/healthywater/hygiene/disease/dental_caries.html. Accessed July 28, 2015.

(2) Dye BA, Li X, Thornton-Evans G. Oral health disparities as determined by selected Healthy People 2020 oral health objectives for the United States, 2009–2010. NCHS data brief, no 104. Hyattsville, MD: National Center for Health Statistics. 2012.

(3) Edelstein BL, Chinn CH. Update on disparities in oral health and access to dental care for America's children. Acad Pediatr. 2009;9(6):415–9. PMID: 19945076.

National Quality Forum Domain: Process¹

Institute of Medicine Aim: Equity, Effectiveness

National Quality Strategy Priority: Health and Wellbeing

Level of Aggregation: Health Plan/Program

Improvement Noted As: A higher score indicates better quality.

Data Required: Administrative enrollment and claims data; single year. When using claims data to determine service receipt, include both paid and unpaid claims (including pending, suspended, and denied claims).

Measure Purpose: Examples of questions that can be answered through this measure at each level of aggregation:

1. What is the percentage of children who received a comprehensive or periodic oral evaluation as a dental service during the reporting period?

¹ **Process (measure type):** "A healthcare service provided to, or on behalf of, a patient. This may include, but is not limited to, measures that may address adherence to recommendations for clinical practice based on evidence or consensus." National Quality Forum. "NQF Glossary." Available at: http://www.qualityforum.org/Masuring_Performance/Measuring_Performance.aspx. Accessed July 28, 2015.

2. Over time, does the percentage of children who receive a comprehensive or periodic oral evaluation stay stable, increase, or decrease?

Applicable Stratification Variables

1. Age: <1; 1-2; 3-5; 6-7; 8-9; 10-11; 12-14; 15-18; 19-20

Oral Evaluation Calculation

1. Check if the enrollee meets age criterion² at the last day of the reporting year:³
 - a. If age criterion is met, then proceed to next step.
 - b. If age criterion is not met or there are missing or invalid field codes (e.g., date of birth), then STOP processing. This enrollee does not get counted in the denominator.
2. Check if subject is continuously enrolled for at least 180 days during the reporting year:⁴
 - a. If subject meets continuous enrollment criterion, then include in **denominator**; proceed to next step.
 - b. If subject does not meet enrollment criterion, then STOP processing. This enrollee does not get counted in the denominator.

YOU NOW HAVE THE DENOMINATOR (DEN) COUNT: All enrollees who meet age and enrollment criteria

3. Check if subject received an oral evaluation as a dental service during the reporting year:
 - a. If [CDT CODE] = D0120 or D0150 or D0145, AND
 - b. If [RENDERING PROVIDER TAXONOMY] code = any of the NUCC maintained Provider Taxonomy Codes in Table 1 below, then include in **numerator**; proceed to next step.⁵
 - c. If both a AND b are not met, then the service was not provided as a "dental service"; STOP processing. This enrollee is already included in the denominator but will not be included in the numerator.

Note: In this step, all **claims** with missing or invalid CDT CODE, missing or invalid NUCC maintained Provider Taxonomy Codes, or NUCC maintained Provider Taxonomy Codes that do not appear in Table 1 should not be included in the numerator.

YOU NOW HAVE NUMERATOR (NUM) COUNT: Enrollees who received an oral evaluation as a dental service

4. Report
 - a. Unduplicated number of enrollees in numerator
 - b. Unduplicated number of enrollees in denominator
 - c. Measure rate (NUM/DEN)
 - d. Rate stratified by age

³ **Age:** Medicaid/CHIP programs use under age 21 (< 21); Exchange quality reporting use under age 19 (<19); other programs check with program officials. The age criterion should be reported with the measure score.

³ **Medicaid/CHIP programs should exclude those individuals who do not qualify for dental benefits.** The exclusion criteria should be reported along with the number and percentage of members excluded.

⁴ **Enrollment in "same" plan vs. "any" plan:** At the **state** program level (e.g., Medicaid/CHIP) a criterion of "**any**" plan applies versus at the **health plan** (e.g., MCO) level a criterion of "**same**" plan applies. The criterion used should be reported with the measure score. While this prevents direct aggregation of results from plan to program, each entity is given due credit for the population it serves. Thus, states with multiple MCOs should not merely "add up" the plan level scores but should calculate the state score from their database to allow inclusion of individuals who may be continuously enrolled but might have switched plans in the interim.

⁵ **Identifying "dental" services:** Programs and plans that do not use standard NUCC maintained provider taxonomy codes should use a valid mapping to identify providers whose services would be categorized as "dental" services. Stand-alone dental plans that reimburse ONLY for services rendered by or under the supervision of the dentist can consider all claims as "dental" services.

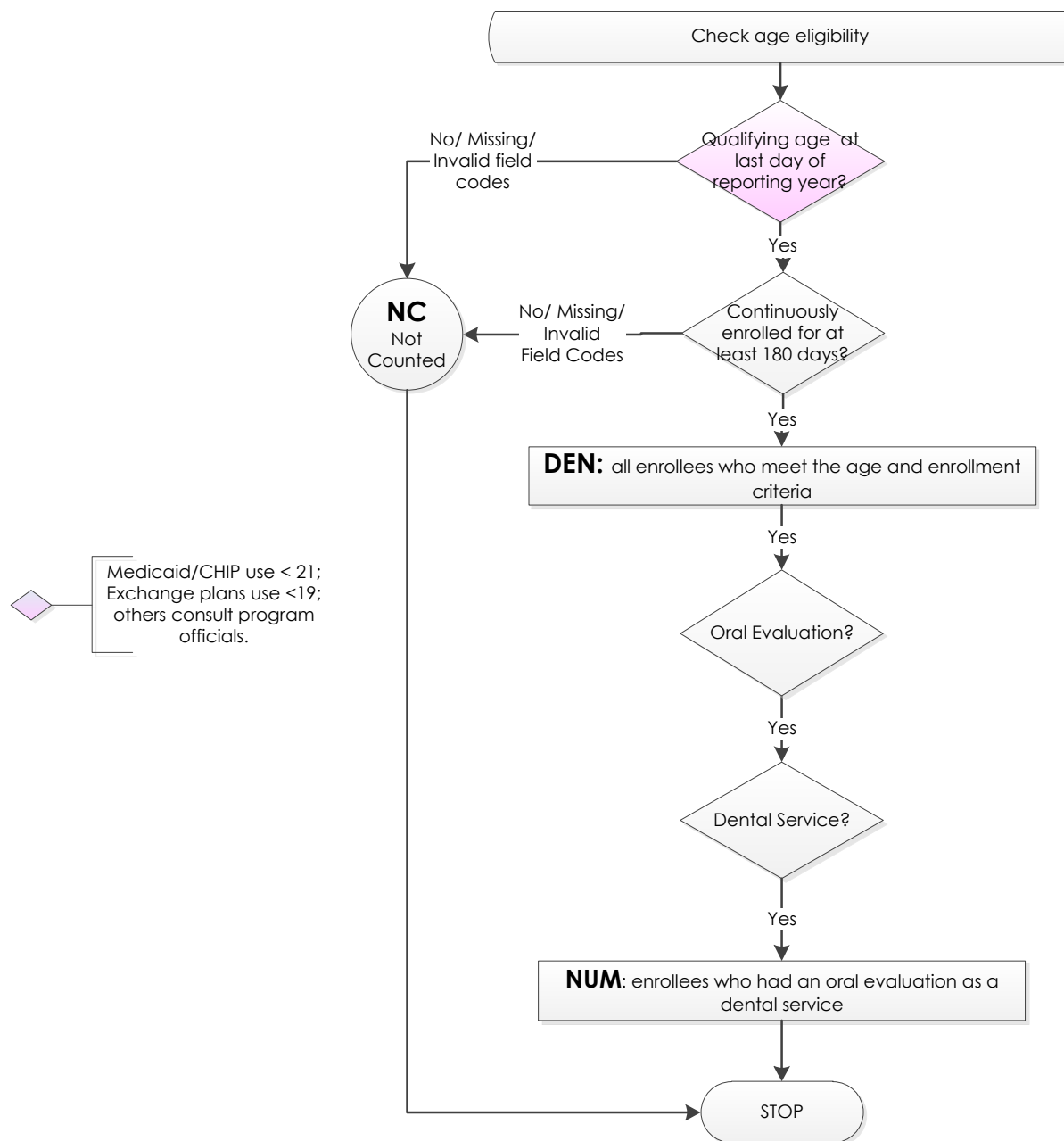
Table 1: NUCC maintained Provider Taxonomy Codes classified as “Dental Service”*

122300000X	1223P0106X	1223X0008X	125Q00000X
1223D0001X	1223P0221X	1223X0400X	261QF0400X
1223D0004X	1223P0300X	124Q00000X+	261QR1300X
1223E0200X	1223P0700X	125J00000X	
1223G0001X	1223S0112X	125K00000X	

*Services provided by County Health Department dental clinics may also be included as “dental” services.

+Only dental hygienists who provide services under the supervision of a dentist should be classified as “dental” services. Services provided by independently practicing dental hygienists should be classified as “oral health” services and are not applicable for this measure.

*** Note: Reliability of the measure score depends on the quality of the data that are used to calculate the measure. The percentages of missing and invalid data for these data elements must be investigated prior to measurement. Data elements with high rates of missing or invalid data will adversely affect the subsequent counts that are recorded. For example, records with missing or invalid CDT CODE may be counted in the denominator but not in the numerator. These records are assumed to not have had a qualifying service. In this case, a low quality data set will result in a low measure score and will not be reliable.***



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For Proprietary Codes:

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NOV 04 2013

Robert A. Faiella, D.M.D., M.M.SC.
President
American Dental Association
211 E. Chicago Avenue
Chicago, IL 60611-2637

Dear Dr. Faiella:

Thank you for your letter concerning the dental quality measures recently tested and validated by the Dental Quality Alliance (DQA). As you mentioned, the DQA was formed at the behest of Centers for Medicare & Medicaid Services (CMS) and we continue to be vitally interested in the group's efforts. We are pleased that Dr. Lynn Mouden, the CMS Chief Dental Officer, serves on the DQA to provide CMS input into the DQA's collaborative efforts.

The dearth of tested quality measures in oral health has been a concern to CMS and other payers of oral health services for quite some time. The DQA-funded testing for feasibility, reliability and validity of the ten measures in the DQA Starter Set is truly a step forward in quality measurement.

The changing landscape of health care, in light of CHIPRA, the Patient Protection and Affordable Care Act, and other factors, continues to drive efforts in CMS to improve health and health care quality. Along with these changes, implementing new quality measures within Medicaid and CHIP will be important.

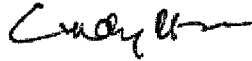
I, Dr. Mouden, and the CMS dental team are now focused on how we can best use these new DQA quality measures. We will consider how the measures could be used within CMS' data collection systems and/or how they could be used in states' data collection and quality improvement efforts. We encourage you to explore endorsement from the National Quality Forum as a means to move these measures forward.

We look forward to our continuing work with the DQA and our joint efforts to measure and improve the quality oral health services for all the beneficiaries served in our programs.

Page 2 – Robert A. Faiella, D.M.D., M.M.SC.

Please feel free to contact Dr. Mouden at 410-786-4126 at any time.

Sincerely,

A handwritten signature in black ink, appearing to read "Cindy Mann", with a stylized flourish at the end.

Cindy Mann
Director

cc:

Dr. Kathy O'Loughlin, Executive Director, ADA
Dr. Ron Hunt, Chair, DQA
Dr. Krishna Aravamudhan
Dr. Lynn Douglas Mouden, Chief Dental Officer, CMS
Laurie Norris, JD, Coordinator, CMS Oral Health Initiative