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

**DQA Measure Technical Specifications: Administrative Claims-Based Measures**

**Preventive Services for Children at Elevated Caries Risk, Dental Services**

"Dental Services"

**Description:** Percentage of a. enrolled children b. enrolled children who received at least one dental service who are at "elevated" risk (i.e., "moderate" or "high") who received a topical fluoride application and/or sealants within the reporting year.

**Numerator:** Unduplicated number of children at "elevated" risk (i.e., "moderate" or "high") who received a topical fluoride application and/or sealants as a dental service

**Denominator:**
- DEN 1: Unduplicated number of all enrolled children at "elevated" risk (i.e., "moderate" or "high")
- DEN 2: Unduplicated number of all enrolled children at "elevated" risk (i.e., "moderate" or "high") who received at least one dental service

**Rates:** NUM/DEN 1; NUM/DEN (Note: These are two different rates based on the two different denominators)

**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). Evidence-based Clinical Recommendations recommend that sealants should be placed on pits and fissures of children's primary and permanent teeth when it is determined that the tooth, or the patient, is at risk of experiencing caries (4). Evidence-based Clinical Recommendations suggest that topical fluoride should be applied at least every three to six months in children at elevated risk for caries (5).


**AHRQ Domain:** Use of Services (DEN 2)

**IOM Aim:** Equity, Effectiveness

**Level of Aggregation:** Health Plan/Program

**Improvement Noted As:** A higher score indicates better quality.

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1 **Use of Services (Related Healthcare Delivery Measure):** Use of services is the provision of a service to, on behalf of, or by a group of persons identified by enrollment in a health plan or through use of clinic services. Use of service measures can assess encounters, tests, or interventions that are not supported by evidence for the appropriateness of the service for the specified individuals. National Quality Measures Clearinghouse. Available at: http://www.qualitymeasures.ahrq.gov/about/domain-definitions.aspx. Accessed August 10, 2015.
Data Required: Administrative enrollment and claims data; single year for measurement (prior 3 years may be needed for risk determination)

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

1. What percentage of children at elevated risk receive any topical fluoride or sealants?
2. Does the percentage of children at elevated risk who receive any topical fluoride or sealants vary by any of the stratification variables?
3. Are there disparities in the receipt of topical fluoride or sealants among different groups based on the stratification variables?
4. Over time, does the percentage of children who receive topical fluoride or sealants stay stable, increase or decrease?
5. How many patients receive topical fluoride or sealants in a public health setting (e.g., in school-based programs, community centers)?

Applicable Stratification Variables (Optional: Contact Program Official to determine reporting requirement)

1. Age (e.g., <1; 1-2; 3-5; 6-7; 8-9; 10-11; 12-14; 15-18; 19-20)
2. Payer Type (e.g., Medicaid; CHIP; private commercial benefit programs)
3. Program/Plan Type (e.g., traditional FFS; PPO; prepaid dental/DHMO)
4. Geographic Location (e.g., rural; suburban; urban)
5. Race
6. Ethnicity
7. Socioeconomic Status (e.g., premium or income category)

Measure Limitations:

- CDT codes do not distinguish between fluoride gel and fluoride foam. This measure assumes that all modes of topical fluoride application are equally effective.
- This measure does not take into account alternate home-use fluoride products including supplements.
- This measure will not delineate those whose teeth have not erupted, those who already received sealants in prior years, and those with decayed/filled teeth not candidates for sealants.
- Some codes (i.e., a few endodontic codes) are included to identify children at elevated risk may also be reported for instances such as trauma and may contribute to some overestimation of children at “elevated risk.”
- Since the “elevated risk” determination requires an evaluation (to record CDT risk code) or treatment visit (to record a CDT treatment code), children who are enrolled but do not have a visit in the reporting year or a treatment visit in any of the prior three years will not have sufficient information to be included in the measure. While this is a limitation, the intent of this PROCESS OF CARE measure is to seek to understand whether children who can be positively identified as being at elevated risk receive the recommended preventive services.
Preventive Services (Dental Services) Calculation for Children at Elevated Caries Risk

1. Run records for one reporting year for paid and unpaid claims.\(^2\)

2. Check if the enrollee meets age criterion\(^3\) at the last day of the reporting year:
   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., birth date), then STOP processing. This enrollee does not get counted.

3. Check if subject is continuously enrolled for at least 180 days\(^4\)
   a. If subject meets continuous enrollment criterion, then proceed to next step.
   b. If subject does not meet enrollment criterion, then STOP processing. This enrollee does not get counted.

YOU NOW HAVE THE COUNT OF THOSE WHO MEET THE AGE AND ENROLLMENT CRITERIA

4. Check if subject is at “elevated risk”:
   a. If subject meets any of the following then include in denominator 1:
      i. the subject has a visit with a CDT code = (D0602 or D0603) in the reporting year, OR
      ii. the subject has a CDT code among those in Table 1 in the reporting year, OR
      iii. the subject has a CDT code among those in Table 1 in any of the three years prior to the reporting year (NOTE: The subject does not need to be enrolled in any of the prior three years for the denominator enrollment criteria; this is a “look back” for enrollees who do have claims experience in any of the prior three years.)
   b. If the subject does not meet any of the above criteria for elevated risk, then STOP processing. This enrollee will not be included in the measure denominators.

YOU NOW HAVE THE DENOMINATOR 1 (DEN 1): Enrollees who are at “elevated risk”

5. Check if subject received any dental service:
   a. If [CDT CODE] = D0100 – D9999; AND
   b. If [RENDERING PROVIDER TAXONOMY] code = *any* of the NUCC maintained Provider Taxonomy Codes in Table 2 below,\(^5\) then include in denominator 2; proceed to next step.
   c. If both a AND b are not met, then the service was not a “dental” service; STOP processing. This enrollee is already included in denominator 1 but will not be included denominator 2.

Note: In this step, all claims with missing or invalid SERVICE CODE, missing or invalid NUCC maintained Provider Taxonomy Codes, or NUCC maintained Provider Taxonomy Codes that do not appear in Table 2 should be excluded.

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\(^2\) 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.

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

\(^4\) 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.
YOU NOW HAVE THE DENOMINATOR 2 (DEN 2): Enrollees who are at “elevated risk” and accessed a dental service (had a visit)

6. Check if subject received topical fluoride or a sealant as dental service:
   a. If [CDT CODE] = D1206 or D1208 or D1351 then include in numerator; STOP processing. (Note: At least one claim for preventive services in the reporting year must be with a provider whose [RENDERING PROVIDER TAXONOMY] code = any of the NUCC maintained Provider Taxonomy Codes in Table 2.)
   b. If not, then service was not provided or service was not a dental service; STOP processing. This enrollee is already included in the denominators but will not be included in the numerator.

YOU NOW HAVE NUMERATOR (NUM) COUNT: Enrollees at “elevated risk” who received preventive services as dental service

7. Report
   a. Unduplicated count of enrollees in numerator
   b. Unduplicated count of enrollees in each denominator
   c. Rates of measures (NUM/DEN1) and (NUM/DEN2)

<table>
<thead>
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<th>Table 1: CDT Codes to identify “elevated risk”</th>
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*Topical Fluoride codes: For reporting years prior to 2013 use D1203 or D1204 or D1206.*
### Table 2: NUCC maintained Provider Taxonomy Codes classified as “Dental Service”**

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*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 to the “dental services” specification of 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 denominator 1 but not in denominator 2 or 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 measure score that will not be reliable.***
Run records for reporting year for paid and unpaid claims

Qualifying age at last day of reporting year?

Yes

No/ Missing/ Invalid field codes

Continuously enrolled for at least 180 days?

Yes

all enrollees who meet the age and enrollment criteria

Elevated risk?

Yes

DEN 1: enrollees who are at elevated risk

Dental Service in reporting year?

Yes

DEN 2: enrollees who had a dental visit in the reporting year who are at elevated risk

Fluoride or sealants?

Yes

NUM: enrollees at elevated risk who received preventive services

STOP

Program specific exclusions may apply

Medicaid/CHIP use <21; Exchange plans use <19; others consult program officials.

NC Not Counted

Child will be counted if any one of the following are present:
(1) CDT code for moderate or high risk in the reporting year
(2) Treatment code from Table 1 in reporting year
(3) Treatment code from Table 1 in any one of the prior three years. Continuity of enrollment not required in prior years.

Use NUCC codes. Exclude records with missing or invalid codes.

Some States may use different file types or custom codes to classify dental and oral health services.
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THE MEASURES ARE PROVIDED “AS IS” WITHOUT WARRANTY OF ANY KIND
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DQA Measure Technical Specifications: Administrative Claims-Based Measures
Preventive Services for Children at Elevated Caries Risk, “Oral Health Services”

“Oral Health services”

Description: Percentage of a. enrolled children b. enrolled children who received at least one oral health service at “elevated” risk (i.e. “moderate” or “high”) who received a topical fluoride application and/or sealants within the reporting year.

Numerator: Unduplicated number of children at “elevated” risk (i.e. “moderate” or “high”) who received a topical fluoride application and/or sealants as an oral health service.

Denominator:
DEN 1: Unduplicated number of all enrolled children at “elevated” risk (i.e., “moderate” or “high”)
DEN 2: Unduplicated number of all enrolled children at “elevated” risk (i.e., “moderate” or “high”) who received at least one oral health service

Rates: NUM/DEN 1; NUM/DEN 2 (Note: These are two different rates based on the two different denominators)

Rationale for “Oral Health” Services Specification:
Apart from routine quality reporting, researchers and policy makers may wish to seek additional information regarding services provided by “non-dental” providers, such as medical primary care providers.

For example, some policy questions of interest may include:

- Among those enrolled, how many received preventive services as an oral health service (e.g., from a medical primary care provider)?
- Among those who had a visit, how many received preventive services as an oral health service (e.g., from a medical primary care provider)?

Note: Not all state Medicaid programs reimburse for “oral health” services up to age 21. Stratifications may be used when interpreting this measure.

The DQA User Guide provides additional information on categorization of “dental” and “oral health” services.

Applicable Stratification Variables (Optional: Contact Program Official to determine reporting requirement):
1. Age (e.g., <1, 1-2; 3-5; 6-7; 8-9; 10-11; 12-14; 15-18; 19-20)
2. Payer Type (e.g., Medicaid; CHIP; private commercial benefit programs)
3. Program/Plan Type (e.g., traditional FFS; PPO; prepaid dental/DHMO)
4. Geographic Location (e.g., rural; suburban; urban)
5. Race
6. Ethnicity
7. Socioeconomic Status (e.g., premium or income category)
Preventive Services (Oral Health Services) Calculation

1. Run records for one reporting year for paid and unpaid claims.

2. Check if the enrollee meets age criterion at the last day of the reporting year:
   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., birth date), then STOP processing. This enrollee does not get counted.

3. Check if subject is continuously enrolled for at least 180 days
   a. If subject meets continuous enrollment criterion, then proceed to next step.
   b. If subject does not meet enrollment criterion, then STOP processing. This enrollee does not get counted.

YOU NOW HAVE THE COUNT OF THOSE WHO MEET THE AGE AND ENROLLMENT CRITERIA

4. Check if subject is at “elevated risk”:
   a. If subject meets any of the following then include in denominator 1:
      i. the subject has a visit with a CDT code = (D0602 or D0603) in the reporting year, OR
      ii. the subject has a CDT Code among those in Table 1 in the reporting year, OR
      iii. the subject has a CDT Code among those in Table 1 in any of the three years prior to the reporting year (NOTE: The subject does not need to be enrolled in any of the prior three years for the denominator enrollment criteria; this is a “look back” for enrollees who do have claims experience in any of the prior three years.)
   b. If the subject does not meet any of the above criteria for elevated risk, then STOP processing. This enrollee will not be included in the measure denominators.

YOU NOW HAVE THE DENOMINATOR 1 (DEN 1): Enrollees who are at “elevated risk”

5. Check if subject received any oral health service:
   a. If [CDT] = D0100 – D9999 and;
   b. If [RENDERING PROVIDER TAXONOMY] code is valid NUCC maintained Provider Taxonomy Code but *not* any of the NUCC maintained Provider Taxonomy Codes in Table 2, then include in count of enrollees who received oral health service; proceed to next step.
   c. If both a AND b are not met, then the service was not an “oral health” service; STOP processing. This enrollee is already included in denominator 1 but will not be included in denominator 2.

Note: In this step, all claims with missing or invalid SERVICE CODE or with missing or invalid NUCC maintained Provider Taxonomy Codes should be excluded.

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7 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.
8 Age: Medicaid/CHIP programs use under age 21 (<21); Exchange quality reporting use under age 19 (<19); other programs check with program officials. This criterion should be reported with the measurement score.
9 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.
10 Services provided by medical providers: In some instances, CPT codes are used for reimbursement of oral health services e.g., medical primary care providers providing oral evaluation, risk assessment, anticipatory guidance or fluoride varnish. Details available at <AAP Table>. For such states these additional codes must be considered.
11 Identifying “oral health” 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” or “oral health” services.
YOU NOW HAVE THE DENOMINATOR 2 (DEN 2): Enrollees who are at “elevated risk” and accessed an oral health service (had a visit)

6. Check if subject received topical fluoride or a sealant as an oral health service:
   a. If [SERVICE CODE] = D1206 or D1208 or D1351, then include in numerator; STOP processing. (Note: At least one claim for preventive services in the reporting year must be with a provider whose [RENDERING PROVIDER TAXONOMY] code = valid NUCC maintained Provider Taxonomy Code but *not* any of the NUCC maintained Provider Taxonomy Codes in Table 2.)
   b. If not, then service was not provided or service was not an “oral health” service; STOP processing. This enrollee is already included in the denominators but will not be included in the numerator.

Note: Some states may use codes other than CDT codes to reimburse for fluoride. These codes should be included in the [SERVICE CODE] codes in addition to D1206, D1208 and D1351.

YOU NOW HAVE NUMERATOR (NUM) COUNT: Enrollees at “elevated risk” who received preventive services as oral health services

7. Report
   a. Unduplicated count of enrollees in numerator
   b. Unduplicated count of enrollees in each denominator
   c. Rates of measures (NUM/DEN1) and (NUM/DEN2)

Table 1: CDT Codes to identify “elevated risk”

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12 Services provided by medical providers: In some instances, CPT codes are used for reimbursement of oral health services e.g., medical primary care providers providing oral evaluation, risk assessment, anticipatory guidance or fluoride varnish. Details available at <AAP Table>. For such states these additional codes must be considered.
Table 2: NUCC maintained Provider Taxonomy Codes classified as “Dental Service”*

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*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.

*** 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 SERVICE CODE may be counted in denominator 1 but not in denominator 2 or 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 measure score that will not be reliable.***
DQA Measure Technical Specifications: Administrative Claims-Based Measures
Preventive Services, Dental or Oral Health Services

“Dental OR Oral Health services”

Description: Percentage of a. enrolled children b. enrolled children who received at least one dental OR oral health service at “elevated” risk (i.e. “moderate” or “high”) who received a topical fluoride application and/or sealants within the reporting year.

Numerator: Unduplicated number of children at “elevated” risk (i.e. “moderate” or “high”) who received a topical fluoride application and/or sealants as a dental OR oral health service

Denominator:
DEN 1: Unduplicated number of all enrolled children at “elevated” risk (i.e. “moderate” or “high”)
DEN 2: Unduplicated number of all enrolled children at “elevated” risk (i.e. “moderate” or “high”) who received at least one dental OR oral health service

Rates: NUM/DEN 1; NUM/DEN 2 (Note: These are two different rates based on the two different denominators)

Rationale for “Dental or Oral Health” Services Specification:
Researchers and policy makers may wish to seek additional information regarding whether certain services were provided to a population. In such cases a “dental OR oral health” specification of the measure may be applicable. The “dental OR oral health” measure is NOT a sum of the “dental” and “oral health” versions of the measure but represents the unduplicated count of children who received a dental or oral health service.

The DQA User Guide provides additional information on categorization of “dental” and “oral health” services.

Applicable Stratification Variables (Optional: Contact Program Official to determine reporting requirement):
1. Age (e.g., 1-2; 3-5; 6-7; 8-9; 10-11; 12-14; 15-18; 19-20)
2. Payer Type (e.g., Medicaid; CHIP; private commercial benefit programs)
3. Program/Plan Type (e.g., traditional FFS; PPO; prepaid dental/DHMO)
4. Geographic Location (e.g., rural; suburban; urban)
5. Race
6. Ethnicity
7. Socioeconomic Status (e.g., premium or income category)
Preventive Services (Dental or Oral Health Services) Calculation

1. Run records for one reporting year for paid and unpaid claims.\footnote{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.}

2. Check if the enrollee meets age criterion\footnote{Age: Medicaid/CHIP programs use under age 21 (<21); Exchange quality reporting use under age 19 (<19); other programs check with program officials. This criterion should be reported with the measurement score.} at the last day of the reporting year:
   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., birth date), then STOP processing. This enrollee does not get counted.

3. Check if subject is continuously enrolled for at least 180 days:\footnote{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.}
   a. If subject meets continuous enrollment criterion, then proceed to next step.
   b. If subject does not meet enrollment criterion, then STOP processing. This enrollee does not get counted.

YOU NOW HAVE THE COUNT OF THOSE WHO MEET THE AGE AND ENROLLMENT CRITERIA

4. Check if subject is at “elevated risk”:
   a. If subject meets any of the following then include in denominator 1:
      i. the subject has a visit with a CDT code = (D0602 or D0603) in the reporting year, OR
      ii. the subject has a CDT Code among those in Table 1 in the reporting year, OR
      iii. the subject has a CDT Code among those in Table 1 in any of the three years prior to the reporting year (\textit{NOTE:} The subject does not need to be enrolled in any of the prior three years for the denominator enrollment criteria; this is a “look back” for enrollees who do have claims experience in any of the prior three years.)
   b. If the subject does not meet any of the above criteria for elevated risk, then STOP processing. This enrollee will not be included in the measure denominators.

YOU NOW HAVE THE DENOMINATOR 1 (DEN 1): Enrollees who are at “elevated risk"

5. Check if subject received any \textit{dental or oral health} service:
   a. If [SERVICE CODE] = D0100 – D9999\footnote{Services provided by medical providers: In some instances, CPT codes are used for reimbursement of oral health services e.g., medical primary care providers providing oral evaluation, risk assessment, anticipatory guidance or fluoride varnish. Details available at <AAP Table>. For such states these additional codes must be considered.} and;
   b. If [RENDERING PROVIDER TAXONOMY] code is *any* valid of the NUCC maintained Provider Taxonomy Code,\footnote{Identifying “dental” or “oral health” 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” or “oral health” services.} then include in count of enrollees who received dental or oral health service; proceed to next step.
   c. If both a AND b are not met, then the service was not a “dental or oral health” service; STOP processing. This enrollee is already included in denominator 1 but will not be included in denominator 2.

\textbf{Note:} In this step, all claims with missing or invalid SERVICE CODE or with missing or invalid NUCC maintained Provider Taxonomy Codes should be excluded.
YOU NOW HAVE THE DENOMINATOR 2 (DEN 2): Enrollees who are at “elevated risk” and accessed a dental or oral health service (had a visit)

6. Check if subject received topical fluoride or a sealant as a **dental or oral health** service:
   a. If [SERVICE CODE] = D1206 or D1208 or D1351, then include in numerator; STOP processing. (Note: At least one claim for preventive services in the reporting year must be with a provider whose [RENDERING PROVIDER TAXONOMY] code = 'any' valid NUCC maintained Provider Taxonomy code)
   b. If not, then service was not provided or service was not a “dental OR oral health” service; STOP processing. This enrollee is already included in the denominators but will not be included in the numerator.

Note: Some states may use codes other than CDT codes to reimburse for fluoride. These codes should be included in the [SERVICE CODE] codes in addition to D1206, D1208 and D1351.

YOU NOW HAVE NUMERATOR (NUM) COUNT: Enrollees at “elevated risk” who received preventive services as dental or oral health services

7. Report
   a. Unduplicated count of enrollees in numerator
   b. Unduplicated count of enrollees in each denominator
   c. Rates of measures (NUM/DEN1) and (NUM/DEN2)

<table>
<thead>
<tr>
<th>Table 1: CDT Codes to identify “elevated risk”</th>
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<tbody>
<tr>
<td>D2140</td>
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<td>D2392</td>
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<td>D2393</td>
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18 Services provided by medical providers: In some instances, CPT codes are used for reimbursement of oral health services e.g., medical primary care providers providing oral evaluation, risk assessment, anticipatory guidance or fluoride varnish. Details available at [AAP Table]. For such states these additional codes must be considered.
*** 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 SERVICE CODE may be counted in denominator 1 but not in denominator 2 or 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 measure score that will not be reliable.***