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

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

**Prevention: Topical Fluoride for Adults at Elevated Caries Risk**

| **Description:** | Percentage of enrolled adults aged 18 years and older who are at “elevated” risk (i.e., “moderate” or “high”) who received at least 2 topical fluoride applications within the reporting year |
| **Numerator:** | Unduplicated number of adults at “elevated” risk (i.e., “moderate” or “high”) who received at least 2 topical fluoride applications |
| **Denominator:** | Unduplicated number of enrolled adults at “elevated” risk (i.e., “moderate” or “high”) |
| **Rate:** | NUM/DEN |

| **Rationale:** | In the United States, 91% of adults aged 20–64 years and 96% of adults aged 65 years and older had dental caries in their permanent teeth in 2011–2012. (1) American Dental Association evidence-based guidelines suggest that professionally applied fluoride varnish every three to four months is effective in preventing caries in adults at elevated risk for dental caries. (2) Studies published following publication of this systematic review further support this preventive approach. (3,4) |


**AHRQ Domain:** PROCESS¹

**IOM Aim:** Equity, Effectiveness

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

**Improvement Noted As:** A higher score indicates better quality²

**Data Required:** Dental administrative enrollment and claims data; single year (prior 3 years needed for risk determination)

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¹ Process (Clinical Quality Measure): “A process of care is a health care-related activity performed for, on behalf of, or by a patient. Process measures are supported by evidence that the clinical process—that is the focus of the measure—has led to improved outcomes.” National Quality Measures Clearinghouse. Available at: http://www.qualitymeasures.ahrq.gov/about/domain-definitions.aspx. Accessed August 29, 2017.

² Evidence-based guidelines suggest that at-risk adults benefit from topical fluoride applications applied at least every 3–6 months.
Claims Data: 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 percentage of adults at elevated risk for dental caries receive at least 2 topical fluoride applications during the reporting year?
2. Does the receipt of professionally applied topical fluoride for adults at elevated risk vary by any of the stratification variables?
3. Are there disparities in receipt of professionally applied topical fluoride among different groups based on the stratification variables?
4. Over time, is the percentage of adults who receive at least 2 topical fluoride applications stable, increasing or decreasing?

Applicable Stratification Variables

1. Age: 18-20, 21-24, 25-34, 35-44, 45-54, 55-64, 65-74, 75-84, 85 and above  
2. Geographic Location (e.g., rural; suburban; urban)  
3. Race/Ethnicity  
4. 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.
- Since the “elevated risk” determination requires an evaluation (to record CDT risk code) or a treatment visit (to record a treatment code), adults 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 measure is to seek to understand whether adults who can be positively identified as being at elevated risk receive the recommended preventive services.
Topical Fluoride Calculation for Adults at Elevated Caries Risk

1. Check if the enrollee meets age criterion at the last day of the reporting year:3
   a. If subject is >=18, 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.

2. Check if subject is continuously enrolled for the reporting year (12 months) with a single gap of no more than 31 days (one month gap for programs that determine eligibility on a monthly basis):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

3. Check if subject is at “elevated risk”:
   a. If subject meets ANY of the following criteria, then include in denominator: (Note: BOTH (i) and (ii) should be checked to see if subject satisfies any criteria):
      i. the subject has at least 3 instances of the CDT Codes among those in Table 1 in the reporting year OR the three prior years (“look-back” approach).

      Note 1: There must be at least 3 instances of CDT codes contained in Table 1. These three instances may occur during the same visit or during separate visits. The three instances may occur in any one or more of: the reporting year and the three prior years. The three instances may all occur in the same year, or they may be spread across the years. The same code can be used to count for more than one instance. This criterion does not require unique dates or service or unique codes.

      Note 2: 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.

      OR

      ii. the subject has a visit with a CDT code = (D0602 or D0603) in the reporting year.

   b. If the subject does not meet either of the above criteria for elevated risk, then STOP processing. This enrollee will not be included in the measure denominator.

YOU NOW HAVE THE DENOMINATOR: Enrollees who are at “elevated risk”

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3 Medicaid programs exclude those enrollees who do not qualify for dental benefits. The exclusion criterion 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.
4. Check if subject received at least 2 fluoride applications during the reporting year — at least two unique dates of service when topical fluoride was provided. Service provided on each date of service should satisfy the following criterion:
   a. If [CDT CODE] = D1206 or D1208 then include in numerator; STOP processing.
   b. If not, then service was not provided, STOP processing. This enrollee is already included in the denominator but will not be included in the numerator.

   **NOTE:** No more than one fluoride application can be counted for the same member on the same date of service.

   **YOU NOW HAVE NUMERATOR (NUM) COUNT:** Enrollees at “elevated risk” who received at least two topical fluoride applications during the reporting year

5. 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

### Table 1: CDT Codes to identify “elevated risk” for adults

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***Note: Reliability of the measure score depends on the quality of the data that are used to calculate the measures. 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 excluded from measurement. 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.***
Check age eligibility

Age >= 18?

Yes

Continuously enrolled for 12 months with a gap of no more than 31 days?

Yes

Elevated Risk?

Yes

DEN: Enrollees who are at “Elevated Risk”

Yes

#1 Date of Service: Fluoride Application

Yes

#2 Date of Service: Fluoride Application

NUM: Enrollees who are at “elevated caries risk” who received at least 2 fluoride applications during the reporting year

STOP

Program specific exclusions may apply

NC Not Counted

No/ Missing/ Invalid field codes
Dental Quality Alliance Measures (Measures) and related data specifications, developed by the Dental Quality Alliance (DQA), are intended to facilitate quality improvement activities. These Measures are intended to assist stakeholders in enhancing quality of care. These performance Measures are not clinical guidelines and do not establish a standard of care. The DQA has not tested its Measures for all potential applications.

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