

****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 one of the most common chronic diseases in children in the United States (1). For 2015–2016, prevalence of total caries (untreated and treated) was 45.8% and untreated caries was 13.0% among youth aged 2–19 years (2). Identifying caries early is important to reverse the disease process, prevent progression of caries, and reduce incidence of future lesions. In 2014, 52% of all children and 60% of poor children (FPL<100%) did not have a dental visit during the year (3).

- (1) Centers for Disease Control and Prevention. Oral Health Conditions: Cavities (Tooth Decay). Available at: <https://www.cdc.gov/oralhealth/conditions/index.html>. Accessed July 27, 2023.
- (2) Fleming E, Afful J. Prevalence of total and untreated dental caries among youth: United States, 2015–2016. NCHS Data Brief, no 307. Hyattsville, MD: National Center for Health Statistics. 2018.
- (3) Nasseh K, Vujicic M. Dental care utilization steady among working-age adults and children, up slightly among the elderly. Health Policy Institute Research Brief. American Dental Association. October 2016. Available from: https://www.ada.org/-/media/project/ada-organization/ada/ada-org/files/resources/research/hpi/hpibrief_1016_1.pdf. Accessed July 27, 2023.

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:

* Measure is endorsed by the Centers for Medicare and Medicaid Services (CMS) Consensus-Based Entity (CBE), formerly the National Quality Forum. Endorsed measures can now be found at <https://p4qm.org/measures>.

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."

1. What is the percentage of children who received a comprehensive or periodic oral evaluation as a dental service during the reporting period?
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 subject 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 subject is not 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 subject is not counted in the denominator.

YOU NOW HAVE THE DENOMINATOR (DEN) COUNT: All subjects 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.⁵
 - c. If both a AND b are met, then include in **numerator**; proceed to next step.
 - d. If either a OR b is NOT met, then a dental service was not provided; STOP processing. This subject 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: Subjects who received an oral evaluation as a dental service

² **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.

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

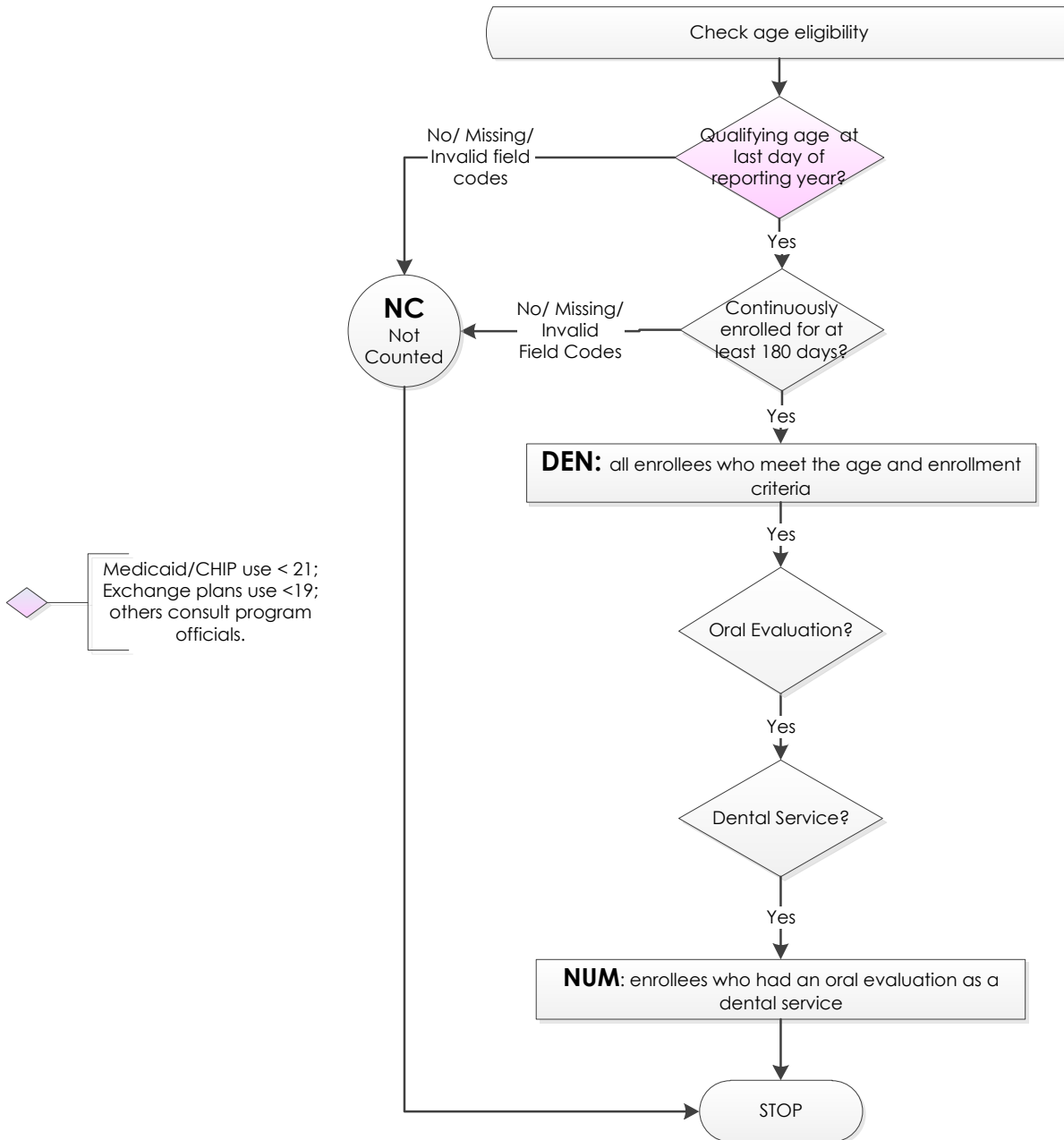
Table 1: NUCC maintained Provider Taxonomy Codes classified as “Dental Service”*

| | | | | |
|------------|------------|-------------|------------|------------|
| 122300000X | 1223P0106X | 1223X0008X | 125Q00000X | 126800000X |
| 1223D0001X | 1223P0221X | 1223X0400X | 261QF0400X | 261QD0000X |
| 1223D0004X | 1223P0300X | 124Q00000X+ | 261QR1300X | 204E00000X |
| 1223E0200X | 1223P0700X | 125J00000X | 1223X2210X | 261QS0112X |
| 1223G0001X | 1223S0112X | 125K00000X | 122400000X | |

*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 elements that are used to calculate the measure. The percentages of missing or invalid data for each data element used to calculate the measure 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, subjects who have 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 measure score that will not be reliable.***



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