DQA Measure Technical Specifications: Administrative Claims-Based Measures

**Description:** Percentage of enrolled children who received a treatment service within the reporting year

**Numerator:** Unduplicated number of children who received at least one treatment service as a dental service

**Denominator:** Unduplicated number of enrolled children

**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) In 2014, 52% of all children and 60% of poor children (FPL<100%) did not have a dental visit during the year (3). Identifying caries early is important to reverse the disease process, prevent progression of caries, and reduce incidence of future lesions. If left untreated, tooth decay can negatively affect a child’s physical and social well-being and school performance.


**AHRQ Domain:** Use of Services

**IOM Aim:** Equity

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

**Improvement Noted As:** This is a related health care delivery measure that should be interpreted in the context of other performance measures. Because specific services are not delineated for this measure, higher or lower rates are not necessarily indicative of better or worse performance.

**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:** This measure assesses utilization of a broad range of treatment services that include, but are not limited to, restorations, endodontic procedures, periodontal procedures, and extractions. Diagnostic and preventive services (such as fluoride applications, sealants, and cleanings) are not included.

---

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 clinical 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: https://www.ahrq.gov/gam/summaries/domain-definitions/index.html. Accessed July 19, 2023.
Examples of questions that can be answered through this measure at each level of aggregation:

1. What is the utilization of dental treatment services by children?
2. Does the use of dental treatment services vary by any of the stratification variables?
3. Are there disparities in the use of treatment services among different groups based on the stratification variables?
4. Over time, does the percentage of children who receive treatment services stay stable, increase or decrease?

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)
Treatment Services Calculation

1. Check if the subject meets age criterion\(^2\) 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 a treatment service as a dental service during the reporting year:
   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 a treatment service

4. Report
   a. Unduplicated number of subjects in numerator
   b. Unduplicated number of subjects in denominator
   c. Measure rate (NUM/DEN)

---
\(^2\) **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.
Table 1: NUCC maintained Provider Taxonomy Codes classified as “Dental Service”**

<table>
<thead>
<tr>
<th>Code</th>
<th>Code</th>
<th>Code</th>
<th>Code</th>
<th>Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>122300000X</td>
<td>1223P0106X</td>
<td>1223X0008X</td>
<td>125Q00000X</td>
<td>126800000X</td>
</tr>
<tr>
<td>1223D0001X</td>
<td>1223P0221X</td>
<td>1223X0400X</td>
<td>261QF0400X</td>
<td>261QD0000X</td>
</tr>
<tr>
<td>1223D0004X</td>
<td>1223P0300X</td>
<td>124Q00000X+</td>
<td>261QR1300X</td>
<td>204E00000X</td>
</tr>
<tr>
<td>1223E0200X</td>
<td>1223P0700X</td>
<td>125J00000X</td>
<td>1223X2210X</td>
<td>261QS0112X</td>
</tr>
<tr>
<td>1223G0001X</td>
<td>1223S0112X</td>
<td>125K00000X</td>
<td>122400000X</td>
<td></td>
</tr>
</tbody>
</table>

*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.***
Check Age Eligibility

No/ Missing/ Invalid field codes

Qualifying age at last day of reporting year?

Yes

Continuously enrolled for at least 180 days?

Yes

DEN: all enrollees who meet the age and enrollment criteria

Treatment service provided?

Yes

Dental service?

Yes

NUM: enrollees who had a treatment

STOP

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

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.
2024 American Dental Association on behalf of the Dental Quality Alliance (DQA) ©. All rights reserved. Use by individuals or other entities for purposes consistent with the DQA’s mission and that is not for commercial or other direct revenue generating purposes is permitted without charge.

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. Measures are subject to review and may be revised or rescinded at any time by the DQA. The Measures may not be altered without the prior written approval of the DQA. The DQA shall be acknowledged as the measure steward in any and all references to the measure. Measures developed by the DQA, while copyrighted, can be reproduced and distributed, without modification, for noncommercial purposes. Commercial use is defined as the sale, license, or distribution of the Measures for commercial gain, or incorporation of the Measures into a product or service that is sold, licensed or distributed for commercial gain. Commercial uses of the Measures require a license agreement between the user and DQA. Neither the DQA nor its members shall be responsible for any use of these Measures.

THE MEASURES ARE PROVIDED “AS IS” WITHOUT WARRANTY OF ANY KIND

Limited proprietary coding is contained in the Measure specifications for convenience. For Proprietary Codes:

The code on Dental Procedures and Nomenclature is published in Current Dental Terminology (CDT), Copyright © 2023 American Dental Association (ADA). All rights reserved.

This material contains National Uniform Claim Committee (NUCC) Health Care Provider Taxonomy codes (http://www.nucc.org/index.php?option=com_content&view=article&id=14&Itemid=125). Copyright © 2023 American Medical Association. All rights reserved.

Users of the proprietary code sets should obtain all necessary licenses from the owners of these code sets. The DQA, American Dental Association (ADA), and its members disclaim all liability for use or accuracy of any terminologies or other coding contained in the specifications.

THE SPECIFICATIONS ARE PROVIDED “AS IS” WITHOUT WARRANTY OF ANY KIND