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Dental Quality Alliance  
User Guide for Adult Measures  
Calculated Using Administrative Claims Data

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# 1. Background

## A. Measure Development

The [Dental Quality Alliance \(DQA\)](#) was formed in 2010 as a multi-stakeholder group to advance oral healthcare performance measurement. The DQA develops aligned, standardized, and validated measures that can be applied in the public and private sectors. DQA Measures include oral healthcare access, process, and outcomes quality measures and related healthcare delivery measures (e.g., utilization and cost of care). Measures developed by the DQA undergo rigorous validation.<sup>1</sup>

DQA Measures can be used to:

1. uniformly assess evidence-based quality of care across reporting entities;
2. inform performance improvement projects longitudinally and monitor improvements in care;
3. identify variations in care;
4. develop benchmarks for comparison; and
5. uniformly assess utilization of care.

DQA Measures include measures calculated using administrative claims data that are designed for use by public programs (e.g., Medicaid and CHIP), state marketplaces, dental benefits administrators (DBAs), and managed care organizations (MCOs). DQA Measures have been formally adopted by the Centers for Medicare and Medicaid Services (CMS), the Health Services and Resources Administration (HRSA), state Medicaid programs, and state Marketplaces.<sup>2-4</sup> This User Guide was developed to assist in implementing the administrative claims-based DQA Measures for adults.

## B. DQA Measures Summary

Table 1 summarizes all validated DQA administrative claims-based measures for **adults** as of September 1<sup>st</sup>, 2020. Detailed specifications are available on the [DQA website](#).<sup>5</sup> Information on measures currently in development also is available on the [DQA website](#).<sup>6</sup> DQA measures are reviewed on an annual basis with new versions effective January 1<sup>st</sup> of each year. This User Guide is updated on the same schedule.

### *Adult Measures*

The DQA approved three adult measures focused on prevention and disease management in December 2016 (Table 1). Since then, three additional adult measures to assess ambulatory care sensitive dental-related emergency department visits and oral evaluation for individuals with diabetes were approved by the DQA in June 2019. These measures were developed for implementation with administrative enrollment and claims data for plan and program level reporting. This User Guide focuses on these measures.

### *Pediatric Measures*

The DQA's initial measure set ("Starter Set"), Dental Caries in Children: Prevention and Disease Management, was approved by the DQA and published in July 2013. These measures were developed for implementation with administrative enrollment and claims data for plan and program level reporting. Two measures of ambulatory care sensitive emergency department visits among children for reasons related to dental caries and subsequent follow-up with a dental provider were subsequently developed in 2014 for implementation with administrative enrollment and claims data for program level reporting. DQA measures have been endorsed by the National Quality Forum.

Two measure concepts from the Starter Set that were developed for implementation with electronic health records (EHRs) were approved by the DQA and published in the United States Health Information Knowledgebase in October 2014.<sup>7,8</sup>

The pediatric measures and companion User Guide is available on the [DQA website](#).

Table 1. DQA Administrative Claims-Based Measures for Adults Summary†

**Evaluating Utilization**

Measure Abbreviation	Measure Name	Description	NQF #	Data Source	Measure Domains	Level(s) of Measurement
PEV-A-A	Periodontal Evaluation in Adults with Periodontitis	Percentage of enrolled adults aged 30 years and older with history of periodontitis who received a comprehensive or periodic oral evaluation or a comprehensive periodontal evaluation within the reporting year.	N/A	Administrative enrollment and claims	Related Health Care Delivery: Use of Services	Program, Plan

**Evaluating Quality of Care**

Measure Abbreviation	Measure Name	Description	NQF #	Data Source	Measure Domains	Level of Measurement
POC-A-A	Non-Surgical Ongoing Periodontal Care for Adults with Periodontitis	Percentage of enrolled adults aged 30 years and older with a history of periodontitis who received an oral prophylaxis OR scaling/root planing OR periodontal maintenance visit at least 2 times within the reporting year.	N/A	Administrative enrollment and claims	Process	Program, Plan
TFL-A-A	Topical Fluoride for Adults at Elevated Caries Risk	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.	N/A	Administrative enrollment and claims	Process	Program, Plan
EDV-A-A	Ambulatory Care Sensitive Emergency Department Visits for Non-Traumatic Dental Conditions in Adults	Number of emergency department (ED) visits for ambulatory care sensitive dental conditions per 100,000 member months for enrolled adults	N/A	Administrative enrollment and claims	Access	Program, Plan
EDF-A-A	Follow-up after Emergency Department Visits for Non-Traumatic	The percentage of ambulatory care sensitive dental condition emergency department visits among adults aged 18 years and older in the reporting period for which the member visited a	N/A	Administrative enrollment and claims	Process	Program, Plan

	Dental Conditions in Adults	dentist within (a) 7 days and (b) 30 days of the ED visit				
DOE-A-A	Adults with Diabetes – Oral Evaluation	Percentage of enrolled adults with diabetes who received a comprehensive or periodic oral evaluation or a comprehensive periodontal evaluation within the reporting year	N/A	Administrative enrollment and claims	Process	Program, Plan

†The detailed specifications can be found on the DQA website at: <https://www.ada.org/en/science-research/dental-quality-alliance/dqa-measure-activities/measures-medicare-and-dental-plan-assessments>



## C. Implementation Considerations

To implement standardized performance measurement that fosters quality improvement and improved health outcomes, clearly specified, feasible, reliable, and valid measures are required. When standardized measures are implemented across reporting entities, benchmarks can be established, comparisons can be made, and improvement opportunities can be identified. DQA Measures are standardized with detailed specifications and have been validated for feasibility, reliability, usability, and validity.

Equally important to valid measurement is appropriate implementation of the measures. Measure users should verify that they can feasibly, reliably and validly implement the measures within their own systems of care.<sup>1</sup> This includes assessing the completeness and accuracy of the critical data elements used to calculate the measures, implementing the measures following the detailed measure specifications, and evaluating face validity of the resulting measure scores with individuals who have appropriate local expertise.

### *Implementing Measures for the Appropriate Reporting Units/Level of Care and Data Sources*

Quality of care is assessed at multiple levels, such as practices, MCOs or medical/dental benefits administrators, public insurance programs, and public health programs. There often are different measurement considerations at different "levels" of care. The level for which a measure is specified may also be referred to as the "reporting unit." In addition, different types of data sources (e.g., administrative claims, EHRs, or surveys) have different strengths and limitations. Measure development takes into account both the reporting unit and the data source.

**Measures should be reported at the level (e.g., program, plan, or practice) and using the data source (e.g., administrative claims or EHR) for which they were developed and validated.**

**Implementation of measures at different levels or with different data sources than those for which the measure was intended may not be reliable.**

### *Implementing Measures in Accountability Applications*

Performance measures are increasingly being used for accountability applications, which include consumer report cards, pay for performance programs, certification, and accreditation.

**Before using a measure for accountability purposes, it is strongly recommended that the accountability application be preceded by a period during which reporting entities gain experience with measure implementation, data are collected to establish baseline values, and appropriate benchmarks for comparison and performance goals are identified.**

The National Quality Forum advises:<sup>9</sup>

When performance measures are used for accountability applications such as public reporting and pay-for-performance, then purchasers, policymakers and other users of performance measures should assess the potential impact on disadvantaged patient populations and the providers/health plans serving them to identify unintended consequences and to ensure alignment with program and policy goals. Additional actions such as creating peer groups for comparison purposes could be applied. (p. 11)

Incorporating quality measures for accountability applications should be tested using multiple years of measure data to evaluate whether the application achieves the intended goals and whether there are unintended consequences that may undermine quality improvement efforts. It is incumbent upon the users of performance measures to carefully evaluate these impacts prior to implementing the accountability application. Development of benchmarks for quality measures used in any reporting applications should be guided by historical data evaluation for the population being served. When used in pay-for-performance application, the Medicaid state agency or other organization instituting the program should develop benchmarks using historical data based on the same definition of the measure that plans will be held accountable to and testing the application prior to implementation. Additionally, benchmarks need to be evaluated for each re-measurement period to avoid undermining the strides in quality improvements.

Implementing measures initially in non-accountability quality improvement initiatives can inform the development of accountability applications. Accountability applications should be considered only after there is experience with measure implementation, careful review and interpretation of the resulting measure rates, and an evaluation of the measure's effectiveness in promoting identified quality improvement and care goals.

## 2. Data Collection, Preparation, and Reporting for Measures Implemented using Administrative Enrollment and Claims/Encounter Data

### A. Defining Reporting Year: Calendar Year versus Federal Fiscal Year

If not otherwise specified, the definition of “reporting year” can be either calendar year (CY) (January 1, 20XX – December 31, 20XX) or federal fiscal year (FFY) (October 1, 20XX through September 30, 20YY). During testing of the DQA Starter Set, the results were similar between these two definitions. Agencies requesting measurement scores should specify the reporting year. The reporting year should be reported with the measurement score. Some measures require data from time periods preceding the reporting year. The measure technical specifications indicate the data collection period required.

### B. Level of Measurement/Reporting Unit

Measures using administrative data may be specified for reporting at the program (e.g., Medicaid) or plan (e.g., MCO or DBA) level. The technical specifications for each measure specify for which reporting unit the measure was developed and validated. Reporting on the measure for a unit other than that for which the measure was developed may not be reliable.

### C. Data Quality

Critical data elements are those without which the measure cannot be calculated (e.g., birth date, date of service, and procedure codes). Stratification data elements are those data elements used for stratification of the measure score (e.g., race, ethnicity, and geographic location). Particularly for critical data elements, reporting entities should identify error thresholds — the maximum percentage of missing or invalid values that will be accepted — prior to adopting a measure. Following guidance from CMS, it is recommended that data element error thresholds be set below 5%.<sup>10</sup> Reporting entities should have detailed protocols in place for routinely assessing data completeness, accuracy, and quality.

**Although reliability and validity of the DQA Measures has been established, ultimate reliability and validity of reported measure scores depend critically on the quality of the data that are used to calculate the measures. The completeness (percentage of missing or invalid values) and**

**accuracy of all critical data elements should be investigated prior to measurement for the reporting unit and reporting year.**

#### **D. Age Eligibility**

The technical specifications identify the eligibility criteria for each measure. DQA Measures are developed for alignment and use across public and private sectors. When used for comparisons across Medicaid/CHIP programs, the DQA has included individuals aged younger than 21 years (<21 years) in its pediatric measures to be consistent with Medicaid Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) eligibility. When used for reporting within a Health Insurance Marketplace under the Affordable Care Act, plans should include individuals younger than aged 19 years (<19 years) for pediatric measures to be consistent with the age requirements for Essential Dental Benefit coverage. Entities reporting for other programs or purposes should check with program officials regarding the appropriate age criterion. The age criterion used should be reported with the measurement score.

The DQA uses 18 years as its lower age bound for potential inclusion in adult measures to be consistent with the lower age bound included in the Medicaid Core Set of Adult Health Care Quality Measures and the Health Insurance Marketplace Quality Rating System. Because age eligibility varies for pediatric and adult dental benefit coverage across the public and private sectors, the age ranges for pediatric measures and adult measures may overlap. Measure specifications between adult and pediatric populations for the same measure concept (e.g., topical fluoride) may be different; therefore, it is important that measure implementers consult the appropriate specifications and not use the same measure specifications across both populations. Program officials should be consulted to confirm the upper bound of the age range that should be reported for pediatric measures and the lower bound of the age range that should be reported for adult measures. The age criteria used should be reported with the measure scores, and comparisons between programs should be limited to uniform age bounds.

#### **E. Dental Benefits Eligibility**

Enrolled members who are not eligible for dental benefits should be excluded. The number of individuals excluded should be reported.

## **F. Measures Requiring Additional Claims Data (e.g., Medical and Pharmacy)**

Some measures, such as Ambulatory Care Sensitive Emergency Department Visits for Non-Traumatic Dental Conditions in Adults and Adults with Diabetes – Oral Evaluation, require claims data from medical encounters (both measures) and pharmacy services (diabetes measure). Consequently, these measures will only apply to programs such as Medicaid or plans that offer integrated dental benefits (both medical insurance and dental benefits). Use of these measures as a requirement for stand-alone dental benefit plans will result in feasibility issues due to lack of access to appropriate data. Use by health plans that provide both medical insurance and dental benefits to a population may be considered after assessment of data element feasibility within the plans' databases.

## **G. Enrollment Eligibility: Calculating Continuous Enrollment for Reporting at the Plan (“Same” Plan) and Program (“Any” Plan) Levels**

Continuous enrollment for measures with 180-day (6-month) enrollment criteria requires that there be no gap in coverage. Continuous enrollment for measures with full-year enrollment criteria allows for a single one-month gap in coverage (or 31 days). At the state program level (e.g., Medicaid) a criterion of “any” plan applies when assessing continuous enrollment, whereas at the plan level (e.g., MCO or DBA) a criterion of “same” plan applies. That is, at the program level, all enrollment months are counted regardless of whether the enrollee switched plans during the reporting period; at the plan level, only enrollment months in the particular plan are counted. The criterion of “any” plan versus “same” plan should be reported with the measure rate. While this prevents direct aggregation of results from plan to program, each entity is given due credit for the population it serves. Thus, programs with multiple MCOs and/or DBAs should not merely “add up” the plan level rates but should calculate the overall program rate (i.e., using the “any” plan criterion) from their databases to allow inclusion of individuals who were continuously enrolled but switched plans during the reporting year. Measure implementers also are encouraged to report the average enrollment duration of all members included in the denominator with the measure rate (total number of months enrolled/total unduplicated members).

## **H. Paid and Unpaid Claims**

The technical specifications for each measure indicate whether only paid claims should be used or whether both paid and unpaid claims (including pending, suspended, and denied claims)

should be used. The intent of measures that specify both paid and unpaid claims is to capture whether or not the enrollee received the service that is the focus of the measurement during the reporting period regardless of whether the claim for that service was paid. Paid claims include services covered under a per member per month (PMPM) payment. Only the most recent disposition of adjudicated claims should be used, and implementers should allow for at least three months of claims run-out from the end of the reporting period before calculating the measures. For example, if the reporting period is calendar year 2020, then the measures should not be run before April 1, 2020 to allow sufficient time for claims processing. Implementers should check with program administrators for any requirements related to claims run-out. In the absence of program requirements, implementers should verify that the run-out period is long enough to have sufficiently complete claims for reliable reporting. The claims run-out period should be reported with the measure rate.

## **I. Bundled Services Reported Using a Single Code on Dental Procedures and Nomenclature (CDT) Code**

Some state programs may reimburse a single amount for a bundled set of services – e.g., oral evaluation, topical fluoride, and prophylaxis. In such instances, providers should be encouraged to record all the services rendered on the claim form using the appropriate CDT codes. For calculating a measure, procedure codes should be interpreted according to the descriptions in the CDT manual. For example, if professionally applied topical fluoride is included as part of a bundled service under a procedure code other than CDT codes D1206 or D1208 and there is no record of D1206 or D1208 on the claim submitted for the bundled service, then it would not be included in the numerator for the Topical Fluoride measure.

## **J. FQHC Encounter Billing**

Some FQHCs may be reimbursed based on an encounter — i.e., they are reimbursed based on each visit and not on the individual services provided during that visit. In such instances, that encounter may be captured in the claims system as a designated procedure/encounter code. Information on the specific services provided during that encounter is not captured. Performance reports from programs and plans should note such reimbursement policies and acknowledge the policy's limitation for accurately capturing service provision.

## K. Non-FFS Reimbursement

Providers who are reimbursed using payment methods other than fee-for-service (e.g., capitation, salary, and hybrid payment methodologies) should be required to submit information on all rendered services on the encounter form to enable appropriate quality measurement. Programs and plans that reimburse FQHCs on an encounter payment basis may similarly want to consider approaches for capturing information on all rendered services to promote accurate quality measurement.

## L. Identifying Individuals at “Elevated” Risk

Evidence-based guidelines suggest a risk-based approach to prevention.<sup>11</sup> Consequently, some DQA measures are limited to individuals identified as being at “elevated risk” for caries. Individuals are identified as being at caries risk through the presence of caries risk assessment findings codes (D0602 and D0603) or the presence of CDT codes signifying caries-related treatment (Table 2) using the following approach:

- 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 2 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 2. 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.

**Table 2: CDT Codes to identify adults at “elevated risk”**

D1352	D1354	D2393	D2620	D2712
D2790	D2140	D2394	D2630	D2720
D2791	D2150	D2410	D2642	D2721

D2792	D2160	D2420	D2643	D2722
D2794	D2161	D2430	D2644	D2740
D2799	D2330	D2510	D2650	D2750
D2931	D2331	D2520	D2651	D2751
D2932	D2332	D2530	D2652	D2752
D2933	D2335	D2542	D2662	D2753
D2390	D2543	D2663	D2781	D2780
D2391	D2544	D2664	D2782	
D2392	D2610	D2710	D2783	

The measure specifications include identification of elevated risk through specific procedure codes indicative of caries-related lesion treatment identified in administrative claims data during the period spanning the reporting year and the three prior years. **Implementers should check for both the risk assessment findings codes and the caries-related treatment codes to identify individuals at elevated risk. These are NOT alternative methodologies; they are complementary methodologies.** Individuals do not have to be enrolled in the prior years. The past history is only a look-back period for available claims. **The reporting year remains a single year and is the only year for which minimum enrollment length must be verified.** Some individuals who meet enrollment criteria in the reporting year may not have the claims history with the same plan for all three prior years. The denominator requires inclusion of those individuals who can be confirmed as being at elevated risk with administrative claims data and is not intended to be a prevalence measure of all individuals at elevated risk.

### M. Stratification by Enrollee and Program Characteristics

The DQA encourages the measure results to be stratified by age, race, ethnicity, geographic location, socioeconomic status, payer type, and program/plan type. Such stratifications will enable implementers to identify variations in care by enrollee and program characteristics, which can be used to inform quality improvement initiatives. To stratify the measure results, the denominator population is divided into different subsets based on the characteristic of interest (e.g., age, race, ethnicity, or geographic location) and the rates are reported for each sub-population. Guidance on reporting on stratification variables is provided below.

#### Race and Ethnicity

To promote consistency in the race/ethnicity categories, measures may be stratified by the following aggregated and **mutually exclusive** race and ethnicity categories:



- Hispanic
- Non-Hispanic White
- Non-Hispanic Black
- Non-Hispanic other race or multiple race

Report the percentage of individuals in the overall measure denominator with unknown/missing values.

Individuals should be assigned to only one of the above categories. Individuals who select Hispanic ethnicity alone, or in combination with any of the race categories, should be classified as Hispanic. Non-Hispanic individuals who select more than one race category should be classified as multiple race.

### **Sex**

- Female
- Male

Report the percentage of individuals in the overall measure denominator with unknown/missing values.

### **Payer Type**

- Private
- Medicaid
- Other Public
- Uninsured

Report the percentage of individuals in the overall measure denominator with unknown/missing values.

### **Geographic Location**

- Urban
- Rural

Report the percentage of individuals in the overall measure denominator with unknown/missing values.

To classify geographic location:

- Use the enrollee's residence zip code.
- Map the zip code to one of Rural-Urban Commuting Areas (RUCA) codes using RUCA 3.1 available at: <https://ruralhealth.und.edu/ruca>.
- Use Categorization D to classify rural versus urban place of residence; available at: <http://depts.washington.edu/uwruca/ruca-uses.php>.

### **Patients with special health care needs (SHCN)**

Identifying SHCN individual from claims data is now possible through the introduction of the new CDT code:

CDT code (D9997) dental case management - patients with special health care needs

Descriptive: Special treatment considerations for patients/individuals with physical, medical, developmental or cognitive conditions resulting in substantial functional limitations, which require that modifications be made to delivery of treatment to provide comprehensive oral health care services.

Report the percentage of individuals in the overall measure denominator with unknown/missing values.

States should evaluate the extent to which there is missing information. The percentage of missing values should be reported with the stratifications. When missing data exceed 10%, stratifications should be interpreted with caution.

### 3. Measure Specification Updates

The DQA has an annual measure review and maintenance process that includes a 30-day public comment period. The annual measure review reports are available on the [DQA website](#).<sup>6</sup> During the 2020 annual measure review, there were some changes to the measure specifications. Measure specification updates are summarized in [Appendix 1](#).

## 4. Frequently Asked Questions

### A. Classifying Individuals at Elevated Caries Risk

#### Applicable Measure:

- Topical Fluoride for Adults at Elevated Caries Risk

#### ***A1. Why did the DQA not consider all Medicaid-enrolled individuals as being at “elevated risk”?***

According to the definition of healthcare quality promulgated by the Institute of Medicine<sup>i</sup> and reiterated by the definitions of quality domains from the National Quality Measures

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<sup>i</sup> The Institute of Medicine defines healthcare quality as “the degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge.” Institute of Medicine (U.S.). Committee on Quality of Health Care in America. Crossing the quality chasm: a new health system for the 21st century. Washington, D.C.: National Academies Press; 2001.

Clearinghouse,<sup>ii</sup> to be indicative of “quality,” a performance measure should be based on current best evidence. Accordingly, measures of quality, especially those that will be used to assess performance and provision of appropriate services, are generally grounded in evidence-based guidelines. The evidence-based guidelines regarding topical fluoride developed by the American Dental Association<sup>12</sup> recommend that these services be provided for individuals “at-risk” for dental caries. The DQA has focused on individuals at elevated risk for such prevention measures to focus measurement on priority populations where evidence of effectiveness is greatest and there is the least uncertainty about the appropriateness of the intervention. Testing data found that significant performance gaps existed within the elevated risk populations.<sup>13,14</sup>

Within the care delivery system, evidence-based guidelines also recommend that **patient-level risk assessment** should drive treatment planning and care delivery. Accordingly, the DQA's approach to performance measurement within the care delivery system is based on these patient-centered decisions instead of using broad population level indicators such as socio-economic status to measure performance. Not every person enrolled in Medicaid is at elevated caries risk. While social determinants play a significant role in influencing outcomes, their impact on each patient needs to be carefully assessed. Encouraging individualized risk-based care, in itself, is a quality improvement activity.

Creation of a “performance” measure should not be construed as a policy statement or as a basis for altering benefit design. For example, a performance measure focusing on preventive services for individuals **at elevated risk** does not imply that only individuals at elevated risk should receive the services; the measure is simply a means of assessing to what degree preventive services are being provided to a particular group of individuals for whom guidelines have established good evidence for recommending the services.

## ***A2. Why use methodologies that require prior years' data to identify elevated risk, which may impact feasibility?***

Based on the best current evidence, the National Institute for Health and Care Excellence (NICE) suggests that “clinical judgment of the dentist and his or her ability to combine risk factors, based on their knowledge of the patient and clinical and socio-demographic information is as good

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<sup>ii</sup> 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 NQMC Measure Domain Definitions. Agency for Healthcare Research and Quality, Rockville, MD. 2018; <https://www.ahrq.gov/gam/summaries/domain-definitions/index.html>. Accessed April 26, 2019.

as, or better than, any other method of predicting caries risk.”<sup>15</sup> Therefore, the DQA risk-based measures specifications include the caries-risk assessment CDT codes introduced in 2014. In addition, evidence from a systematic review indicates that previous caries experience is an important predictor of future disease.<sup>16</sup> Therefore, additional methodology to identify individuals at elevated risk was included that is based on prior caries experience, which can be identified using caries-related treatment codes in administrative claims data. The DQA “look-back method” uses a tested methodology to identify individuals whose claims history is indicative of caries risk. Measure implementers should use both caries risk assessment codes and the caries-related treatment codes to identify individuals at elevated caries risk.

**It is important to note that the elevated risk identification methodology is not intended as a “risk assessment tool” to be used at the level of individual patients either to assess risk or to define dental benefits or qualification for services for specific groups of individuals. It is only a model used to identify individuals who can be confirmed to be at “elevated risk” for caries using claims data for the purpose of measuring program performance. This method is not intended to identify every person who may be at elevated risk.**

### ***A3. Should individuals be enrolled in each of the three years to apply the ‘look-back method’?***

There is no enrollment requirement during the three years prior to the reporting year. The past history is a look-back period for *available* claims. The reporting year remains a single year and is the only year during which minimum enrollment length must be verified.

### ***A4. What should I do if I do not have 3 years of claims history prior to the reporting year for some individuals meeting the enrollment criteria in the reporting year?***

The measure specifications require looking for specified caries-indicative codes in the reporting year and in the three prior years for available claims. Some individuals who meet enrollment criteria in the reporting year may not have the claims history with the same plan for prior years. The intent is to identify those individuals who can be confirmed as being at elevated risk; the intent is not to identify all individuals at elevated risk. The measure includes the subset of individuals who can be identified as being at elevated risk using claims data.

**A5. If I am a new plan in Medicaid or am entering a new market and do not have any claims from prior years, what can I do?**

If the prior three years claims history is not available, this should be noted within the final reports with an indication of how many prior years (if any) of data were used. When fewer years of historical data are used, the number of individuals who qualify for the denominator will decrease and the measure rates may be impacted. Comparison between plans may not be valid unless all plans use the same look-back period.

**B. For the measure *Topical Fluoride for Adults at Elevated Caries Risk*, why were 2 fluoride applications selected to qualify for the numerator?**

Evidence-based guidelines for adults suggest that professionally applied fluoride every 3-4 months is effective in preventing caries in adults at elevated risk for dental caries.<sup>11</sup> Programs and plans that wish to further explore receipt of topical fluoride among their enrollees to inform quality improvement efforts may find it useful to evaluate the number and percentage of individuals at increased caries risk who received 0, 1, 2, 3, or 4 or more topical fluoride applications.

**C. Identifying Individuals with a History of Periodontitis**

**Applicable Measures:**

- Periodontal Evaluation in Adults with Periodontitis
- Non-Surgical Ongoing Periodontal Care in Adults with Periodontitis

**C1. Do the measures distinguish between aggressive and chronic periodontitis?**

No, due to lack of diagnostic codes in claims data, these measures do not distinguish between aggressive and chronic periodontitis. CDT procedure codes indicative of periodontal treatment or maintenance are used to identify "history of periodontitis."

**C2. Why use methodologies that require prior years' data to identify individuals with periodontitis, which may impact feasibility?**

Both measures are designed to evaluate whether individuals who have a **history of periodontitis** continue to receive care. Therefore, the denominator population is comprised of individuals with periodontal treatment or maintenance in the three prior years.

***C3. Should individuals be enrolled in each of the three years to identify “history of periodontitis”?***

There is no enrollment requirement during the three years prior to the reporting year. The past history is based on *available* claims. The reporting year remains a single year and is the only year during which minimum enrollment length must be verified.

***C4. What should I do if I do not have a full 3 years of claims history prior to the reporting year for some individuals meeting the enrollment criteria in the reporting year?***

The measure specifications require looking for specified periodontitis-indicative codes in the three prior years. Some individuals who meet enrollment criteria in the reporting year may not have the claims history with the same plan for all three prior years. The intent is to identify those individuals who can be identified as having periodontitis; the intent is not to identify all individuals with periodontitis. The measure includes the subset of individuals who can be identified as having periodontitis.

***C5. If I am a relatively new plan in Medicaid or recently entering a new market and do not have claims history in that program/market for 3 prior years, what can I do?***

When three years claims history in the program or market is not available, this should be noted within the final reports with an indication of how many years of data were used. When fewer than three years of historical data are used, the number of individuals who qualify for the denominator will decrease and the measure rates may be impacted. Comparison between plans may not be valid unless all plans use the same look-back period.

***C6. If I am a new plan in Medicaid or am entering a new market and do not have any claims from prior years, what can I do?***

If there is **no** claims history in prior years, it will not be possible to identify individuals with a history of periodontitis and, therefore, this measure cannot be calculated

***D. Why is Periodontal Evaluation in Adults with Periodontitis considered a “utilization” measure and Ongoing Care in Adults with Periodontitis considered a “process quality measure”?***

Utilization measures are identified by the National Quality Measures Clearinghouse as “related health care delivery measures” that “can assess encounters, tests, or interventions that are not

supported by evidence for the appropriateness of service for the specified individuals."<sup>17</sup> A process of care quality measure 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."<sup>17</sup> There currently is an insufficient evidence base for associating oral evaluations with improved outcomes for patients with a history of periodontitis. However, oral evaluations can be used to identify the extent to which adults with a history of periodontitis are being seen for care. The measure *Ongoing Care in Adults with Periodontitis* identifies specific dental care services indicative of ongoing care associated with successful long-term management of periodontal disease.<sup>18-21</sup> The two measures provide complementary information. *Periodontal Evaluation* indicates the percentage of enrollees with a history of periodontitis who are seen for care, whereas *Periodontal Ongoing Care* identifies the percentage of individuals with a history of periodontitis who receive ongoing care. *Periodontal Evaluation* measure scores can provide context for interpreting *Periodontal Ongoing Care* scores by enabling programs to identify what percentage of patients with a history of periodontitis are accessing care.

## E. Why are beneficiaries dually eligible for Medicaid and Medicare (Dual Eligibles) excluded from the medical-dental measures?

### Applicable Measures:

- Ambulatory Care Sensitive Emergency Department Visits for Non-Traumatic Dental Conditions in Adults
- Follow-up after Emergency Department Visits for Non-Traumatic Dental Conditions in Adults
- Adults with Diabetes – Oral Evaluation

These measures require medical administrative claims data as well as dental. Medicaid programs frequently do not have access to complete Medicare claims data for dual eligible beneficiaries. Thus, the measure cannot be reliably calculated. A program that does have access to complete Medicare claims data may want to additionally run these measures for its dual eligible population. If a program elects to do this, measure scores for the dual eligible population should be reported separately from the non-dual eligible population. In addition, the program should clearly indicate how it is identifying and defining "dual eligibles" because not all dual eligibles are fully eligible for Medicaid benefits (i.e., some dual eligible beneficiaries may only be eligible for limited Medicaid coverage). The definition for "dual eligible" and the extent of Medicaid benefits coverage for those individuals should be included in reports of measure scores for the dual eligible population.

**F. Why are inpatient admissions excluded from Ambulatory Care Sensitive Emergency Department Visits for Non-Traumatic Dental Conditions in Adults and Follow-Up after Emergency Department Visits for Non-Traumatic Dental Conditions in Adults?**

The intent is to measure access by evaluating the proportion of the population that seeks care in the emergency department for ambulatory care sensitive non-traumatic dental conditions and who are subsequently discharged from the ED. Patients who are admitted for hospitalization represent a different category of health care needs and a different episode of care. Patients who receive care in the ED typically do not receive definitive care and are referred to a dental provider. Consequently, the measure of follow-up care focuses on those patients discharged from the ED. Measure testing found that these ED visits resulting in inpatient admissions represent fewer than 2% of ED visits. Consequently, exclusion of these visits will not materially affect relative comparisons between programs or evaluation of within-program trends over time. It is important that measure implementers recognize that this measure is **not designed to measure resource use**. The DQA recognizes that non-traumatic dental condition ED visits that result in inpatient admissions are significant in terms of both health consequences and system resources. Consequently, the measure specifications require that programs report the number of visits excluded because they resulted in inpatient admissions so that programs and other stakeholders are aware of the magnitude of these visits and can monitor trends over time.

**G. For the measure Follow-Up after Emergency Department Visits for Non-Traumatic Dental Conditions in Adults, are the 7-day and 30-day follow up periods for visits with a dentist after a non-traumatic dental condition emergency department visit mutually exclusive?**

No, visits that are captured in the 7-day follow-up visit also will be captured in the 30-day follow-up visit.

**Please contact DQA staff at [dqa@ada.org](mailto:dqa@ada.org) with additional implementation questions.**



## End Notes

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## Appendix 1: Measure Specification Updates

### 2021 Updates: Effective January 1, 2021

<b>General Updates</b>	
<ul style="list-style-type: none"> <li>Updated effective date, copyright, and weblink citations.</li> </ul>	
<b>User Guide Updates</b>	
<ul style="list-style-type: none"> <li>Added guidance for stratifying measure scores by special health care needs.</li> </ul>	
<b>Updates to the Technical Specifications</b>	
<b>Measure</b>	<b>Change(s)</b>
Topical Fluoride for Adults at Elevated Caries Risk (TFL-A-A)	<p>Added the following CDT codes to Table 1: Codes to identify “elevated risk”</p> <ul style="list-style-type: none"> <li>D1352 preventive resin restoration in a moderate to high caries risk patient – permanent tooth</li> <li>D2753: crown – porcelain fused to titanium and titanium alloys</li> </ul>
Follow-up after Emergency Department Visits for Non-Traumatic Dental Conditions in Adults (EDF-A-A)	<p><b>NUCC Code Update</b></p> <p><b>1223X2210X</b> Dental Providers; Dentist - Orofacial pain</p> <p>A dentist who assesses, diagnoses, and treats patients with complex chronic orofacial pain and dysfunction disorders, oromotor and jaw behavior disorders, and chronic head/neck pain. The dentist has successfully completed an accredited postdoctoral orofacial pain residency training program for dentists of two or more years duration, in accord with the Commission on Dental Accreditation's Standards for Orofacial Pain Residency Programs, and/or meets the requirements for examination and board certification by the American Board of Orofacial Pain.</p> <p>Source: American Academy of Orofacial Pain, <a href="http://www.aaop.org">http://www.aaop.org</a>            Additional Resources: American Board of Orofacial Pain, <a href="http://www.abop.net">http://www.abop.net</a>            Version 19.1 of the NUCC Health Care Provider Taxonomy Codes (<a href="http://nucc.org/index.php/code-sets-mainmenu-41/provider-taxonomy-mainmenu-40">http://nucc.org/index.php/code-sets-mainmenu-41/provider-taxonomy-mainmenu-40</a>)</p>

### 2020 Updates: Effective January 1, 2020

<b>General Updates</b>
<ul style="list-style-type: none"> <li>Updated effective date, copyright, and weblink citations.</li> </ul>
<b>User Guide Updates</b>

<ul style="list-style-type: none"> <li>Incorporated three additional measures approved by the DQA in June 2019: Ambulatory Care Sensitive Emergency Department Visits for Non-Traumatic Dental Related Reasons in Adults; Follow-up after Emergency Department Visits for Non-Traumatic Dental Related Reasons in Adults; and Adults with Diabetes – Oral Evaluation</li> </ul>	
<ul style="list-style-type: none"> <li>Added guidance for stratifying measure scores by race/ethnicity, sex, payer type, and geographic location.</li> </ul>	
<ul style="list-style-type: none"> <li>Added Measure Specification Updates section.</li> </ul>	
<ul style="list-style-type: none"> <li>Clarified measure intent of <i>Ongoing Care in Adults with Periodontitis</i> in FAQs.</li> </ul>	
<ul style="list-style-type: none"> <li>Added FAQ about the rationale for excluding Medicaid-Medicaid dual eligibles in medical-dental measures.</li> </ul>	
<ul style="list-style-type: none"> <li>Added FAQ about the inpatient admissions exclusions for Ambulatory Care Sensitive Emergency Department Visits for Non-Traumatic Dental Related Reasons in Adults</li> </ul>	
<ul style="list-style-type: none"> <li>Added FAQ about the follow-up time frames for the measure <i>Follow-Up after Emergency Department Visits for Non-Traumatic Dental Conditions in Adults</i> to clarify that the 7-day and 30-day follow-up time frames are not mutually exclusive.</li> </ul>	
<ul style="list-style-type: none"> <li>Added Appendix 1 – Measure Specification Updates.</li> </ul>	
<p><b>Technical Specification Updates</b></p>	
<b>Measure</b>	<b>Change(s)</b>
Ongoing Care in Adults with Periodontitis (POC-A-A)	Clarified that the measure intent is purposely broader than a measure focused only on D4910, periodontal maintenance in the Measure Purpose section.
Topical Fluoride for Adults at Elevated Caries Risk (TFL-A-A)	Clarified the different types of fluoride captured in the numerator in the Measure Limitations section.