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# DENTAL QUALITY ALLIANCE: 2019 ANNUAL MEASURES REVIEW

REPORT FROM THE DQA MEASURES  
DEVELOPMENT AND MAINTENANCE  
COMMITTEE

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JUNE 2019

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## INTRODUCTION AND PURPOSE

The purpose of this report is to summarize the outcomes of the 2019 annual review of the Dental Quality Alliance's (DQA's) quality measures for pediatric and adult populations. DQA measures address prevention and disease management of oral health diseases for both children and adults, including measures of utilization, access, cost, and quality of dental services for individuals enrolled in public (Medicaid, CHIP) and private (commercial) insurance programs.

The detailed specifications can be found on the DQA website at:

<http://www.ada.org/en/science-research/dental-quality-alliance/dqa-measure-activities/measures-medicare-and-dental-plan-assessments>

## PROCESS

The DQA has established an annual measure review and maintenance process. This measure review process is overseen by the DQA's Measures Development and Maintenance Committee (MDMC), which is comprised of six subject matter experts, a member of the DQA Executive Committee, and DQA Chairs. ([Appendix A](#)).

The DQA released a call for comments to its members and the broader oral health community in February 2019. Following a 30-day comment period, the MDMC carefully considered and addressed the comments.

The DQA's MDMC would like to thank all stakeholders who submitted comments to the DQA review processes to allow for thorough review of its measures. The DQA reviewed and reaffirmed its measures by approving this report at its meeting on June 14<sup>th</sup> 2019.

## CODE UPDATES

Review of the 2019 CDT Manual and National Uniform Code Committee Health Care Provider Taxonomy code updates did not identify new codes relevant to the measures.

Review of the International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10) identified the following codes as additions to the code sets for Tables 1 and 2 in the measure specifications for Ambulatory Care Sensitive Emergency Department Visits for Dental Caries in Children and Follow-Up after Emergency Department Visits for Dental Caries in Children:

Table 1 additions:

KØ2.52	Dental caries on pit and fissure surface penetrating into dentin
KØ2.53	Dental caries on pit and fissure surface penetrating into pulp
KØ4.Ø1	Reversible Pulpitis
KØ4.Ø2	Irreversible pulpitis
KØ8.439	Partial loss of teeth due to caries, unspecified class
KØ8.89	Other specified disorders of teeth and supporting structures

Table 2 additions (must be paired with an additional-listed diagnosis code from Table 1):

LØ3.213	Periorbital cellulitis
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## COMMENTS TO DQA ANNUAL MEASURE REVIEW

The following paragraphs summarize the review of the comments as addressed by the MDMC. The detailed public comments are contained in [Appendix B](#).

### Utilization of Services

The measure titled Utilization of Services is the percentage of enrolled children under age 21 years who received at least one dental service within the reporting year (NQF #2511).

### *Optional Stratification Variables*

The measure specifications include stratification by age. One commenter recommended incorporating additional optional stratification variables including payer type (e.g., Medicaid, CHIP, and private commercial benefit programs), geographic location, and race/ethnicity. The MDMC appreciates the suggestion of including additional stratifications. Utilization of Services is a National Quality Forum (NQF) endorsed measure, and the NQF does not allow for optional stratifications. The proposed stratifications were not included as required stratifications due to such feasibility issues as significant missing data and/or additional measure complexity. However, as noted in the User Guide, the DQA recognizes the value of measure stratification to identify disparities and target outreach efforts. Therefore, the DQA encourages measure results be stratified by these additional characteristics where feasible: "Such stratifications will enable implementers to identify variations in care by child and program characteristics, which can be used to inform quality improvement initiatives." [\[2019 DQA User Guide\]](#) To further support such

stratification, additional guidance on how to implement stratifications has been incorporated into the 2020 User Guide.

### *Clarification to the Rationale Section*

A second comment questioned the link between the language in the Rationale section of the measure specification and the lack of specificity of the procedure codes used to compute the measure numerator. The commenter specifically questioned if the procedure codes included in the measure logic should instead be focused on caries prevention and disease management as suggested in the measure specification rationale. The DQA noted that this measure was developed as part of a measure set that targets prevention and management of dental caries in children given that dental caries is the most common chronic condition in children. This measure is designed to be a broad access to care measure given the overall low utilization of dental services by children within the delivery systems. The DQA appreciates the suggestion and will update the rationale to clarify the intent of the measure.

### Preventive Services

The measure titled Preventive Services for Children at Elevated Caries Risk is the percentage of enrolled children who are at “elevated” risk (i.e., “moderate” or “high”) who received a topical fluoride application and/or sealants within the reporting year. The DQA maintains three versions of this measure (dental services, oral health services, or dental or oral health services) to capture preventive services that are rendered by both dental and non-dental providers. There were two comments for this measure.

### *Elevated Risk*

The first commenter requested the consideration of removal of the elevated risk criteria from the measure denominator and remarked that all children in Medicaid may be considered to be at risk. The commenter also suggested that the ‘elevated risk’ criteria could instead be a stratification variable. The DQA has focused on children at elevated risk for 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. Validation testing data found that significant performance gaps existed within the elevated risk populations. In addition, 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 child 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.

However, the DQA recognizes the value in assessing receipt of preventive services for all children and notes that such a revision would more closely align with the Centers for Medicare and Medicaid Services’ (CMS’s) Medicaid and CHIP Child Core Set measure, Percentage of Eligibles Who Received Preventive Dental Services (P-DENT). Modifying the measure to remove elevated risk involves some important considerations. For example, by not limiting the denominator to the elevated risk population, there may be confounding by access to care. The elevated risk

criteria necessarily includes only children who have accessed the care system; otherwise, they could not be identified as being at risk. Removal of this criterion would create confounding of the measure by access; i.e., programs with lower access to care in general will have lower performance on the preventive services measure because non-users of the system will be included in the measure denominator. Consequently, consideration is needed about whether another method of controlling access would need to be incorporated into the measure. The DQA believes a review of the data based on the proposed changes is needed and recommends a more thorough evaluation of this commenter's suggestion for future iteration of the measure.

### *Expansion of the Numerator Criteria to Define Preventive Services*

The second comment addressed the whether other preventive services should be included in the numerator to track utilization trend for all preventive services rather than just focusing only on sealants and fluoride. The DQA noted that considerations of inclusion of any additional services to the numerator should be evidence-based. The DQA noted that there were other preventive services such as the amorphous calcium phosphates that are supported by evidence to reverse the disease process, prevent progression of caries, and reduce incidence of future lesions. However, there are currently no procedure codes to document these services in the claims system. The DQA also noted that preventive resin restoration (PRR) and silver diamine fluoride (SDF) as suggested by one commenter for inclusion are indicated only in the presence of an active carious lesion to arrest the progression of disease. These are distinguished from sealants and fluoride, which are evidence-based services demonstrated to be most effective in preventing future disease in the absence of an active diseased state. The DQA also noted that there are other services, such as nutritional counselling and motivational interviewing<sup>1,2</sup>, that are considered preventive in nature and may be considered for the numerator. However, such an addition would require testing to establish feasibility, validity and reliability. To that end, the MDMC has elected not to change the measure for this review cycle and will explore testing the above considerations for future iteration of the measure.

### Oral Evaluation

Oral Evaluation is the percentage of enrolled children under age 21 who received a comprehensive or periodic oral evaluation within the reporting year (NQF #2517).

This is a process of care measure of whether children are receiving regular oral evaluations, including diagnostic services that are critical to evaluating oral disease and dentition development and to developing an appropriate oral health prevention regimen and treatment plan. There were two comments for this measure.

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<sup>1</sup> Mohammadi, T. M., Hajizamani, A., & Bozorgmehr, E. (2015). Improving oral health status of preschool children using motivational interviewing method. *Dental research journal*, 12(5), 476–481.

<sup>2</sup> Gao, X., Lo, E. C., Kot, S. C. and Chan, K. C. (2014), Motivational Interviewing in Improving Oral Health: A Systematic Review of Randomized Controlled Trials. *Journal of Periodontology*, 85: 426-437. doi:[10.1902/jop.2013.130205](https://doi.org/10.1902/jop.2013.130205)

### Optional Stratification Variables

The first comment recommended the consideration of additional optional stratification variables including payer type (e.g., Medicaid, CHIP, private commercial benefit programs), geographic location, and race/ethnicity. The MDMC appreciates the suggestion of including additional stratifications. This measure is an NQF endorsed measure and does not include these additional stratifications for the same reasons as detailed under Utilization of Services above. However, also as noted above, the DQA recognizes the value of the proposed stratifications; to further support such stratification, additional guidance on how to implement stratifications has been incorporated into the 2020 User Guide.

### Age Range Revision

The second comment suggested revising the age range currently included in the measure to be limited to children between the ages 1-21 years instead of 0-21 years. Evidence-based guidelines recommend clinical oral evaluations with a regular recall schedule that is tailored to individual needs based on assessments of existing disease and risk of disease (e.g., caries risk) with the recommended recall frequency ranging from 3 months to no more than 12 months for individuals younger than 18 years of age.<sup>3</sup> Clinical guidelines and literature support the recommended age for the first oral evaluation to be at the time of the eruption of the first tooth and no later than 12 months of age.<sup>4,5,6,7,8</sup> Consequently, the DQA maintains the measure as applicable to all children under the age of 21 years. The DQA also notes that the age stratifications include the age band of 0-1 years of age to allow implementers to understand measure performance across age groups.

### Topical Fluoride for Children at Elevated Caries Risk

This measure titled Topical Fluoride for Children at Elevated Caries Risk indicates the percentage of children at “elevated” risk (i.e., “moderate” or “high”) for caries who received at least two topical fluoride applications during the reporting year. The DQA maintains three versions of this measure (dental services, oral health services, or dental or oral health services) to capture topical fluoride applications that are rendered by both dental and non-dental providers

The commenter requested the consideration of removal of the elevated risk criteria from the measure denominator and remarked that all children in Medicaid may be considered to be at risk. The commenter also suggested that the ‘elevated risk’ criteria could instead be a stratification variable. The DQA has focused on children at elevated risk for 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. Validation testing

<sup>3</sup> National Institute for Health and Care Excellence (NICE). 2004. Clinical Guidelines. “CG19: Dental Recall – Recall Interval between Routine Dental Examinations.” Available at: <http://guidance.nice.org.uk/CG19>.

<sup>4</sup> American Academy of Pediatric Dentistry. Perinatal and infant oral health care. *Pediatr Dent* 2018;40(6):216-20.

<sup>5</sup> American Academy of Pediatric Dentistry. Policy on the dental home. *Pediatr Dent* 2018;40(6):29-30.

<sup>6</sup> “Get It Done In Year One”. <http://www.mychildrensteeth.org/assets/2/7/GetItDoneInYearOne.pdf>

<sup>7</sup> American Academy of Pediatrics. Maintaining and improving the oral health of young children. *Pediatrics* 2014;134(6):1224-9.

<sup>8</sup> American Academy of Pediatric Dentistry. Periodicity of Examination, Preventive Dental Services, Anticipatory Guidance/Counseling, and Oral Treatment for Infants, Children, and Adolescents. <https://www.aapd.org/research/oral-health-policies--recommendations/periodicity-of-examination-preventive-dental-services-anticipatory-guidance-counseling-and-oral-treatment-for-infants-children-and-adolescents/>

data found that significant performance gaps existed within the elevated risk populations. In addition, 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 child 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.

The DQA notes that evidence-based clinical recommendations suggest that topical fluoride should be applied at least every three to six months specifically in children at elevated risk for caries. **Error! Bookmark not defined.** Consequently, the DQA has elected to retain the elevated risk criteria.

### Treatment Services

The measure titled Treatment Services is the percentage of enrolled children who received a treatment service within the reporting year.

The comment on this measure requested clarification of the term "treatment service". The DQA notes that this is a related health care delivery measure and should be interpreted only in the context of other performance measures. The DQA also noted that specific services are not delineated for this measure, and higher or lower rates are not necessarily indicative of better or worse performance. The DQA notes that to make this rationale clearer, it will update the 2020 specification to clarify the term.

### Care Continuity

The measure titled Care Continuity is the percentage of children enrolled in two consecutive years who received a comprehensive or periodic oral evaluation in both years.

The comment for this measure referenced the procedure codes that are used to identify eligibility for inclusion in the numerator. The numerator for this measure includes the codes used to identify comprehensive and periodical oral evaluations (D0120, D0145 and D0150) that are critical to evaluating oral disease and dentition development. More specifically, the commenter suggested that CDT code D0150 could be removed from the numerator, positing that it would have low frequency. However, the DQA notes that this code may be applied to *new* or *established* patients and that excluding it would remove eligible patients from the numerator without any offsetting benefit. Consequently, the DQA will retain this code in the numerator.

### Ambulatory Sensitive Emergency Department Visits for Dental Caries for Children

This measure is defined as the number of emergency department (ED) visits for caries-related reasons per 100,000 member months for all enrolled children. One commenter requested that the DQA re-examine the following codes included in the diagnosis codeset used to identify caries-related ED visits for their relevancy and consider their removal from Table 1 of the measure:



- 525.3 Retained dental root
- 525.63 Fractured dental restorative material without loss of material
- 525.64 Fractured dental restorative material with loss of material
- 525.9 Unspecified disorder of the teeth and supporting structures
- 526.4 Inflammatory conditions of jaw
- 526.5 Alveolitis of jaw
- 526.61 Performance of root canal space
- 526.62 Endodontic overfill
- 526.63 Endodontic underfill
- 526.69 Other periradicular pathology associated with previous endodontic treatment
- 528.3 Cellulitis and abscess of oral soft tissues

The DQA's MDMC reviewed the processes used to develop the codeset, which included:

- Initial set developed by the research team based on a literature review to identify a comprehensive set of dental-related codes and using a consensus process that evaluated each code for whether it specifically is indicative of a *caries-related* visit;
- MDMC review and recommendations;
- Administrative data runs;
- Chart validation; and
- Face validity assessments through a public interim report and comment period, full DQA review of interim and final reports, DQA voting on approval of the measure, and peer-reviewed publication.<sup>9</sup>

The DQA's MDMC re-examined the specific codes called into question and the original testing data, including administrative data analyses and validation against medical charts. The MDMC re-affirmed that, in children, these conditions are more likely than not to stem from caries and caries-related sequelae.

Particular attention was paid to code 525.9. This code is a high frequency code and captures a significant proportion of caries-related diagnoses; consequently, removal of this would miss capturing a significant proportion of caries-related ED visits even though there is a risk of identifying some non-caries related visits. Based on its review of the chart validation data, the MDMC determined that consideration of the number of true positives excluded outweighed the risk of capturing some false positives. During initial testing, the committee explored moving the 525.9 code to Table 2 so that only those visits with this codes would be captured if a separate code from Table 1 accompanied this code. During chart reviews, the MDMC found that doing so decreased kappa values and sensitivity. Consequently, the MDMC determined that this code is appropriately included in Table 1. The current MDMC (which contains a different composition of members) re-evaluated all of these data and affirmed this determination. Consequently, the DQA will maintain the current codeset.

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<sup>9</sup> Herndon, J., Crall, J., Carden, D., Catalanotto, F., Tomar, S., Aravamudhan, K., Light, J. & Shenkman, E. (2017). *Measuring Quality: Caries-related Emergency Department Visits and Follow-up Among Children*. *Journal of Public Health Dentistry*, 10.1111/jphd.12206.

## Topical Fluoride for Adults at Elevated Caries Risk

This measure is defined as the 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.

There was one comment on this measure in relation to the Measure Limitations section of the measure specifications. One of the recognized limitations states that the measure does not distinguish between fluoride foam or fluoride gel. The commenter noted the absence of language referencing fluoride varnish. To be included in the numerator, the measure calls for the documentation of at least two instances (on different dates of service) of any combination of two fluoride specific CDT codes, D1206 and D1208. D1206 refers to professionally applied fluoride varnish and D1208 is any topical application of fluoride including fluoride gels or fluoride foams (excluding fluoride varnish). The DQA will revise the section, Measure Limitations, to reflect the difference in the topical fluoride mediums and specifically reference fluoride varnish.

## Ongoing Care in Adults with Periodontitis

The measure titled Ongoing Care in Adults with Periodontitis is the 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. There were two comments for this measure.

### Optional Stratification Variables

The first comment addressed the consideration of additional optional stratification variables including payer Type (e.g., Medicaid; CHIP; private commercial benefit programs); geographic location and race/ethnicity. The MDMC appreciates the suggestion of including additional stratifications, and has incorporated additional guidance on how to implement stratifications into the 2020 User Guide.

### Identifying Ongoing Care

The second comment referred to the CDT codes that are used to identify “ongoing care”. The measure is specified such that if an individual who had a history of periodontitis received oral prophylaxis (D0110) or scaling/root planing (D4341/4342) or periodontal maintenance (D4910) twice in a year, then s/he would be counted in the numerator. The commenter noted that D4910 captures periodontal maintenance for chronic periodontitis and questioned whether the addition of codes D1110 or D4341/4342 would *encourage coding misuse for “cleanings” after SRP since the appropriate code (especially if SRP has been recently performed) would be D4910.*

The DQA appreciates the comment and would like to clarify that the intent of the measure is not simply to track periodontal maintenance as specified by the code D4910 but rather ongoing care/therapy for the patient who has chronic periodontitis. To that end, the MDMC states that the intent of the measure is:

*"to identify specific dental care services indicative of ongoing care associated with successful long-term management of periodontal disease. The measure was specifically designed to be broader than a measure based ONLY on D4910, periodontal maintenance. For that reason, the measure is termed "ongoing care" instead of "periodontal maintenance." It includes a broader set of services, reflective of the different types of care that patients with a history of periodontal disease may receive as part of conservative/limited ongoing disease management.*

## Other Comments: Nursing Home and Geriatric Measures

One commenter noted the lack of dental quality measures focused specifically on the geriatric population and encouraged the DQA to prioritize measures related to dental care in nursing homes. The DQA appreciates this comment. The DQA has [three nursing home measures](#) in its list of measure concepts for use by Medicaid programs to assess care for their nursing home enrollees through the administrative claims system. The current data infrastructure (Minimum Data Set), part of the federally mandated process for clinical assessment of all residents in Medicare and Medicaid certified nursing homes includes several items addressing oral health (Section L) <sup>10</sup>. However, research demonstrate that MDS does not reliably inform,<sup>11 12, 13</sup> on the oral hygiene status of residents, provision of much needed care following initial screening and assessment (referral/ preventive/ restorative/ surgical), which are all keys to performance measurement. The DQA urges the CMS to facilitate the improvement of the data infrastructure to help assess the quality of oral care for nursing home residents.

<sup>10</sup> MDS 3.0 Frequency Reports <http://www.cms.gov/Research-Statistics-Data-and-Systems/Computer-Data-and-Systems/Minimum-Data-Set-3-0-Public-Reports/Minimum-Data-Set-3-0-Frequency-Report.html>

<sup>11</sup> The oral health of vulnerable older adults and persons with disabilities. Douglass CW, Glassman P. Spec Care Dentist. 2013 Jul-Aug;33(4):156-63. doi: 10.1111/scd.12020. Epub 2013 Mar 11.

<sup>12</sup> Akar GC, Ergul S. The oral hygiene and denture status among residential home residents. Clin Oral Investig. 2008;12(1):61-65.

<sup>13</sup> Spec Care Dentist. 2013 Jul-Aug;33(4):204-6. doi: 10.1111/scd.12033. Proceedings of the national coalition consensus conference on oral health of vulnerable older adults and persons with disabilities.

## Appendix A: Measures Development and Maintenance Committee

### **Measures Development and Maintenance Committee:**

Craig W. Amundson, DDS, General Dentist, HealthPartners, National Association of Dental Plans. Dr. Amundson serves as chair for the Committee.

Mark Casey, DDS, MPH, Dental Director, North Carolina Department of Health and Human Services Division of Medical Assistance

Natalia Chalmers, DDS, PhD, Diplomate, American Board of Pediatric Dentistry, Director, Analytics and Publication, DentaQuest Institute

Frederick Eichmiller, DDS, Vice President & Science Officer, Delta Dental of Wisconsin

Chris Farrell, RDH, BSDH, MPA, Oral Health Program Director, Michigan Department of Health and Human Services

Gretchen Gibson DDS, MPH, Director, Oral Health Quality Group, VHACO Office of Dentistry, Veterans Health Care System of the Ozarks (VHSO)

### **DQA Executive Committee Liaison to the MDMC:**

Cary Limberakis, DMD, ADA/ Council on Dental Practice

### **DQA Leadership:**

Allen Moffitt, DMD, Chair, Dental Quality Alliance

Mark Koday, DDS, Chair-Elect, Dental Quality Alliance

### **The Committee was supported by:**

Krishna Aravamudhan, BDS, MS, Director, Council on Dental Benefits Program, American Dental Association

Jill Boylston Herndon, PhD, Methodology Consultant to the DQA; Managing Member and Principal, Key Analytics and Consulting, LLC

Diptee Ojha, BDS, PhD, Senior Manager, Office of Quality Assessment and Improvement, American Dental Association

Lauren Kirk, Coordinator, Office of Quality Assessment and Improvement, American Dental Association.

## Appendix B: Public Comments

### COMMENTS TO DQA ANNUAL MEASURE REVIEW

Measure	Comment	Submitted By
<p><a href="#">Ongoing Care: Adults with Periodontitis</a>  <b>Description:</b> 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</p> <p><b>Numerator:</b> Unduplicated number of enrolled adults treated for periodontitis who received an oral prophylaxis OR scaling/root planing OR periodontal maintenance visit at least 2 times</p> <p><b>Denominator:</b> Unduplicated number of enrolled adults with a history of periodontitis</p> <p><b>Rate:</b> NUM/DEN</p>	<p>According to the American Academy of Periodontology (J Periodontol 2003;74:1395-1401 see attached) Scaling and root planning (SRP) procedure is effective if the patient is subsequently able to maintain their periodontal health without further bone or attachment loss and if it prevents recurrent infection with periodontal pathogens. The long term effectiveness of scaling and root planning depends upon a number of factors which includes ongoing Periodontal Maintenance (D4910) visits usually recommended every three to four months to sustain health.</p> <p>The concern with the numerator in this measure as written would encourage misuse of coding for "cleanings" after SRP since the appropriate code (especially if SRP has been recently performed) would be D4910.</p> <p>My understanding of including scaling/root planning (D4341) and prophylaxis (D1110) in the numerator was based on dental benefit plan limitations. Can the committee consider adding a note in the specification that plans that cover D4910 use only that in the numerator (eliminating D4341 in the numerator) to accurately evaluate on-going periodontal care. This also may encourage plans if they are benefiting SRP to expand coverage and benefit the appropriate recare code (D4910) as well.</p>	<p>Linda Vidone                      VP Clinical Management, Delta Dental of MA</p>
	<p>Is it possible to add other optional stratification variables beside age? It would be useful to at least add the following:</p> <ul style="list-style-type: none"> <li>• Payer Type (e.g., Medicaid; CHIP; private commercial benefit programs)</li> <li>• Geographic Location</li> <li>• Race/Ethnicity</li> </ul>	<p>Alia Katabi,                      Evaluation and Data Analyst, MA                      Arcora Foundation</p>
<p><a href="#">Dental Services: Utilization of Services</a>  <b>Description:</b> Percentage of all enrolled children under age 21 who received at least one</p>	<p>Is it possible to add other optional stratification variables beside age? It would be useful to at least add the following:</p>	<p>Alia Katabi,                      Evaluation and Data Analyst, MA                      Arcora Foundation</p>

<p>dental service within the reporting year (NQF #2511).</p> <p><b>Numerator:</b> Unduplicated number of children who received at least one dental service</p> <p><b>Denominator:</b> Unduplicated number of all enrolled children under age 21</p> <p>Rate: NUM/DEN</p>	<ul style="list-style-type: none"> <li>• Payer Type (e.g., Medicaid; CHIP; private commercial benefit programs)</li> <li>• Geographic Location</li> <li>• Race/Ethnicity</li> </ul>	
	<p>It seems to me that the Rationale reference is to control caries, but ANY CDT code in the specified range will qualify. This was confusing to me. Should only the codes specific to control caries be used?</p>	<p>Stephen J. Canis, DMD</p> <p>Dental Director United Concordia Dental</p>
<p><a href="#">Dental Services: Preventive Services</a></p> <p><b>Description:</b> Percentage of enrolled children who are at "elevated" risk (i.e., "moderate" or "high") who received a topical fluoride application and/or sealants within the reporting year</p> <p><b>Numerator:</b> 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</p> <p><b>Denominator:</b> Unduplicated number of enrolled children at "elevated" risk (i.e., "moderate" or "high")</p> <p>Rate: NUM/DEN</p>	<ul style="list-style-type: none"> <li>• Is it possible to include all children in this measure specification instead of only focusing on those who are at "elevated" risk? Perhaps the "elevated" risk variable can be added to the stratified list. It is important to track the extent in which all children receive preventive services. Medicaid-insured children may all be considered at risk; therefore, it would be essential to track the utilization of preventive services for all Medicaid-insured children in addition to those at "elevated" risk.</li> <li>• Can this measure include the utilization of all preventive services instead of just focusing on sealant and fluoride varnish preventive services? Since there are two additional measures that track utilization of sealant and fluoride varnish separately, it would be useful to differentiate this measure by including all preventive services and hence eliminate redundancy.</li> </ul>	<p>Alia Katabi,</p> <p>Evaluation and Data Analyst, MA</p> <p>Arcora Foundation</p>
	<ul style="list-style-type: none"> <li>• 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 (<i>perhaps it would be wise to add varnish to this list</i>)</li> </ul> <p><i>I realize we are talking about fluoride and sealants, however, preventive resin restorations and any form of remineralization also has strong evidence based science in support of such treatment modalities.</i></p>	<p>Stephen J. Canis, DMD</p> <p>Dental Director United Concordia Dental</p>
<p><a href="#">Oral Health Services: Preventive Services</a></p> <p><b>Description:</b> Percentage of enrolled children who are at "elevated" risk (i.e.,</p>	<ul style="list-style-type: none"> <li>• Is it possible to include all children in this measure specification instead of only focusing on those who are at "elevated" risk? Perhaps the "elevated" risk variable can be added to the stratified list. It is</li> </ul>	<p>Alia Katabi,</p> <p>Evaluation and Data Analyst, MA</p> <p>Arcora Foundation</p>

<p>“moderate” or “high”) who received a topical fluoride application and/or sealants within the reporting year</p> <p><b>Numerator:</b> 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</p> <p><b>Denominator:</b> Unduplicated number of enrolled children at “elevated” risk (i.e., “moderate” or “high”)</p> <p><b>Rate:</b> NUM/DEN</p>	<p>important to track the extent in which all children receive preventive services. Medicaid-insured children may all be considered at risk; therefore, it would be essential to track the utilization of preventive services for all Medicaid-insured children in addition to those at “elevated” risk.</p> <ul style="list-style-type: none"> <li>• Can this measure include the utilization of all preventive services instead of just focusing on sealant and fluoride varnish preventive services? Since there are two additional measures that track utilization of sealant and fluoride varnish separately, it would be useful to differentiate this measure by including all preventive services and hence eliminate redundancy.</li> </ul>	
<p><a href="#">Dental or Oral Health Services: Preventive Services</a></p> <p><b>Description:</b> Percentage of enrolled children who are at “elevated” risk (i.e., “moderate” or “high”) who received a topical fluoride application and/or sealants within the reporting year</p> <p><b>Numerator:</b> 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 or a dental service</p> <p><b>Denominator:</b> Unduplicated number of enrolled children at “elevated” risk (i.e., “moderate” or “high”)</p> <p><b>Rate:</b> NUM/DEN</p>	<ul style="list-style-type: none"> <li>• Is it possible to include all children in this measure specification instead of only focusing on those who are at “elevated” risk? Perhaps the “elevated” risk variable can be added to the stratified list. It is important to track the extent in which all children receive preventive services. Medicaid-insured children may all be considered at risk; therefore, it would be essential to track the utilization of preventive services for all Medicaid-insured children in addition to those at “elevated” risk.</li> <li>• Can this measure include the utilization of all preventive services instead of just focusing on sealant and fluoride varnish preventive services? Since there are two additional measures that track utilization of sealant and fluoride varnish separately, it would be useful to differentiate this measure by including all preventive services and hence eliminate redundancy.</li> </ul>	<p>Alia Katabi, Evaluation and Data Analyst, MA Arcora Foundation</p>
<p><a href="#">Oral Evaluation: Dental Services</a></p> <p><b>Description:</b> Percentage of enrolled children under age 21 who received a</p>	<p>Is it possible to add other optional stratification variables beside age? It would be useful to at least add the following:</p> <ul style="list-style-type: none"> <li>• Payer Type (e.g., Medicaid; CHIP; private commercial benefit programs)</li> </ul>	<p>Alia Katabi, Evaluation and Data Analyst, MA Arcora Foundation</p>

<p>comprehensive or periodic oral evaluation within the reporting year (NQF #2517)</p> <p><b>Numerator:</b> Unduplicated number of children who received a comprehensive or periodic oral evaluation as a dental service</p> <p><b>Denominator:</b> Unduplicated number of enrolled children under age 21</p> <p><b>Rate:</b> NUM/DEN</p>	<ul style="list-style-type: none"> <li>• Geographic Location</li> <li>• Race/Ethnicity</li> </ul> <p>This measure includes all children under 21 and only requires 180 continuous enrollment. Because of this, the measure would include children 7-12 months old. We recommend removal of children under one so that the measure is consistent with the ADA/AAPD Preventive Care Guidelines which have a child seeing a dentist beginning at age one.</p>	<p>DeDe Davis, VP, Dental Management and Quality Improvement</p> <p>MCNA Dental Plans</p>
<p><a href="#">Dental Services: Topical Fluoride: Children at Elevated Caries Risk</a></p> <p><b>Description:</b> Percentage of enrolled children aged 1–21 years who are at “elevated” risk (i.e. “moderate” or “high”) who received at least 2 topical fluoride applications within the reporting year (NQF #2528)</p> <p><b>Numerator:</b> Unduplicated number of children at “elevated” risk (i.e. “moderate” or “high”) who received at least 2 topical fluoride applications as a dental service</p> <p><b>Denominator:</b> Unduplicated number of enrolled children aged 1–21 years at “elevated” risk (i.e. “moderate” or “high”)</p> <p><b>Rate:</b> NUM/DEN</p>	<ul style="list-style-type: none"> <li>• Is it possible to include all children in this measure specification instead of only focusing on those who are at “elevated” risk? Perhaps the “elevated” risk variable can be added to the stratified list. It is important to track the extent in which all children receive Fluoride Varnish services. Medicaid-insured children may all be considered at risk; therefore, it would be essential to track the utilization of topical fluoride services for all Medicaid-insured children in addition to those at “elevated” risk.</li> </ul>	<p>Alia Katabi,</p> <p>Evaluation and Data Analyst, MA</p> <p>Arcora Foundation</p>
<p><a href="#">Oral Health Services: Topical Fluoride: Children at Elevated Caries Risk</a></p> <p><b>Description:</b> Percentage of enrolled children aged 1–21 years who are at “elevated” risk (i.e. “moderate” or “high”) who received at least 2 topical fluoride applications</p>	<ul style="list-style-type: none"> <li>• Is it possible to include all children in this measure specification instead of only focusing on those who are at “elevated” risk? Perhaps the “elevated” risk variable can be added to the stratified list. It is important to track the extent in which all children receive Fluoride Varnish services. Medicaid-insured children may all be considered at risk; therefore, it would be essential to track the utilization of topical</li> </ul>	<p>Alia Katabi,</p> <p>Evaluation and Data Analyst, MA</p> <p>Arcora Foundation</p>



<p>as oral health services within the reporting year</p> <p><b>Numerator:</b> Unduplicated number of children at "elevated" risk (i.e. "moderate" or "high") who received at least 2 topical fluoride applications as oral health services</p> <p><b>Denominator:</b> Unduplicated number of enrolled children aged 1–21 years at "elevated" risk (i.e. "moderate" or "high")</p> <p><b>Rate:</b> NUM/DEN</p>	<p>fluoride services for all Medicaid-insured children in addition to those at "elevated" risk.</p>	
<p><a href="#">Dental or Oral Health Services: Topical Fluoride: Children at Elevated Caries Risk</a></p> <p><b>Description:</b> Percentage of enrolled children aged 1–21 years who are at "elevated" risk (i.e. "moderate" or "high") who received at least 2 topical fluoride applications as dental OR oral health services within the reporting year</p> <p><b>Numerator:</b> Unduplicated number of children at "elevated" risk (i.e. "moderate" or "high") who received at least 2 topical fluoride applications as dental OR oral health services</p> <p><b>Denominator:</b> Unduplicated number of enrolled children aged 1–21 years at "elevated" risk (i.e. "moderate" or "high")</p> <p><b>Rate:</b> NUM/DEN</p>	<ul style="list-style-type: none"> <li>Is it possible to include all children in this measure specification instead of only focusing on those who are at "elevated" risk? Perhaps the "elevated" risk variable can be added to the stratified list. It is important to track the extent in which all children receive Fluoride Varnish services. Medicaid-insured children may all be considered at risk; therefore, it would be essential to track the utilization of topical fluoride services for all Medicaid-insured children in addition to those at "elevated" risk.</li> </ul>	<p>Alia Katabi, Evaluation and Data Analyst, MA Arcora Foundation</p>

<p><a href="#">Prevention: Topical Fluoride for Adults at Elevated Caries Risk</a>  <b>Description:</b> 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</p> <p><b>Numerator:</b> Unduplicated number of adults at "elevated" risk (i.e., "moderate" or "high") who received at least 2 topical fluoride applications</p> <p><b>Denominator:</b> Unduplicated number of enrolled adults at "elevated" risk (i.e., "moderate" or "high")</p> <p><b>Rate:</b> NUM/DEN</p>	<p>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. <i>(might want to include varnish also)</i></p>	<p>Stephen J. Canis, DMD  Dental Director United Concordia Dental</p>
<p><a href="#">Dental Services: Treatment Services</a>  <b>Description:</b> Percentage of enrolled children who received a treatment service within the reporting year</p> <p><b>Numerator:</b> Unduplicated number of children who received at least one treatment service as a dental service</p> <p><b>Denominator:</b> Unduplicated number of all enrolled children</p> <p><b>Rate:</b> NUM/DEN</p>	<p>Perhaps a "treatment service" should be defined for clarity.</p>	<p>Stephen J. Canis, DMD  Dental Director United Concordia Dental</p>
<p><a href="#">Dental Services: Care Continuity</a>  <b>Description:</b> Percentage of all children enrolled in two consecutive years who received a comprehensive or</p>	<p>By definition (according to the CDT descriptor for D0150- (who have been absent from active treatment for 3 years or more) I would think the utilization of this code for this age group and since this is a 2 year care continuity plan would be</p>	<p>Stephen J. Canis, DMD  Dental Director United Concordia Dental</p>

<p>periodic oral evaluation in both years</p> <p><b>Numerator:</b> Unduplicated number of children who received a comprehensive or periodic oral evaluation as a dental service in both years</p> <p><b>Denominator:</b> Unduplicated number of all children enrolled in two consecutive years</p> <p><b>Rate:</b> NUM/DEN</p>	<p>very low and almost not noteworthy as part of the numerator.</p>	
<p><a href="#">Ambulatory Care Sensitive Emergency Department Visits for Dental Caries in Children</a></p> <p><b>Description:</b> Number of emergency department (ED) visits for caries-related reasons per 100,000 member months for all enrolled children</p> <p><b>Numerator:</b> Number of ED visits with a caries-related diagnosis code among all enrolled children</p> <p><b>Denominator:</b> All member months for enrollees 0 through 20 years during the reporting year</p> <p><b>Rate:</b> (NUM/DEN)x100,000</p>	<p>This measure includes diagnosis codes that are unrelated to dental caries, not all of them are preventable with routine dental care, and some are potentially trauma related. We would like consideration of removal of the following diagnosis (Only ICD9 codes listed but would also include corresponding ICD10 codes as well) from Table 1 of the measure:</p> <ul style="list-style-type: none"> <li>o 525.3 Retained dental root</li> <li>o 525.63 Fractured dental restorative material without loss of material</li> <li>o 525.64 Fractured dental restorative material with loss of material</li> <li>o 525.9 Unspecified disorder of the teeth and supporting structures</li> <li>o 526.4 Inflammatory conditions of jaw</li> <li>o 526.5 Alveolitis of jaw</li> <li>o 526.61 Performance of root canal space</li> <li>o 526.62 Endodontic overfill</li> <li>o 526.63 Endodontic underfill</li> <li>o 526.69 Other periradicular pathology associated with previous endodontic treatment</li> <li>o 528.3 Cellulitis and abscess of oral soft tissues</li> </ul>	<p>DeDe Davis, VP, Dental Management and Quality Improvement</p> <p>MCNA Dental Plans</p>

<p>Nursing Home Measures/ General</p>	<p>Dear DQA staff or administrators,</p> <p>Having seen the below on the DQA on an ADEA website....</p> <p>The Dental Quality Alliance (DQA) was established by the American Dental Association to develop performance measures for oral health care. The DQA is an organization of major stakeholders in oral health care delivery that use a collaborative approach to develop oral health care measures. The mission of the DQA is to advance performance measurement as a means to improve oral health, patient care and safety through a consensus-building process.</p> <p>.....and noticed that there was no specific, listed 'performance measure for oral health care' for the geriatric population. So, I've attached our JADA 2010 paper on Oral Neglect of Institutionalized Elders (from our ONiE Project.....see attached document) as it is a 'consensus-built' (via a U.S. national Delphi Survey of Academic Dental Geriatric Leaders) 'performance measurement' to apply in nursing homes as a means to improve oral health and patient care. Might the DQA include this need in its listing of topics they are committed to....and also 'to act upon it' as an advocate. Our ONiE definition of oral neglect for institutionalized elders, as consensus developed via our ONiE Project, was approved and endorsed by both the Special Care Dentistry Association (SPDA) and the American Society for Geriatric Dentistry (ASGD).</p> <p>Please let me know 'what, if anything' the DQA can do on this long-standing (at least the last 50 years) deficit in oral health in the U.S.....and what I might do to move it along within your DQA organization.</p>	<p>Ralph V. Katz, DMD, MPH, PhD Professor Department of Epidemiology &amp; Health Promotion NYU College of Dentistry</p>
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