DQA Measure Specifications: Administrative Claims-Based Measures

Adults with Diabetes – Oral Evaluation

**Description:** Percentage of enrolled adults with diabetes who received a comprehensive or periodic oral evaluation or a comprehensive periodontal evaluation within the reporting year

**Numerator:** Unduplicated number of adults with diabetes who received a comprehensive or periodic oral evaluation or a comprehensive periodontal evaluation

**Denominator:** Unduplicated number of all enrolled adults with diabetes

**Rate:** NUM/DEN

***All notations in RED need to be finalized though validation studies***

**AHRQ Domain:** Process

**IOM Aim:** Equity, Effectiveness

**Level of Aggregation:** Program (NOTE: This measure only applies to programs such as Medicaid that provide both medical insurance and dental benefit to identify people with diabetes. Use of this measure 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 benefit to a population may be considered after assessment of data element feasibility within the plans databases).

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

**Data Required:** Dental administrative enrollment and claims data; single year (prior year needed for diabetes identification)

**Claims Data:** When using claims data to determine service receipt, include both paid and unpaid claims (including pending, suspended, and denied claims).

**Measure Purpose:** Examples of questions that can be answered through this measure at each level of aggregation

1. What is the percentage of adults with diabetes who received a comprehensive, periodic, or periodontal oral evaluation during the reporting period?
2. Does the percentage of adults with diabetes who received a comprehensive, periodic, or periodontal oral evaluation vary by any of the stratification variables?
3. Are there disparities in receipt of comprehensive, periodic, or periodontal oral evaluations based on stratification variables?

**Footnote:**

*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: [http://www.qualitymeasures.ahrq.gov/about/domain-definitions.aspx](http://www.qualitymeasures.ahrq.gov/about/domain-definitions.aspx). Accessed April 2013.*
4. Over time, does the percentage of adults with diabetes receiving a comprehensive, periodic, or periodontal oral evaluation stay stable, increase or decrease?

Applicable Stratification Variables
1. Age: (e.g. 18, 19-20, 21-24, 25-34, 35-44, 45-54, 55-64, 65-75, 75-84, 85+)
2. Geographic Location (e.g., rural; suburban; urban)
3. Race/Ethnicity
4. Socioeconomic Status (e.g., premium or income category)

Adults with Diabetes: Oral Evaluation Calculation

**Diabetes identification follows the approach used for the NCQA/HEDIS® measure Comprehensive Diabetes Care to achieve alignment with existing diabetes measures reported for Medicaid programs and Marketplace QRS reporting (https://www.medicaid.gov/medicaid/quality-of-care/downloads/performance-measurement/2018-adult-core-set.pdf)**

**Adults with Diabetes: Oral Evaluation Calculation***

1. Check if the enrollee meets age criterion at the last day of the reporting year:⁵
   a. If subject is >=18, then proceed to next step.
   b. If age criterion is not met or there are missing or invalid field codes (e.g., date of birth), then STOP processing. This enrollee does not get counted in the denominator.

2. Check if subject was dually eligible for Medicaid and Medicare during the reporting year.
   a. If subject is a dual eligible; STOP processing. This enrollee is excluded from the denominator.
   b. If subject is NOT a dual eligible, then proceed to next step.

3. Check if subject is continuously enrolled for the reporting year (12 months) with a single gap of no more than 45 days (one month gap for programs that determine eligibility on a monthly basis):⁶
   a. If subject meets continuous enrollment criterion, then proceed to next step.
   b. If subject does not meet enrollment criterion, then STOP processing. This enrollee does not get counted.

4. Exclude subject if care received at a Hospice facility
   a. If subject does not have any Hospice encounter claims (Hospice value set) in the reporting year of the year prior, then proceed to next step.
   b. If subject had any Hospice encounter claims (Hospice value set) in the reporting year of the year prior, then STOP processing. This enrollee does not get counted.

YOU NOW HAVE A COUNT OF ENROLLEE WHO MEET THE AGE AND ENROLLMENT REQUIREMENT (EXCLUDING

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⁵ Medicaid programs exclude those enrollees who do not qualify for dental benefits. The exclusions criterion should be reported along with the number and percentage of members excluded.

⁶ Enrollment in “same” plan vs. “any” plan: At the state program level (e.g., Medicaid) a criterion of “any” plan applies versus at the health plan (e.g., MCO) level a criterion of “same” plan applies. The criterion used should be reported with the measure score. While this prevents direct aggregation of results from plan to program, each entity is given due credit for the population it serves. Thus, states with multiple MCOs should not merely “add up” the plan level scores but should calculate the state score from their database to allow inclusion of individuals who may be continuously enrolled but might have switched plans in the interim.
THOSE WHO RECEIVED CARE AT A HOSPICE FACILITY

5. Check if subject has diabetes:

a. Adults with diabetes (type I or type II) can be identified by either claims/encounter data that include a diagnosis of diabetes or by pharmacy data. Both claims/encounter data and pharmacy data must be checked, but a patient needs to be identified by only one method for inclusion in the denominator.

If subject meets at least one of the following criteria in either the measurement year or the preceding year, then include in denominator:

Claims/Encounter Data
i. The subject has at least two outpatient visits (Outpatient Value Set), observation visits (Observation Value Set), ED visits (ED Value Set) or nonacute inpatient encounters (Nonacute Inpatient Value Set) on different dates of service, with a diagnosis of diabetes (Diabetes Value Set). Visit type need not be the same for the two visits.

OR

ii. At least one acute inpatient encounter (Acute Inpatient Value Set) with a diagnosis of diabetes (Diabetes Value Set).

OR

Pharmacy Claims Data
iii. The subject was dispensed insulin or oral hypoglycemics/antihyperglycemics during the measurement year or year prior to the measurement year on an ambulatory basis

b. Exclude subjects who do not have a diagnosis from the NCQA Diabetes Value Set (type I or type II Diabetes) and are in the NCQA Diabetes Exclusion Value Set (e.g., have gestational diabetes, steroid/ drug induced diabetes)

i. If subject does not have any encounter claims from the Diabetes Exclusion Value Set in the reporting year of the year prior, then proceed to next step.

ii. If subject has any encounter claims within the Diabetes Exclusion Value Set in the reporting year or the year prior and was not identified in a(i) or a(ii) above, then STOP processing. This enrollee does not get counted. (NOTE: If subject was identified in step 5a(i) or 5a(ii) has having diabetes, this subject should remain in the denominator and not be excluded.)

YOU NOW HAVE DENOMINATOR (DEN) COUNT: Enrollees with diabetes who meet the age and enrollment criteria

6. Check if subject received a comprehensive, periodic, or periodontal oral evaluation:

a. If [CDT CODE] = D0120 or D0150 or D0180, then include in numerator, STOP processing.
b. If not, then service was not provided, STOP processing. This enrollee is already included in the denominator but will not be included in the numerator.

**YOU NOW HAVE NUMERATOR (NUM) COUNT: Enrollees with diabetes who received a periodontal or comprehensive or periodic oral evaluation**

7. Report:
   a. Unduplicated count of enrollees in numerator
   b. Unduplicated count of enrollees in denominator before exclusions
   c. Unduplicated count of enrollees in denominator after exclusions
   d. Measure rate (NUM/DEN after exclusions)

*** Note: Reliability of the measure score depends on the quality of the data that are used to calculate the measures. The percentages of missing and invalid data for these data elements must be investigated prior to measurement. Data elements with high rates of missing or invalid data will adversely affect the subsequent counts that are recorded. For example, records with missing or invalid CDT CODE may be excluded from measurement. These records are assumed to not have had a qualifying service. In this case, a low quality data set will result in a measure score that will not be reliable.***
Check age eligibility

Age > 18 at last day of reporting year?

Continuously enrolled for the reporting year?

Care received at a Hospice facility?

Type I / Type II Diabetes Diagnosis?

Diabetes identified through pharmacy claims

Diabetes identified through pharmacy claims

YES

DEN: Enrollees with Diabetes who meet the age and enrollment requirement

Oral Evaluation?

YES

NUM: Enrollees with Diabetes who received a periodontal or comprehensive or periodic oral evaluation

STOP
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