DQA Measure Technical Specifications: Administrative Claims-Based Measures

Prevention: Topical Fluoride for Children at Elevated Caries Risk, Dental or Oral Health Services

“Dental” OR “Oral Health” Services

**Description:** 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.

**Numerator:** 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.

**Denominator:** Unduplicated number of enrolled children aged 1–21 years at “elevated” risk (i.e. “moderate” or “high”).

**Rate:** NUM/DEN

**Rationale:** Dental caries is the most common chronic disease in children in the United States (1). In 2009–2010, 14% of children aged 3–5 years had untreated dental caries. Among children aged 6–9 years, 17% had untreated dental caries, and among adolescents aged 13–15, 11% had untreated dental caries (2). Identifying caries early is important to reverse the disease process, prevent progression of caries, and reduce incidence of future lesions. Approximately three quarters of children younger than age 6 years did not have at least one visit to a dentist in the previous year (3). Evidence-based Clinical Recommendations suggest that topical fluoride should be applied at least every three to six months in children at elevated risk for caries (4).

**Rationale for “Dental or Oral Health” Services Specification:**
Apart from routine quality reporting, researchers and policy makers may wish to seek additional information regarding whether certain services were provided to a population. In such cases a “dental OR oral health” specification of the measure may be applicable. The “dental OR oral health” measure is **NOT** a sum of the “dental” and “oral health” Topical Fluoride measures but represents the unduplicated count of children who received topical fluoride as a dental or oral health service. The DQA Measures User Guide provides additional information on categorization of “dental” and “oral health” services.

**Note:** Not all state Medicaid programs reimburse for “oral health” services up to age 21. Age stratifications may be used when interpreting this measure.


**National Quality Forum Domain:** Process

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1 **Process (measure type):** “A healthcare service provided to, or on behalf of, a patient. This may include, but is not limited to, measures that may address adherence to recommendations for clinical practice based on evidence or consensus.” National Quality Forum. “NQF Glossary.” Available at: [http://www.qualityforum.org/Measuring_Performance/Measuring_Performance.aspx](http://www.qualityforum.org/Measuring_Performance/Measuring_Performance.aspx). Accessed July 28, 2015.
Institute of Medicine Aim: Equity, Effectiveness

National Quality Strategy Priority: Health and Well-Being

Level of Aggregation: Health Plan/Program

Improvement Noted As: This measure should be interpreted in conjunction with the DQA measures: (1) Topical Fluoride for Children at Elevated Caries Risk, Dental Services (NQF#2528) and (2) Topical Fluoride for Children at Elevated Caries Risk, Oral Health Services. In general, a higher percentage of children at elevated caries risk who receive at least two topical fluoride applications during the reporting year indicates better performance.²

Data Required: Administrative enrollment and claims data; single year for measurement (prior 3 years needed for risk determination). 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 percentage of children at elevated risk for dental caries receive at least 2 topical fluoride applications as dental or oral health services during the reporting period?
2. Over time, is the percentage of children who receive at least 2 topical fluoride applications as dental or oral health services stable, increasing, or decreasing?

Applicable Stratification Variables (Optional: Contact Program Official to determine reporting requirements)

1. Age (e.g., 1-2; 3-5; 6-7; 8-9; 10-11; 12-14; 15-18; 19-20)
2. Payer Type (e.g., Medicaid; CHIP; private commercial benefit programs)
3. Program/Plan Type (e.g., traditional FFS; PPO; prepaid dental/DHMO)
4. Geographic Location (e.g., rural; suburban; urban)
5. Race
6. Ethnicity
7. Socioeconomic Status (e.g., premium or income category)

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.
- This measure does not take into account alternate home-use fluoride products including supplements.
- Some codes (i.e., a few endodontic codes) included to identify children at elevated risk may also be reported for instances such as trauma and may contribute to some overestimation of children at “elevated risk.”
- Since the “elevated risk” determination requires an evaluation (to record a CDT risk code) or a treatment visit (to record a CDT treatment code), children who are enrolled but do not have a visit in the reporting year or a treatment visit in any of the prior three years will not have sufficient information to be included in the measure. While this is a limitation, the intent of this PROCESS OF CARE measure is to seek to understand whether children who can be positively identified as being at elevated risk receive the recommended preventive services.

²Evidence-based guidelines suggest that at-risk children benefit from topical fluoride applications applied at least every 3–6 months.
Topical Fluoride (Dental or Oral Health Services) Calculation for Children at Elevated Caries Risk

1. Check if the enrollee meets age criteria at the last day of the reporting year:
   a. If child is >=1 and <21, then proceed to next step.
   b. If age criteria are not met or there are missing or invalid field codes (e.g., date of birth), then STOP processing. This enrollee does not get counted.

2. Check if subject is continuously enrolled for the reporting year (12 months) with a gap of no more than 31 days (one month gap for programs that determine eligibility on a monthly basis):
   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.

YOU NOW HAVE THE COUNT OF THOSE WHO MEET THE AGE AND ENROLLMENT CRITERIA

3. Check if subject is at “elevated risk”:
   a. If subject meets ANY of the following criteria, then include in denominator:
      i. the subject has a CDT Code among those in Table 1 in the reporting year, OR
      ii. the subject has a CDT Code among those in Table 1 in any of the three years prior to the reporting year. **(NOTE: 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
      iii. the subject has a visit with a CDT code = (D0602 or D0603) in the reporting year.
   b. If the subject does not meet any of the above criteria for elevated risk, then STOP processing. This enrollee will not be included in the measure denominator.

YOU NOW HAVE THE DENOMINATOR (DEN): Enrollees who are at “elevated risk”

4. Check if subject received at least two fluoride applications as dental or oral health services during the reporting year – at least two unique dates of service when topical fluoride was provided. Service provided on each date of service should satisfy the following criteria:
   a. If [SERVICE Code] = CDT D1206 or D1208 AND
   b. If [RENDERING PROVIDER TAXONOMY] code is *any* valid NUCC maintained Provider Taxonomy Code, then include in numerator; STOP processing.
   c. If both a AND b are not met, then the service was not a “dental or oral health” service; STOP processing. This enrollee is already included in the denominator but will not be included in the numerator.

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3 Medicaid/CHIP programs should exclude those individuals who do not qualify for dental benefits. The exclusion criteria should be reported along with the number and percentage of members excluded.

4 Age: Medicaid/CHIP programs use under age 21 (<21) as upper bound of age range; Exchange quality reporting use under age 19 (<19) as the upper bound of the age range; other programs check with program officials. The age criteria should be reported with the measure score.

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

6 Topical Fluoride codes: For reporting years prior to 2013, use CDT codes D1203 or D1204 or D1206.

7 Identifying “dental” or “oral health” services: Programs and plans that do not use standard NUCC maintained provider taxonomy codes should use a valid mapping to identify providers whose services would be categorized as “dental” or “oral health” services.
Note 1: Some states may use codes other than CDT codes to reimburse for fluoride. These codes should be included in the [SERVICE CODE] codes in addition to D1206 and D1208.

Note 2: No more than one fluoride application can be counted for the same member on the same date of service.

Note 3: In this step, all claims with missing or invalid SERVICE CODE or with missing or invalid NUCC maintained Provider Taxonomy Codes should be excluded.

YOU NOW HAVE NUMERATOR (NUM) COUNT: Enrollees at “elevated risk” who received at least two fluoride applications as dental or oral health services

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

Table 1: CDT Codes to identify “elevated risk”

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*** Note: Reliability of the measure score depends on the quality of the data that are used to calculate the measure. 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 SERVICE CODE to identify topical fluoride may be counted in the denominator but not in the numerator. These records are assumed to not have had a qualifying service. In this case, a low quality data set will result in a low measure score and will not be reliable.***
Check age eligibility

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

Child will be counted if any one of the following are present:
1. CDT code for moderate or high risk in the reporting year
2. Treatment code from Table 1 in reporting year
3. Treatment code from Table 1 in any one of the prior three years.
Continuity of enrollment not required in prior years.

NC Not Counted

Qualifying age at last day of reporting year?

Yes

Continuous enrollment for the reporting year (12 months) with a gap of no more than 31 days?

Yes

No/ Missing/ Invalid field codes

all enrollees who meet the age and enrollment criteria

Elevated risk?

Yes

DEN: enrollees who are at elevated risk

Yes

#1 Date of Service: Fluoride as a dental or oral health service?

Yes

#2 Date of Service: Fluoride as a dental or oral health service?

Yes

NUM: enrollees at elevated risk who received at least 2 fluoride applications as a dental or oral health service

STOP
DQA Measure TFL-CH-A(D/OH), Dental or Oral Health Services
Effective January 1, 2018

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