



DENTAL QUALITY ALLIANCE: 2023 ANNUAL MEASURES REVIEW

REPORT FROM THE DQA MEASURE
DEVELOPMENT AND MAINTENANCE
COMMITTEE

JUNE 2023

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INTRODUCTION AND PURPOSE

The purpose of this report is to summarize the 2023 annual review of the Dental Quality Alliance's (DQA's) quality measures for pediatric and adult populations. DQA measures address prevention and disease management to promote oral health for both children and adults. DQA measures report results related to 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:

<https://www.ada.org/resources/research/dental-quality-alliance/dqa-dental-quality-measures>.

ANNUAL MEASURE REVIEW PROCESS

The DQA has established an annual measure review and maintenance process. This measure review process is conducted by the DQA's Measure Development and Maintenance Committee (MDMC). The MDMC is comprised of seven subject matter experts and a member of the DQA Executive Committee. Members of DQA Leadership regularly attend MDMC meetings. ([Appendix A](#)).

The DQA released a call for comments to its members and the broader oral health community in February 2023. Following a 30-day comment period, the MDMC considered and addressed the comments.

The DQA's MDMC would like to thank all interested parties who submitted comments to the DQA in support of this review of the measures. The DQA reviewed and reaffirmed its measures by approving this report at its meeting on June 16, 2023.

PUBLIC COMMENTS TO DQA ANNUAL MEASURE REVIEW

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

MEASURE-SPECIFIC COMMENTS: PEDIATRIC MEASURES

Ambulatory Care Sensitive Emergency Department Visits for Dental Caries in Children

Ambulatory Care Sensitive Emergency Department (ED) Visits for Dental Caries in Children measures the number of ED visits among children for caries-related reasons per 100,000 member months. A respondent to the DQA's annual request for comments commented that diagnostic coding depends on the knowledge to recognize the correct codes. The DQA appreciates this comment and notes that during measure testing, the DQA undertook a systematic analysis of the reliability and the validity of the codes used to identify caries-related visits. This analysis included medical record reviews that confirmed reliable identification of caries-related visits using the diagnostic code set that was contained in the measure.¹

After the conversion from the ICD-9-CM to ICD-10-CM diagnosis codes, a comprehensive review of the ICD-9-CM to ICD-10-CM crosswalk, using the general equivalence mapping, was conducted to re-affirm and update the diagnosis codes used to identify caries-related visits. Both forward and backward mappings were conducted. Expert review of the clinical comparability of the two code systems found no concerns. A comparison of the code descriptions between the two code systems found that the main difference between the ICD-9-CM and ICD-10-CM diagnosis codes specified for this measure is that the ICD-10-CM codes provide more granularity. Because there is a collective set of codes used to identify caries-related visits, which rely on the comparable code descriptions in both the ICD-9-CM and ICD-10-CM code systems, the update to the ICD-10-CM codes did not meaningfully impact the measure scores. Additional chart validation of the caries-related diagnosis code set using ICD-10-CM codes mapped from the original ICD-9-CM code set was conducted and affirmed the continued reliability of the code set to identify caries-related visits. Pre and post ICD-10-CM conversion performance scores from two of the programs included in the original measure testing further supported the conclusion that the conversion did not impact the measure scores.

The same commenter also recommended that this measure be reported with Care Continuity to provide a clearer understanding of access to care. The DQA agrees with the importance of using measure sets, rather than relying on an individual measure, to understand quality of care. Although each DQA measure can be calculated independently and has been tested individually to establish measure reliability and validity, all DQA measures are intended to be reported in conjunction with complementary measures to provide a more complete picture of care. The DQA's [User Guide](#) devotes a section to implementation considerations that discusses the importance of using sets of measures and not relying solely on a single measure to drive quality improvements.

Care Continuity, Dental Services and Usual Source of Services, Dental Services

The DQA measure Care Continuity, Dental Services measures the percentage of children enrolled in two consecutive years who received a comprehensive or periodic oral evaluation in both years. The measure Usual Source of Services, Dental Services measures the percentage of children enrolled in two consecutive years who visited the same practice or clinical entity in both years.

One commenter inquired how the measure Care Continuity takes into consideration of changes in plan enrollment (i.e., when a member switches plans). The DQA provides guidance within all of its program- and plan-level measure specifications about how to implement measures at the program level, which captures movement between plans, and at the plan level, which restricts enrollment to a specific plan for denominator inclusion:

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.

One commenter suggested that the DQA consider changing the measure titles of both the Care Continuity and Usual Source of Services measures. The DQA notes that both measure titles have been in place for more than 10 years and that any change must be weighed carefully to avoid confusion for measure implementers. In particular, the commenter was concerned that the term "Care Continuity" is used differently in some other settings and applications and offered an alternative title of "Care Consistency" for the DQA measure. The MDMC noted that as a program- and plan-level measure, attribution is to those entities, and the measure is intended to assess whether children enrolled in the program or the plan are established into routine care that provides diagnosis, risk assessment, and prevention and treatment planning over time. The DQA's MDMC members did not feel that the proposed title of "Care Consistency" reflected the measure's intent and re-affirmed "Care Continuity" as an appropriate title to reflect year-over-year receipt of oral evaluation.

The same commenter suggested changing the name of Usual Source of Service to "Practice Continuity" and noted support for measuring this based on patients seeing the same practice year-over-year rather than seeing the same individual provider year-over-year. The MDMC

members determined that the current title of "Usual Source of Services" is appropriate and does not need to be modified. The MDMC also affirmed that the measure specifications are focused on service receipt by the same practice or clinical entity and not the individual clinician because of the challenges in reliably identifying the same individual rendering clinician, especially in cases of multi-provider settings where claims may be submitted through one clinical provider.

Another commenter asked why there were two separate measures rather than a single measure that examines having a periodic or comprehensive oral evaluation with the same practice or clinical entity in each of the two years. Because these are program and plan level measures versus practice or provider level measures, there was interest in understanding both (1) whether beneficiaries/members are receiving care that includes a comprehensive oral evaluation in consecutive years and (2) if beneficiaries/members are being seen by the same practice/clinical entity year over year. Care Continuity, Dental Services is focused on a specific, important category of care that includes diagnosis, risk assessment, and prevention and treatment planning. Changes in provider networks, provider participation, or relocation by the family may result in care from multiple clinical entities. Care Continuity, Dental Services is based on an interest in ensuring that the child continues to receive periodic and comprehensive oral evaluations even if not with the same practice/clinical entity. The MDMC notes that combining the two measures of Care Continuity and Usual Source of Services would add complexity both in implementation and interpretation.

Preventive Services for Children

Preventive Services for Children is a utilization measure that assesses the percentage of children who received a topical fluoride application and/or sealants within the reporting year. One commenter supported including independently practicing hygienists in this measure. The DQA notes that the measure of Preventive Services includes specifications with three numerators that allow for reporting by the type of clinician rendering the preventive services: (1) dental services, (2) oral health services, and (3) dental or oral health services. For alignment, the DQA follows the approach adopted by [CMS](#) in defining "dental services" as "services provided by or under the supervision of a dentist." "Oral health services" is defined as services "provided by any qualified health care practitioner or by a dental professional who is neither a dentist nor providing services under the supervision of a dentist." Consequently, independently practicing dental hygienists are captured in both the "oral health services" numerator and the "dental or oral health services" numerator. The "dental or oral health services" numerator is agnostic to provider type and provides a comprehensive indication of preventive services provided by all team members. The DQA will continue to monitor how oral health services are delivered and assess the implications for measure specifications and reporting.

Sealant Receipt on Permanent 1st Molars and Sealant Receipt on Permanent 2nd Molars

The two sealant measures assess whether children have received (1) at least one sealant and (2) all four molars sealed by the 10th (permanent first molars) and 15th (permanent second molars) birthdays, respectively. A commenter suggested that the denominator inclusion age should be younger than the specified ages of 10 years and 15 years and also inquired why there was a 48-month look-back period to identify exclusions.

Generally, permanent first molar eruption occurs at 6-7 years of age, and permanent second molar eruption occurs at 11-13 years of age. Both sealant measures use a 48-month lookback period to: (1) identify exclusions for the denominator calculation and (2) identify placement of sealants for the numerator calculation. For the first permanent molar measure, children who reach age 10 in the reporting year would be aged 9 to 10 years during the reporting year; therefore, they would be aged 5-6 years at the beginning of the 48-month lookback period. For the second permanent molar measure, children who reach age 15 during the reporting year would be aged 14 to 15 years during the reporting year; therefore, they would be aged 10-11 years at the beginning of the 48-month lookback period. The result is that nearly all children with erupted molars are included in the denominator for the appropriate measure. Testing data, which included both public and private programs, indicated that sealant placement on permanent first molars is concentrated among children ages 6-9 years and sealant placement on permanent second molars is concentrated among children ages 10-14 years. A period of 48 months prior to the relevant birthday is also used for the exclusions to have a consistent look-back time frame for all reporting entities and to allow for identifying any treatments that occurred after tooth eruption and prior to the child's 10th or 15th birthdate that would render the tooth not sealable.

Treatment Services, Dental Services

Treatment Services is a utilization measure that assesses the percentage of children who received a treatment service within the reporting year. One commenter suggested removing codes that signify non-clinical procedures, such as D9986 (missed appointment) and D9987 (cancelled appointment). Treatment Services is a broad measure of utilization that measures the percentage of beneficiaries who had at least one treatment service as defined by any one procedure code in the range D2000 through D9999. Inclusion in the numerator requires only one instance of any of the procedure codes in the range of D2000 through D9999. Analyses of Medicaid claims data indicate that the total frequencies of codes D99XX are very low (<1% of all procedures). It is even less likely that one of these codes would be the only code in the range of D2000 through D9999 that a child would have during the year. Consequently, the inclusion of these codes does not materially affect the measure score. The MDMC determined that

excluding these codes would increase implementation and measure maintenance complexity without any material effect on the measure scores and, therefore, did not recommend changes to the measure.

Another commenter suggested that patients who do not require additional dental services be excluded from the measure. Due to lack of diagnostic data in claims data, it is not possible to reliably identify treatment needs for the purposes of denominator inclusion or exclusion. Treatment Services is designed to be reported with other performance measures, such as Utilization of Services and Preventive Services, which can assist with interpretation of the performance scores.

Per Member Per Month Cost of Clinical Services, Dental Services

Per Member Per Month Cost of Clinical Services measures the total amount paid on direct provision of dental care (reimbursed for clinical services) per member per month for all enrolled children during the reporting year. One commenter noted that there is wide variability among fee schedules and contracts and also questioned whether this is an efficiency measure or a quality measure. Another commenter suggested this measure be stratified by practice type. The MDMC clarified that this measure, as specified, captures only paid amounts as represented in claims data. It does not reflect other sources of funding, such as patient cost sharing, and other types of financing models not reflected in claims data. Regarding stratification of the measure by practice type, claims data lack consistent classification and structured capture of practice type information, threatening the feasibility and reliability of such stratification. The MDMC notes that this measure merits ongoing attention and monitoring of how the measure is being used and for what purposes.

MEASURE-SPECIFIC COMMENTS: ADULT MEASURES

Adults with Diabetes – Oral Evaluation

Adults with Diabetes – Oral Evaluation measures the percentage of adults with diabetes who received a comprehensive or periodic oral evaluation or a comprehensive periodontal evaluation during the reporting year. One commenter inquired why dual-eligible patients are excluded from the measure. Medical claims data are required to identify patients with diabetes, and Medicaid programs may not have access to Medicare medical claims. The DQA's [User Guide for Adult Measures Calculated Using Administrative Claims Data](#) provides the rationale for excluding Medicare and Medicaid dually eligible beneficiaries based on these data limitations and offers guidance for reporting on dual eligibles by programs that have sufficient data:

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.

Another commenter suggested consideration to add the following codes to qualify as an oral evaluation for numerator inclusion: D0140 (limited oral evaluation – problem focused), D0190 (screening of a patient) and D0191 (assessment of a patient). The MDMC notes that the intent of the measure is to assess the percentage of patients with diabetes who are accessing routine care that includes risk assessment, diagnosis, and prevention and treatment planning versus accessing only episodic or problem-based care. Consequently, problem-focused or limited evaluation codes, such as D0140, were not included in the oral evaluation code set for inclusion in the numerator. Codes D0190 and D0191 are identified as pre-diagnostic services that are distinct from clinical oral evaluations; as such, visits coded as D0190 and D0191 were deemed as not sufficiently comprehensive to meet the measure's intent.

Non-Surgical Ongoing Periodontal Care for Adults with Periodontitis

Non-Surgical Ongoing Periodontal Care for Adults with Periodontitis measures the percentage of adults with a history of periodontitis who received an oral prophylaxis, or scaling and root planing, or periodontal maintenance visit at least two times during the reporting year. One commenter suggested that the periodontal maintenance code (D4910) and the scaling and root planing codes (D4341 and D4342) not be grouped together in the numerator because scaling and root planing (D4341/D4342) in the numerator value set constitute active treatment and not a follow-up or maintenance procedure.

Based on similar feedback in the past, the DQA issued a call for comments specifically on this measure during the 2022 Annual Measure Review cycle. After undertaking this additional evaluation, the DQA reaffirmed the measure intent is:

to identify specific dental care services, indicative of ongoing care associated with successful long-term management of periodontal disease. The measure was

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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.

The MDMC has clarified that the measure, as defined, is not intended to simply track periodontal maintenance but rather ongoing care/therapy for the patient who has been treated for periodontitis in the past.

In addition, during the 2022 Annual Measure Review public comment period, the MDMC requested specific feedback from the measure implementation and user community on measuring performance of programs (e.g., Medicaid) and dental plans related to periodontal disease prevention and management and the utility of adding an additional measure. The MDMC specifically requested the following feedback regarding the utility of developing an additional measure to assess program and plan performance related to periodontal disease prevention and management:

1. Is there a need for an additional, separate measure that specifically tracks prophylaxis (D1100) and periodontal maintenance (D4910) as follow up for adults with history of periodontitis (D4240 or D4241 or D4260 or D4261 or D4341 or D4342 or D4910)? Please explain your response from the perspective of how such a measure would or would not contribute to population-based assessments of care quality above and beyond the existing measure.
2. The MDMC welcomes additional feedback on the existing measure as well as any other feedback on this topic.

Four comments were received. All commenters supported the existing measure as an appropriate measure of "ongoing care." Two commenters additionally noted that they did not see a need for an additional measure. Two commenters indicated support for an additional measure that would track prophylaxis and periodontal maintenance specifically.

The MDMC reviewed and considered the comments. Given the continued support for the current measure, mixed feedback on the need for an additional measure to meaningfully drive quality improvement, and the resources required to fully develop and test a new measure, the MDMC recommended in favor of maintaining the existing measure and against a new, additional measure. The DQA membership approved these recommendations at its June 3, 2022 meeting. The MDMC may explore stratification of the existing measure of Ongoing Care by numerator procedures.

Oral Evaluation During Pregnancy and Utilization of Services During Pregnancy

Two new measures of dental care access during pregnancy were developed, tested, and approved during CY 2022. Utilization of Services During Pregnancy measures the percentage of 15–44-year-olds with live-birth deliveries in the reporting year who received any dental service during pregnancy, and Oral Evaluation measures the percentage who had a periodic or comprehensive oral evaluation. Public commenters commended the development of these measures. One commenter suggested including D0180 in the numerator code set for Oral Evaluation During Pregnancy and including D0140 in the numerator code set for Utilization of Services During Pregnancy. The DQA confirms that these codes were already included in the code sets of the approved measures. The detailed measure specifications with the code sets are available on the [DQA website](#).

Another commenter inquired why the denominator was limited to live-birth deliveries and not any pregnancy status. Because the intent is to measure oral healthcare services received *during pregnancy*, it is necessary to identify the pregnancy episode (i.e., the period prior to the delivery date). To identify the pregnancy period, an “event” – a procedure or encounter – relative to which the pregnancy episode can be defined must be identified. Live-birth deliveries are commonly the basis for defining pregnancy episodes in widely used quality measures^{2,3} and has also been the basis for other oral healthcare performance metrics focused on pregnant persons.⁴ The pregnancy episode can be defined as the period prior to the delivery date. Because different pregnancy outcomes (e.g., stillbirths, ectopic pregnancies, and terminations) have pregnancy episodes with different durations, each outcome requires identification of an event that forms the basis for reliably identifying the pregnancy episode. Published research validating identification of pregnancies using claims data demonstrate the complex logic required to capture pregnancy episodes across multiple types of outcomes.⁵⁻⁷ Research also estimates that live births represent more than 70% of pregnancy episode outcomes (when an outcome can be identified)^{5,7} and tend to be more reliably identified than other pregnancy outcomes.^{5,6} With these feasibility and reliability considerations, live-birth deliveries were selected as a starting point for developing oral healthcare measures for pregnant individuals.

GENERAL COMMENTS ON EXISTING MEASURES

Measures Requiring Medical and Dental Claims

One commenter noted that some DQA measures, such as *Ambulatory Care Sensitive Emergency Department Visits for Dental Caries in Children*, *Ambulatory Care Sensitive Emergency Department Visits for Non-Traumatic Dental Conditions in Adult*, and *Adults with Diabetes – Oral Evaluation*, require both medical and dental claims which would be of interest

to many federally qualified health centers but may not be feasible for settings without integrated medical and dental systems or data. The DQA measure specifications for measures that require both medical and dental claims are specified for program-level reporting by entities that have both medical and dental claims and contain the following note:

This measure requires claims data from medical encounters. Consequently, this measure applies to programs, such as Medicaid, that provide both medical and dental benefits. Use of this measure for stand-alone dental benefit plans may result in feasibility issues due to lack of access to necessary data. Use by health plans that provide both medical and dental benefits may be considered after assessment of data element feasibility within the plans' databases.

The DQA appreciates the commenter's feedback and supports adoption of its medical-dental measures by FQHCs that have integrated medical and dental systems.

Need for Diagnosis Codes to Advance Measurement

One commenter emphasized the importance of greater adoption and implementation of diagnosis codes to support measurement. The commenter noted that doing so, for example, would enable the measures focused on individuals with a history of periodontal disease to be identified through diagnosis codes rather than procedure codes signifying treatment history. The same commenter noted that diagnosis codes would also enable refinement of the measure of treatment services. The DQA agrees with the importance of adoption and capture of structured diagnosis data in dentistry to advance oral healthcare quality measurement and medical-dental integration.

PUBLIC RECOMMENDATIONS FOR NEW MEASURES

The MDMC values the recommendations and interest received from the implementation and user community regarding opportunities for future measure development. The Annual Measure Review process does not include an in-depth evaluation of proposed measure concepts. Rather, the MDMC makes high-level recommendations that feed into the DQA's measure development processes. The detailed measure development processes are described in the DQA's [Procedure Manual for Performance Measures Development and Maintenance](#). This manual includes a quality measurement framework that is used to support identification of measurement gaps and priorities. The DQA considers several factors when prioritizing resources for future measure development, including feasibility of implementation with existing data sources, extent of evidence that improvement on the measure will lead to improvements in care quality and patient outcomes, the extent of performance gap and opportunity for improvement, the ability for the measured entities to achieve improvement on the measure,

and preliminary assessments of whether the measure concept can be measured reliably and validly.

Improved Caries Risk Status for Children and for Adults

One commenter suggested new measures that assess improved caries risk status for children and for adults.

Caries Risk Assessment Documentation for Adults

One commenter recommended developing a measure that documents caries risk assessment for adults.

The DQA has existing measure concepts in the areas of Improved Caries Risk Status for Children, Improved Caries Risk Status for Adults, and Caries Risk Documentation for Adults that are included in ongoing measure development considerations. These measure concepts, along with others that were identified through the processes outlined in the Procedure Manual for Performance Measures Development and Maintenance, are posted on the DQA website as [Measures Under Consideration](#).

Measure Concepts Related to Dental Insurance Coverage

One commenter recommended the DQA consider measurement related to the adequacy of dental insurance coverage relative to “medical necessity” criteria. Four specific areas were identified.

- 1. Orthodontic examination (children).** The measure concept of orthodontic examination proposes to evaluate the percentage of all children (i.e., not just those referred to orthodontic care) who have an orthodontic screening examination by an orthodontist by their 7th birthday. The MDMC recommended against prioritizing such a measure for development because it lacks utility in driving improvements in care and outcomes by failing to account for similar developmental assessments by pediatric or primary care dentists.
- 2. Orthodontic treatment (children).** The second orthodontic measure concept evaluates coverage of orthodontic care for children by evaluating prior authorization requests for orthodontic treatment and approval of those requests based on whether they meet “medical necessity” criteria. Given the potential for significant variation in the definition of “medically necessary” orthodontic treatment, the limitations of claims data (e.g., lack of diagnostic codes) to reliably identify the denominator population, and the complexities of evaluating prior authorization requests and approval of those requests, the concept was deemed not feasible for measurement. This type of measure also likely falls outside of the DQA’s quality measurement framework.

- 3. Restorative treatment (adults).** The concept of restorative treatment proposes to assess restoration of missing teeth by evaluating the number and location of missing teeth through patient chart reviews. This proposed measure development, as a measure of the adequacy of dental insurance coverage, was deemed complex, resource intensive, and not currently feasible for measurement.
- 4. Palliative treatment (adults).** The concept of palliative treatment proposes to assess adequacy of dental insurance coverage by evaluating treatment of dental pain as measured by the number of providers claiming for palliative care codes. Given the lack of codes and methodologies to reliably identify individuals in need of treatment when using claims data, this concept was deemed not feasible for measurement. However, dental pain is widely recognized as an important domain for patient-reported outcomes ([DQA Environmental Scan of Patient Reported Oral Healthcare Measurement](#)) and may be better suited for consideration when developing patient-reported outcome-based performance measures.

GENERAL UPDATES TO MEASURE SPECIFICATIONS

In addition to the public comments submitted, the MDMC annually reviews routine updates to the measure specifications. These include code updates and editorial updates.

Code on Dental Procedures and Nomenclature

Review of the 2023 CDT Manual code updates did not identify new codes relevant to the DQA measures.

Health Care Provider Taxonomy Codes

Review of the 2023 Health Care Provider Taxonomy code set maintained by the National Uniform Code Committee (NUCC) identified no new codes relevant to the DQA measures.

ICD-10-CM Diagnosis Codes

Review of the ICD-10-CM Diagnosis codes identified no new codes relevant to the DQA measures.

Appendix A: Measure Development and Maintenance Committee

Measure Development and Maintenance Committee:

Craig W. Amundson, DDS, General Dentist, HealthPartners. Dr. Amundson serves as chair of the Committee.

Frederick Eichmiller, DDS, Vice President and Science Officer, Delta Dental Wisconsin

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

An Nguyen, DDS, MPH, Chief Dental Officer, Clinica Family Health

Chris Okunseri, BDS, MSc, Director, Predoctoral Program, Dental Public Health, Marquette University

Bob Russell, DDS, MPH, MPA, CPM, FACD, FICD, Previous State Public Health Dental Director, Chief, Bureau of Oral and Health Delivery Systems, Iowa

Tim Wright, DDS, MS, Distinguished Professor, University of North Carolina School of Dentistry

DQA Executive Committee Liaison to the MDMC:

Robert Margolin, DDS, ADA/Council on Advocacy for Access and Prevention

DQA Leadership:

Ralph Cooley, DDS, Chair, Dental Quality Alliance

Linda Vidone, DMD, Chair-Elect, Dental Quality Alliance

The Committee was supported by:

Krishna Aravamudhan, BDS, MS, Senior Vice President, Practice Institute, American Dental Association

Neel Shimpi, BDS, MM, PhD, FAMIA, Director, Dental Quality Alliance & Clinical Data Registry, American Dental Association

Erica Colangelo, MPH, Manager, Dental Quality Alliance, American Dental Association

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

Appendix B: Public Comments

MEASURE	COMMENT	SUBMITTED BY
PEDIATRIC MEASURES		
AMBULATORY CARE SENSITIVE EMERGENCY DEPARTMENT VISITS FOR DENTAL CARIES IN CHILDREN & AMBULATORY CARE SENSITIVE EMERGENCY DEPARTMENT VISITS FOR NON-TRAUMATIC DENTAL CONDITIONS IN ADULTS	NNOHA supports these measures for both children and adults but acknowledges that they may not be applicable or feasible in settings without integrated medical and dental systems or integrated data sets.	Phillip Thompson, MS, Executive Director An Nguyen, DDS, MPH, Quality Committee Chair National Network for Oral Health Access
AMBULATORY CARE SENSITIVE EMERGENCY DEPARTMENT VISITS FOR DENTAL CARIES IN CHILDREN	<ul style="list-style-type: none"> - ICD-10 coding is dependent on the education level/ knowledge to recognize the correct ICD-10 code to use for ED Visits for caries related issues. - This measure needs to be reported along with / in conjunction with care continuity to understand the problem of access to care, provider network insufficiency or patient compliance 	Shirley A. Spater, DMD, MPH Clinical Director, Benefits Management Dr. Vinod Miriyala, BDS, MPH, CAGS, DDS Pediatric and Public Health Dentist SKYGEN USA
CARE CONTINUITY, DENTAL SERVICES	<p>Aligning terminology across the spectrum of healthcare is recommended whenever possible. Continuity is a term frequently used by accreditation bodies (including NCQA and AAAHC) to support patient-centered medical and dental home certification, where it refers to an ongoing relationship of a patient with a provider or care team. DQA's "Care Continuity" measure is not specified to reflect continuity in this way, and considerations for retitling this measure is recommended.</p> <p>NNOHA offers "Care Consistency" as an option to consider. If possible, it could be impactful to consider aligning considerations of "continuity" in measurement with other areas of work occurring nationally, including within the Patient-Centered Dental Home project conducted through the University of Iowa.</p>	Phillip Thompson, MS, Executive Director An Nguyen, DDS, MPH, Quality Committee Chair National Network for Oral Health Access

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	<ul style="list-style-type: none"> - How to track this measure/ take into consideration when the patient moves between plans – “plan mobility”. - Plans might or might not have shared data of paid claims among payors and relevant agencies. - Still a good measure to track. 	<p>Shirley A. Spater, DMD, MPH</p> <p>Clinical Director, Benefits Management</p> <p>Dr. Vinod Miriyala, BDS, MPH, CAGS, DDS</p> <p>Pediatric and Public Health Dentist</p> <p>SKYGEN USA</p>
PER MEMBER PER MONTH COST OF CLINICAL SERVICES, DENTAL SERVICES	NNOHA suggests stratifying this measure based on practice type.	<p>Phillip Thompson, MS, Executive Director</p> <p>An Nguyen, DDS, MPH, Quality Committee Chair</p> <p>National Network for Oral Health Access</p>
	<ul style="list-style-type: none"> - Wide variability among fee schedules and contracts to compare - Efficiency vs quality measure 	<p>Shirley A. Spater, DMD, MPH</p> <p>Clinical Director, Benefits Management</p> <p>Dr. Vinod Miriyala, BDS, MPH, CAGS, DDS</p> <p>Pediatric and Public Health Dentist</p> <p>SKYGEN USA</p>
PREVENTIVE SERVICES FOR CHILDREN	NNOHA suggests including independently practicing hygienists in this measure would allow for the capture of an important dental team member in dental service delivery in the states where this practice is allowed.	<p>Phillip Thompson, MS, Executive Director</p> <p>An Nguyen, DDS, MPH, Quality Committee Chair</p> <p>National Network for Oral Health Access</p>

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<p>SEALANT RECEIPT ON PERMANENT 1ST/2ND MOLARS</p>	<ul style="list-style-type: none"> - Denominator inclusion age should be 1-2 years younger than proposed - Exclusion: Why 48 months prior to the 10th or 15th birthday 	<p>Shirley A. Spater, DMD, MPH</p> <p>Clinical Director, Benefits Management</p> <p>Dr. Vinod Miriyala, BDS, MPH, CAGS, DDS</p> <p>Pediatric and Public Health Dentist</p> <p>SKYGEN USA</p>
<p>TREATMENT SERVICES, DENTAL SERVICES</p>	<p>This measure produces the percentage of enrolled children who received a treatment service within the reporting year. The services of interest in the numerator include all dental services except diagnostic and preventive services, accounting for codes D2000-D9999. Of note, adjunctive general services in the D9000-D9999 range are included. This range of codes includes non-clinical procedures that – when standing alone – do not necessarily indicate that traditional dental treatment was provided. As examples, missed and cancelled appointment codes (D9986 and D9987, respectively) are represented in this range, as are case management codes for addressing appointment compliance barriers and coordinating care with other providers (D9991 and D9992, respectively). We agree that the Treatment Services measure should remain broad and inclusive of the widest range of services but question if the inclusion of the D9000 series is appropriate to maintain.</p>	<p>Dr. Paul Casamassimo (Chief Policy Officer),</p> <p>Mr. Scott Litch (General Counsel & COO),</p> <p>Dr. John Rutkauskas (CEO),</p> <p>and Dr. Amr Moursi (President)</p> <p>American Academy of Pediatric Dentistry</p>
	<p>NNOHA suggests patients that do not require any additional dental services be excluded from the measure but understands the limitations on the ability to do this using only claims data.</p>	<p>Phillip Thompson, MS, Executive Director</p> <p>An Nguyen, DDS, MPH, Quality Committee Chair</p> <p>National Network for Oral Health Access</p>
<p>USUAL SOURCE OF SERVICES, DENTAL SERVICES</p>	<p>In light of the previous comment [on Care Continuity], NNOHA suggests considerations for changing the name of this measure to “Practice Continuity” and would prefer the TIN or practice NPI be used for rather than the specific provider NPI. Providers may change locations, but the specific practices or health centers will stay constant and consistent with the definition on continuity.</p>	<p>Phillip Thompson, MS, Executive Director</p> <p>An Nguyen, DDS, MPH, Quality Committee Chair</p> <p>National Network for Oral Health Access</p>

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	<ul style="list-style-type: none"> - What is the need or importance of having 2 different measures? - Why not also require reporting Comprehensive and periodic visits within the same provider entity? 	<p>Shirley A. Spater, DMD, MPH</p> <p>Clinical Director, Benefits Management</p> <p>Dr. Vinod Miriyala, BDS, MPH, CAGS, DDS</p> <p>Pediatric and Public Health Dentist</p> <p>SKYGEN USA</p>
ADULT MEASURES		
ADULTS WITH DIABETES – ORAL EVALUATION	<p>Many federally qualified health centers would be interested in this measure, but they may not be applicable or feasible in settings without integrated medical and dental systems or integrated data sets. NNOHA would also like to understand why dual-eligible patients are excluded from the measure.</p>	<p>Phillip Thompson, MS, Executive Director</p> <p>An Nguyen, DDS, MPH, Quality Committee Chair</p> <p>National Network for Oral Health Access</p>
	<p>It should be considered to add D0140 the problem focused evaluation to the numerator. Also, D0190 Screening and D1091 Assessment would possibly be done when evaluating a diabetic patient to determine if they should be seen by a dentist, since at times, these patients may be screened or assessed by a non-dentist.</p>	<p>Stephanie Heffner Director, Scientific, Clinical, and Academic Affairs</p> <p>American Academy of Periodontology</p>
AMBULATORY CARE SENSITIVE EMERGENCY DEPARTMENT VISITS FOR DENTAL CARIES IN CHILDREN & AMBULATORY CARE SENSITIVE EMERGENCY DEPARTMENT VISITS FOR NON-TRAUMATIC DENTAL CONDITIONS IN ADULTS	<p>NNOHA supports these measures for both children and adults but acknowledges that they may not be applicable or feasible in settings without integrated medical and dental systems or integrated data sets.</p>	<p>Phillip Thompson, MS, Executive Director</p> <p>An Nguyen, DDS, MPH, Quality Committee Chair</p> <p>National Network for Oral Health Access</p>
PERIODONTAL EVALUATION IN ADULTS WITH PERIODONTITIS & NON-SURGICAL ONGOING	<p>The denominator for both of these measures is based on previous treatment of periodontal disease. NNOHA would prefer a movement toward the use of a diagnosis for periodontal disease in the denominator, similar to the 2023 <i>Adults with Diabetes</i> measure. Recognizing that this would require the adoption of standard diagnostic codes for dentistry,</p>	<p>Phillip Thompson, MS, Executive Director</p>

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<p>PERIODONTAL CARE FOR ADULTS WITH PERIODONTITIS</p>	<p>NNOHA makes this recommendation as a forwarding thinking part of DQA's work</p>	<p>An Nguyen, DDS, MPH, Quality Committee Chair</p> <p>National Network for Oral Health Access</p>
<p>NON-SURGICAL ONGOING PERIODONTAL CARE FOR ADULTS WITH PERIODONTITIS</p>	<p>As written, this measure does not provide any usable data that determines if periodontal patients are receiving appropriate care. D4910 indicates maintenance treatment after active periodontal therapy. Scaling and root planning (D4341 and D4342) indicate active therapy. Scaling and root planning are not maintenance treatment. These are two distinct procedures performed for very different reasons and should not be grouped together. Each individually would provide the information needed to determine if periodontal patients are receiving correct care and the type of care. If they require additional active treatment, that is a very different consideration.</p>	<p>Stephanie Heffner Director, Scientific, Clinical, and Academic Affairs</p> <p>American Academy of Periodontology</p>
<p>ORAL EVALUATION DURING PREGNANCY & UTILIZATION OF SERVICES DURING PREGNANCY</p>	<p>We commend the development of the new pregnancy measures. This is of particular interest to our membership, given, as stated in the rationale, "Promoting oral health during pregnancy... lays the foundation for optimal oral and overall health of the child." We look forward to having a longitudinal view of the status of oral health utilization and routine service receipt among pregnant people in the years to come.</p>	<p>Dr. Paul Casamassimo (Chief Policy Officer),</p> <p>Mr. Scott Litch (General Counsel & COO),</p> <p>Dr. John Rutkauskas (CEO),</p> <p>and Dr. Amr Moursi (President)</p> <p>American Academy of Pediatric Dentistry</p>
	<ul style="list-style-type: none"> - Both of the 2 new measures about oral health during Pregnancy are commendable - Numerator – Why “ Live birth deliveries” vs just pregnancy status if we are looking at this measure during pregnancy ? What is the importance of live-birth delivery? 	<p>Shirley A. Spater, DMD, MPH</p> <p>Clinical Director, Benefits Management</p> <p>Dr. Vinod Miriyala, BDS, MPH, CAGS, DDS</p> <p>Pediatric and Public Health Dentist</p> <p>SKYGEN USA</p>

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ORAL EVALUATION DURING PREGNANCY	<p>The numerator includes D0150 and D0120. D0180 should also be added since at times, pregnant patients may be examined by a dentist who immediately sees that the problem involves periodontal issues and will perform a periodontal evaluation in place of an oral evaluation. A patient may also be referred directly to a periodontist who would use D0180 for the evaluation.</p>	<p>Stephanie Heffner Director, Scientific, Clinical, and Academic Affairs</p> <p>American Academy of Periodontology</p>
UTILIZATION OF SERVICES DURING PREGNANCY	<p>A consideration would be to determine if any pregnant patients are seen in emergency rooms for periodontal treatment. This could also be stratified and indicate frequency that a pregnant patient does not see a dentist but is treated for periodontal conditions. D0140 should also be in the numerator since many times the evaluation will be problem focused and not comprehensive for a pregnant patient.</p>	<p>Stephanie Heffner Director, Scientific, Clinical, and Academic Affairs</p> <p>American Academy of Periodontology</p>

PROPOSED NEW MEASURES AND MEASURE CONCEPTS

PROPOSED NEW MEASURE OF IMPROVED CARIES RISK STATUS FOR CHILDREN AND ADULTS	<p>Because dentistry has not yet universally adopted diagnostic coding, nor have we incorporated meaningful measures of patient outcomes into our data collection and reporting systems, caries risk status serves as one of our best tools for monitoring disease susceptibility and improvement of such at the population level. Incorporating this measure into the measure sets in the near future would offer a true baseline of caries risk improvement, given that no other commonly used tools or mechanisms exist for monitoring this beyond the patient- or practice-level. It also is a measure that more closely represents patient outcomes and oral health status than many of the existing procedure-based measures. Additionally, while tangential to the role and work of DQA, AAPD strongly encourages and is eager to collaborate with the ADA and other stakeholders on the identification and promotion of a uniform, clinically useful caries risk assessment tool.</p>	<p>Dr. Paul Casamassimo (Chief Policy Officer),</p> <p>Mr. Scott Litch (General Counsel & COO),</p> <p>Dr. John Rutkauskas (CEO),</p> <p>and Dr. Amr Moursi (President)</p> <p>American Academy of Pediatric Dentistry</p>
PROPOSED NEW MEASURE OF CARIES RISK ASSESSMENT DOCUMENTATION FOR ADULTS	<p>Since this measure [Topical Fluoride for Adults at Elevated Caries Risk] applies to adults with elevated risk, NNOHA supports the creation of a measure to document caries risk assessment for adults.</p>	<p>Phillip Thompson, MS, Executive Director</p> <p>An Nguyen, DDS, MPH, Quality Committee Chair</p> <p>National Network for Oral Health Access</p>

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<p>MEASURE CONCEPTS RELATED TO ADEQUACY OF DENTAL INSURANCE COVERAGE</p>	<p>All programs and plans should be evaluated according to their coverages starting with meeting the Medical Necessity standard. Four specific concepts were suggested to assess dental insurance coverage adequacy:</p> <ol style="list-style-type: none"> 1. Orthodontic examination (children). This concept proposes to measure the percentage of all children who have an orthodontic screening examination (CDT D8660) by their 7th birthdate. 2. Orthodontic treatment (children). This concept proposes to measure medically necessary treatment of malocclusion based on prior authorization requests for D8080 with approvals for D8080 for children <21 years. 3. Restorative treatment (adults). This concept proposes to measure restoration of missing teeth by surveying patients' charts to determine the number and location of missing teeth for patients >21 years. 4. Palliative treatment (adults). This concept proposes to assess treatment of dental pain for patients >21 years by measuring the number of providers claiming for palliative care codes in a geographic area. <p>Note: Due to length, these suggestions were summarized.</p>	<p>Dr. Mouhab Z. Rizkallah, Chairman</p> <p>American Alliance on Dental Insurance Quality</p>
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GENERAL COMMENTS

<p>GENERAL COMMENTS</p>	<p>NNOHA supports the adoption and implementation of diagnostic codes as a mechanism to drive higher levels of transparency, quality, and evidence-based standardization in dentistry and within a larger healthcare context. Widespread adoption of standardized diagnostic codes could enable the field of quality in dentistry to move beyond plan-level and delivery-based procedurally-focused measures to one that can speak more robustly of population health and quality improvement at system and practice levels. This is an area of work for which there is significant opportunity for partnership between NNOHA and DQA.</p>	<p>Phillip Thompson, MS, Executive Director</p> <p>An Nguyen, DDS, MPH, Quality Committee Chair</p> <p>National Network for Oral Health Access</p>
	<p>No recommended changes or comments.</p>	<p>Hans P. Guter, DDS, FAGD</p> <p>President</p> <p>Academy of General Dentistry</p>
	<p>Having just completed reading through the measurements, I am in support of the way they are all currently written.</p>	<p>Stephen J Canis DMD, CDC Chief Dental Officer Progressive Dental Concepts</p>
	<p>NNOHA is pleased to continue to support DQA's measures for 2023 with only limited, specific comments. While we support the inclusion of measures that focus on all services provided, there is a general need for an increased focus on the creation, implementation, and adoption of measures more clearly tied to evidence and evidence-based practice guidelines, which more overtly drive improvements in oral health outcomes.</p>	<p>Phillip Thompson, MS, Executive Director</p> <p>An Nguyen, DDS, MPH, Quality Committee Chair</p> <p>National Network for Oral Health Access</p>

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