Improving Oral Health Through Measurement

DENTAL QUALITY ALLIANCE: 2021 ANNUAL MEASURES REVIEW

REPORT FROM THE DQA MEASURE DEVELOPMENT AND MAINTENANCE COMMITTEE

JUNE 2021

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INTRODUCTION AND PURPOSE

The purpose of this report is to summarize the 2021 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/en/science-research/dental-quality-alliance/dqa-measure-development-reports/dqa-dental-quality-measures

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 2021. Following a 30-day comment period, the MDMC considered and addressed the comments.

The DQA's MDMC would like to thank all stakeholders 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 18, 2020.

EXECUTIVE SUMMARY OF SIGNIFICANT PROPOSED CHANGES TO THE MEASURE SPECIFICATIONS

The following table presents the list of significant changes to the specifications by measure. The updates reported here address significant changes that are recommended based on the assessment of stakeholder feedback, data analyses, and review of available evidence. Additional recommended changes, such as those related to various coding changes, are detailed elsewhere in the report. They are not included in this table.

Measure	Changes
Topical Fluoride for Children at Elevated Risk for Caries	Remove inferred or reported "elevated risk" as criteria for inclusion in the denominator.
	Streamline the specification by incorporating the three, current specifications, based on rendering provider type, into a single specification with three numerators: dental services, oral health services, and dental or oral health services.
	Update the name to **Topical Fluoride for Children**.
	Retire the current, three measure specifications for Topical Fluoride for Children at Elevated Risk for Caries (dental, oral health, and dental or oral health).
Preventive Services for Children at Elevated Risk for Caries	Remove inferred or reported "elevated risk" as criteria for inclusion in the denominator.
	Streamline the specification by incorporating the three, current specifications, based on rendering provider type, into a single specification with three numerators: dental services, oral health services, and dental or oral health services.
	Update the name to **Preventive Services for Children**.
	Retire the current, three measure specifications for Preventive Services for Children at Elevated Risk for Caries (dental, oral health, and dental or oral health).
Topical Fluoride for Adults at Elevated Caries Risk	Exclude edentulous individuals from denominator
Periodontal Evaluation in Adults with Periodontitis	Exclude edentulous individuals from denominator
Non-Surgical Ongoing Periodontal Care for Adults with Periodontitis	Exclude edentulous individuals from denominator

The ensuing paragraphs provide details of the MDMC's deliberations and determinations.

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.

DEFINING THE DENOMINATOR – MEASURES FOCUSED ON POPULATIONS AT "ELEVATED CARIES RISK"

Multiple DQA measures focus ***on a subset of the enrolled population: those at elevated caries risk.*** The intent is to apply the measures to a population for whom evidence of effectiveness is greatest and where there is the least uncertainty about the appropriateness of the measured intervention. The validated methodology for elevated risk, included in measure specifications, limits inclusion in the denominator to individuals who are inferred to be at elevated risk for dental caries based on procedure codes in administrative claims data.

The identification of elevated risk, based on measure specifications, requires an evaluation in the reporting year to record a CDT risk code or a treatment visit in any of the three prior years to record CDT treatment codes. Children who are at elevated risk may be enrolled but may have no history of dental visits that would allow them to be identified as being at elevated risk using current measure specification methodology. This is especially true for young children. The committee recognizes that even with a history of dental visits, children at elevated risk whose claims data do not include specific CDT risk codes, nor have a history of disease progression that warrants treatment of caries-related lesions, will not be included in the denominator. The committee also notes that The United States Preventive Services Task Force (USPSTF) guidelines recommend topical fluoride for all children under the age 5.

During the 2021 review cycle, the MDMC specifically sought stakeholder feedback (Appendix C) about the elevated risk criteria used to populate the denominator for the DQA measures of Topical Fluoride for Children at Elevated Caries Risk.

The MDMC additionally evaluated the rationale and implications of the elevated risk criteria more broadly for inclusion in the denominator for each of the measures that restricts the denominator to individuals inferred to be at elevated risk for dental caries. The measures are:

- Topical Fluoride for Children at Elevated Caries Risk
- Preventive Services for Children at Elevated Caries Risk
- Topical Fluoride for Adults at Elevated Caries Risk

Public Comments Related to Elevated Risk Criteria for Topical Fluoride for Children

Comments regarding whether to retain the elevated risk criteria

Commenters were specifically asked to provide feedback on the denominator specifications, with the following options presented:

1. No change to the denominator. Monitor for current guidelines updates.
2. Develop a separate specification for children below age 6 with no "elevated risk" criteria applied. Modify the age range of the current measure for only ages 6-20.
3. Remove criteria for "elevated risk" [from the denominator) and stratify by elevated risk status with recommendations for how to use the stratifications.

There were comments in support of each option. Three commenters favored keeping the denominator in order to maintain a focus on priority populations and to monitor for changes in the ADA and USPSTF guidelines, which are both currently under review. Two commenters favored splitting the specifications by age with no elevated risk criteria for children under age 6 years and maintaining elevated risk criteria for children ages 6-20 years. One of these commenters suggested expanding the definition of elevated risk to include individuals with no history of a dental visit in the three years prior to the reporting year, which would expand the denominator. Three commenters favored removing elevated risk and allowing for an optional stratification by risk. On balance, the public comments indicated support for expanding the denominator beyond the existing elevated risk definition.

One commenter noted a limitation with the existing denominator's methodology to infer elevated risk: "some teeth with caries may have already exfoliated and not [be] captured with CDT codes in the system." This commenter further suggested including in the identification of individuals at elevated caries risk: "parents/patient reporting history of caries and/or caries treatment," noting that this history may not be identified with CDT codes for different reasons, such as a lack of continuity of care or a tooth with caries that exfoliated or was extracted more than three years ago. While the points made are both important and valid, including patient or parent reported information in the claims and administrative data-based measure specifications is beyond current capabilities. Inclusion will be important in future measure development.

Recently released updated draft recommendations from the USPSTF recommend that "primary care clinicians apply fluoride varnish to the primary teeth of all infants and children starting at the age of primary tooth eruption."[1] In a systematic review of the evidence, the USPSTF considered the role of elevated risk in its recommendation and concluded: "All children with erupted teeth can potentially benefit from the periodic application of fluoride varnish,

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[1] U.S. Preventive Services Task Force. Draft Recommendation on Preventive Cavities in Young Children. Released May 11, 2021. Available at: https://www.uspreventiveservicestaskforce.org/uspstf/draft-recommendation/prevention-of-dental-caries-in-children-younger-than-age-5-years-screening-and-interventions1

regardless of the levels of fluoride in their water. Although the evidence to support fluoride varnish is drawn from higher-risk populations, the provision of fluoride varnish to all children is reasonable since the prevalence of risk factors is high in the U.S. population."[1]

The MDMC specifically recognized the concern that many children who are at elevated risk would not be captured in the measure denominator because they are not accessing the dental care system, and lack of access to care itself is a risk factor. Furthermore, it is likely that children may have caries-related lesions that have not progressed to the point of requiring treatment which is a pre-requisite for being considered to be at "elevated risk." The MDMC also identified primary prevention as an overriding objective of this measure.

The MDMC additionally reviewed the impact of removing the elevated risk criteria on the denominator and overall measure score (**Table 1**). As expected, the denominator significantly increased with the removal of the elevated risk criteria (broadening the population to include all children who meet age and enrollment criteria regardless of caries risk), and the overall measure score decreased.

Table 1. Topical Fluoride for Children, Dental or Oral Health Services
Measure Scores with and without Elevated Risk Criteria for Denominator Inclusion
Medicaid Enrollees, CY 2018

State	With Elevated Risk			Without Elevated Risk		
	DEN	NUM	%	DEN	NUM	%
State 1	34,533	8,173	23.67%	72,115	11,282	15.64%
State 2	45,297	16,850	37.20%	76,355	18,137	23.75%
State 3	23,830	6,683	28.04%	65,309	11,974	18.33%
State 4	52,380	18,712	35.72%	131,011	27657	21.11%
State 5	47,698	18,249	38.26%	93,007	23,443	25.21%
State 6	91,698	29,648	32.33%	215,030	37,562	17.47%
State 7	36,714	14,650	39.90%	78,919	22,943	29.07%
State 8	129,294	48,967	37.87%	257,565	69,935	27.15%
State 9	357,566	126,452	35.36%	817,253	226,180	27.68%
State 10	122,848	38,753	31.55%	273,032	55,201	20.22%
State 11	331,540	121,281	36.58%	675,306	188,746	27.95%

Data source: Transformed Medicaid Statistical Information (T-MSIS) Analytic Files (TAF). Centers for Medicare & Medicaid Services.

The measure specifications currently limit the denominator-eligible population to a subset of children who can be inferred to be at elevated risk. This is based on caries risk assessment (CRA) CDT codes and caries-related treatment codes. The frequency of reporting and documenting CRA CDT codes in claims data is limited. As a result, children who are actually at elevated risk, but without a caries-related treatment code nor documented CRA CDT codes, will not be included in the denominator. If CRA CDT codes are more frequently documented, then it may

be a more valid and useful means of identifying children at elevated risk than inferring elevated risk based on CDT treatment codes. Based on the above considerations, the denominator was updated to include all children who meet the age (1 through 20 years) and enrollment (11-12 months) criteria and not to limit the measure denominator to those children inferred to be at elevated risk. In its deliberations, the MDMC recognized that removing the elevated risk criteria from the measure denominator could potentially create the perception of moving away from individualized, risk-based care. This is not the intent. The MDMC emphasizes that measurement specifications are not care delivery guidelines. Removal of the elevated risk criteria should not be construed as a recommendation to move away from caries risk assessment and the development of individualized care plans.

Determination: Remove elevated risk criteria from the denominator of Topical Fluoride for Children. Guidance will be included in the User Guide related to stratification of the measure results by caries risk.

Comments regarding the code set used to identify elevated risk

There were comments specific to the CDT procedure code set used to infer elevated caries risk. Because the decision was made to remove elevated risk, those comments are not addressed here. However, they are addressed for the adult measure of topical fluoride application below.

Preventive Services for Children

While the MDMC did not specifically seek public comments related to the elevated risk criteria for Preventive Services for Children at Elevated Caries Risk, the retention of the inferred risk criteria was considered by the MDMC as part of the 2021 Annual Measure Review. This measure looks for whether children inferred to be at elevated caries risk receive at least one sealant or one topical fluoride application during the year. When the measure was developed, the separate measures of sealant placement and topical fluoride for children included elevated risk criteria in the denominator. The elevated risk criteria for sealants were removed during the 2019 Annual Measure Review cycle (with an effective date of January 1, 2020).[2] With the recommendation to remove the elevated risk criteria for Topical Fluoride for Children during the current 2021 Annual Measure Review Cycle, the MDMC determined it appropriate to also recommend removing the elevated risk criteria from the denominator of Preventive Services for Children. The MDMC also evaluated data on the impact of removing the elevated risk criteria on the measure denominator and overall measure score (**Table 2**). Similar to the measure of Topical Fluoride for Children, the denominator of Preventive Services for Children increased, and the overall measure score decreased.

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[2] Dental Quality Alliance. 2019. Final Report on Validating Measures of Overall Provision of Sealants. Available at: https://www.ada.org/~/media/ADA/DQA/2019_Sealants.pdf?la=en.

Table 2. Preventive Services for Children, Dental or Oral Health Services Measure Scores with and without Elevated Risk Criteria for Denominator Inclusion Medicaid Enrollees, CY 2018

State	With Elevated Risk			Without Elevated Risk		
	DEN	NUM	%	DEN	NUM	%
State 1	39,804	24,004	60.31%	88,337	35,755	40.48%
State 2	54,757	42,520	77.65%	100,107	48,337	48.29%
State 3	26,160	19,296	73.76%	75,898	41,672	54.91%
State 4	57,589	39,010	67.74%	154,874	61008	39.39%
State 5	54,802	38,844	70.88%	114,460	54,189	47.34%
State 6	117,387	82,595	70.36%	306,673	131,259	42.80%
State 7	41,634	30,439	73.11%	95,987	51,455	53.61%
State 8	151,777	113,566	74.82%	322,990	175,273	54.27%
State 9	425,276	304,290	71.55%	1,033,609	562,663	54.44%
State 10	166,115	117,576	70.78%	401,383	183,349	45.68%
State 11	374,258	275,641	73.65%	814,911	451,436	55.40%

Data source: Transformed Medicaid Statistical Information (T-MSIS) Analytic Files (TAF). Centers for Medicare & Medicaid Services.

Determination: Remove elevated risk criteria from the denominator of Preventive Services for Children. Guidance will be included in the User Guide related to stratification of the measure results by caries risk.

Topical Fluoride for Adults at Elevated Caries Risk

Similar to the pediatric measures, this measure restricts the denominator to those individuals inferred to be at elevated risk for dental caries. The methodology of this inference for the adult population looks for three separate instances of CDT codes included within the code set to identify individuals at elevated risk.

Retention of the elevated risk criteria

The MDMC evaluated the elevated caries risk criteria for inclusion in the denominator of Topical Fluoride for Adults. Even after several years following introduction of CDT codes to document caries risk, there continues to be limited use of these codes for reporting on dental claims. Given this, the MDMC acknowledges that this measure continues to be limited to the sample of adults who may be inferred to be at elevated risk for caries using claims data. The methodology for identifying elevated caries risk relies on prior caries experience as identified through caries-related treatment codes, using a 3-year look-back period. Children generally have less caries experience to draw from both clinically and in the claims data, whereas adults have a longer history to draw from in order to make reliable inferences about risk. Further, the MDMC discussed evidence-based guidelines that suggest that professionally applied fluoride varnish every three

to six months is effective in preventing caries in high-risk adults.[3] Studies published following publication of this systematic review further support this preventive approach.[4,5] Given this, the MDMC continues to support inclusion of the risk criteria for adults. The MDMC acknowledges that some adults who do not access the dental care system or those who do not have a recent treatment history for caries are not likely to be captured in the measure denominator.

Determination: Retain elevated risk for dental caries criteria for inclusion in the denominator of the measure Topical Fluoride for Adults at Elevated Caries Risk.

Comments regarding the code set used to identify elevated risk

There were comments related to the code set used to determine the inference of elevated risk for both the pediatric and the adult measures of topical fluoride. Where comments for the pediatric measure code set were applicable to the adult measure, they are addressed here.

One commenter suggested including CDT codes specific to the presence of orthodontics and prostheses in the oral cavity as an indication of an individual being at risk for developing future disease. The MDMC noted that these codes are not necessarily indicative of historical caries experience and could threaten the validity of the code set. The MDMC determined that the additional complexity in the measure specifications would not be offset by increased measurement precision. The same commenter suggested adding D4355 (*full mouth debridement to enable a comprehensive oral evaluation and diagnosis on a subsequent visit)* to the elevated caries risk code set. However, it was determined that this was more likely to be associated with periodontal treatment than caries-related treatment.

Another commenter indicated that identification of caries risk is through CDT codes "is suspect, since an assumption is made (without validation) that the service that was purportedly provided, was necessary." The DQA risk-based measures specifications include the CRA CDT codes, introduced in 2014. However, the frequency with which these CDT codes are being reported is variable. Therefore, additional methodology to identify individuals at elevated risk was included that uses caries-related treatment codes in administrative claims data to identify prior caries experience, which is an established risk factor. Similar methodology to identify adults at elevated risk for dental caries has been used in the peer-reviewed literature.[5] The committee concluded that it is beyond the scope of this review to adequately respond to concerns that may be associated with the provision of unnecessary care and the impact on the administration of the measure.

Determination: The elevated risk code set for the measure of Topical Fluoride for Adults at Elevated Caries Risk will remain unchanged.

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[3] Weyant, Robert J. et al. Topical fluoride for caries prevention. The Journal of the American Dental Association 2013; 144(11):1279-1291.
[4] Zero DT, Brennan MT, et al. Clinical practice guidelines for oral management of Sjögren disease: Dental caries prevention. J Am Dent Assoc. 2016 Apr;147(4):295-305. doi: 10.1016/j.adaj.2015.11.008. Epub 2016 Jan 5.
[5] Gibson G, Jurasic MM, et al. Longitudinal outcomes of using a fluoride performance measure for adults at high risk of experiencing caries. J Am Dent Assoc. 2014 May;145(5):443-51. doi: 10.14219/jada.2013.53

DEFINING THE DENOMINATOR - EXCLUSION OF EDENTULOUS ENROLLEES IN ADULT MEASURES

One commenter suggested excluding completely edentulous individuals, as identified through CDT codes signifying that an individual has complete dentures, from the denominators of the following measures for the adult population:

1. Topical Fluoride for Adults
2. Periodontal Evaluation in Adults with Periodontitis
3. Nonsurgical Ongoing Periodontal Care for Adults with Periodontitis

Data provided regarding the effect of this exclusion indicate that the impact to the overall measure score is small (**Table 3**). The MDMC agreed that this exclusion would improve face validity of the measure with little additional implementation burden. **Table 4** indicates the codes used to identify adults who should be excluded from each measure.

Table 3. Impact of Excluding Completely Edentulous Individuals using Prosthesis Codes
Topical Fluoride for Adults at Elevated Caries Risk
Plan Level Data, CY 2017 – CY 2020

State	Year	Without Exclusions			With Exclusions			
		DEN	NUM	%	EXC	DEN	NUM	%
State 1	2018	14,110	1,328	9.41%	275	13,835	1,328	9.60%
	2019	13,678	1,501	10.97%	235	13,443	1,499	11.15%
	2020	15,022	1,118	7.44%	166	14,856	1,118	7.53%
State 2	2017	11,563	710	6.14%	97	11,466	710	6.19%
	2018	12,430	957	7.70%	120	12,310	956	7.77%
	2019	13,190	972	7.37%	110	13,080	969	7.41%
State 3	2018	13,087	1,440	11.00%	68	13,019	1,434	11.01%
	2019	14,481	1,835	12.67%	96	14,385	1,831	12.73%
	2020	16,703	1,375	8.23%	100	16,603	1,373	8.27%

Data source: Plan-level data.

In reviewing the prosthesis codes, the MDMC focused on CDT codes specific to complete dentures. During deliberation, the MDMC made the following determinations specific to the adult measures:

For the Adult Topical Fluoride measure:

- Exclude the patient from the denominator if CDT codes indicate the maxillary and mandibular arches have been restored with any combination of complete dentures, implant supported removable dentures or implant supported full arch fixed restorations.
- Do not exclude the patient from the denominator if CDT codes indicate treatment with tooth supported overdentures in either arch.

For the periodontal measures:

- Exclude the patient from the denominator if CDT codes indicate the maxillary and mandibular arches have been restored with complete dentures.
- Do not exclude the patient from the denominator if CDT codes indicate treatment with either tooth or implant supported overdentures in either arch.

Determination: Exclude individuals who can be identified as being completely edentulous using CDT codes signifying the presence of complete dentures.

Table 4. Codes Used to Identify Completely Edentulous Adults

Topical Fluoride for Adults at Elevated Caries Risk	**Periodontal Evaluation in Adults with Periodontitis** and **Nonsurgical Ongoing Periodontal Care for Adults with Periodontitis**
i. Any one CDT code from the set: [D5110 or D5130 or D5810 or D5410 or D5512 or D5710 or D5730 or D5750 or D6110 or D6114 or D6119] AND ii. Any one CDT code from the set: [D5120 or D5140 or D5811 or D5411 or D5511 or D5711 or D5731 or D5751 orD6111 or D6115 or D6118]	i. Any one CDT code from the set: [D5110 or D5130 or D5810 or D5410 or D5512 or D5710 or D5730 or D5750] AND ii. Any one CDT code from the set: [D5120 or D5140 or D5811 or D5411 or D5511 or D5711 or D5731 or D5751]

OTHER MEASURE-SPECIFIC COMMENTS

Measures for Children

Topical Fluoride for Children and Preventive Services for Children

Age Criteria

Two commenters recommended lowering the lower bound of the age range for Topical Fluoride for Children to include children younger than one year of age. Because this measure requires at least 11 months of enrollment in order to assess the provision of at least two topical fluoride applications, the minimum age must be at least 1 year of age. Lowering the age boundary would have no practical effect.

One commenter recommended changing the Preventive Services for Children age range to have a lower bound of 1 instead of 0 to be consistent with the Topical Fluoride for Children measure. The MDMC does not recommend changing the age range due to the different purposes and enrollment intervals for the two measures. Preventive Services is a utilization measure with an enrollment requirement of at least six months. Consistent with other DQA measures that have a six-month enrollment requirement, the lower age bound is 0. The measure includes stratification by age, including the age band of 0-1 years, which allows measure implementers to understand measure performance across age groups.

Determination: No changes to the lower bound of the age criteria for Topical Fluoride for Children or Preventive Services for Children.

Silver Diamine Fluoride (SDF)

Some commenters inquired about the inclusion of codes (D1354 and D1355) that can be used to reflect the application of SDF for potential inclusion in the **numerators** of the Topical Fluoride for Children and Preventive Services for Children measures. Evidence-based guidelines currently support SDF in the presence of an active carious lesion to arrest the progression of disease. Evidence-based guidelines indicate fluoride as effective in preventing future disease in the absence of an active diseased state. It is also noted that the science regarding the use of SDF is continuing to evolve and that there is currently insufficient evidence to support SDF as primary prevention. The MDMC will continue to monitor the evidence regarding the use of SDF in caries prevention and management.

Determination: Do not add codes D1354 or D1355 to the numerators of Topical Fluoride for Children or Preventive Services for Children.

Number of Topical Fluoride Applications

One commenter suggested adding an additional numerator to Topical Fluoride for Children that assesses how many children have at least one topical fluoride application. Evidence suggests that professionally applied topical fluoride, starting as early as six months of age and applied at least every 3 – 6 months in children based on caries risk, is beneficial in preventing dental caries.[6] Thus, the minimum recommended frequency of 6 months would be equivalent to two fluoride applications per year. Programs and plans that wish to further explore receipt of topical fluoride among their enrollees to inform quality improvement efforts may find it useful to evaluate the number and percentage of children who received 0, 1, 2, 3, or 4 or more topical fluoride applications.

Determination: No change to the frequency of topical fluoride applications assessed in the measure.

Oral Evaluation

Age Criteria

One commenter suggested revising the age range currently included in the measure of Oral Evaluation to exclude children six months of age or younger. Although the age criteria do not explicitly exclude children younger than six months of age, the enrollment requirement of at least six months effectively ensures that children are at least six months of age. 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

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[6] Weyant, Robert J. et al. Topical fluoride for caries prevention. The Journal of the American Dental Association 2013; 144(11):1279–1291.

individuals younger than 18 years of age.[7] 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.[8],[9],[10],[11],[12] Consequently, the DQA maintains the measure is 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.

Determination: No changes to the lower bound of the age criteria for Oral Evaluation.

Caries Risk Documentation

This measure assesses if a caries risk assessment (CRA) was documented in the reporting year. One commenter indicated: "that without a universally agreed upon definition, even if imperfect, it is hard to recommend a measure on CRA." The MDMC thanks the commenter for this feedback and notes that this measure is designed to support quality improvement activities by encouraging providers to conduct and document CRA in support of developing individualized care plans.

Another commenter recommended the use of a specific CRA form. The DQA does not recommend any specific CRA tools. The findings of an American Dental Association – American Academy of Pediatric Dentistry Caries Risk Assessment Expert Panel, which reviewed the current state of science on CRA and developed guidance on risk categorization, found that current CRA tools share many common elements to assess risk and affirmed they have at least dichotomous predictive ability to identify "low risk" and "elevated "risk".[13] However, there is no evidence that supports one tool over another. As a result, multiple risk assessment tools are utilized. Providers combine results from assessment tools with clinical judgment to arrive at a caries risk determination. Despite the limited evidence on the relative effectiveness of caries risk prediction using alternative assessment tools, professional clinical guidelines recommend that providers conduct CRA and use that information to develop individualized prevention and treatment care planning. This measure is designed for use in quality improvement applications to support quality improvement efforts around CRA and documentation. In addition, this measure is

[7] 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.
[8] American Academy of Pediatric Dentistry. Perinatal and infant oral health care. Pediatr Dent 2018;40(6):216-20.
[9] American Academy of Pediatric Dentistry. Policy on the dental home. Pediatr Dent 2018;40(6):29-30.
[10] "Get It Done In Year One". https://www.mychildrensteeth.org/globalassets/media/policy-center/year1visit.pdf.
[11] American Academy of Pediatrics. Maintaining and improving the oral health of young children. Pediatrics 2014;134(6):1224-9.
[12] 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/
[13] Dental Quality Alliance Guidance on Caries Risk Assessment in Children: A Report of the Expert Panel for Use by the Dental Quality Alliance: 2018. Available at: https://www.ada.org/~/media/ADA/DQA/CRA_Report.pdf?la=en. Accessed May 21, 2021.

designed only to document that the enrollee received a CRA. This measure is not designed to be used to assess the health state of the population or to create population risk profiles.

Sealants on Permanent First & Second Molars

One commenter inquired whether the sealant measures focused on retention versus prevention of disease. The DQA has two sealant measures, Sealant Receipt on Permanent 1st Molars and Sealant Receipt on Permanent 2nd Molars, that are focused on primary prevention of dental caries. These measures assess the overall provision of sealants on permanent first and second molars by age 10 and 15, respectively. The intent of these population-based measures is to promote prevention of dental caries by sealing all molars by specified age for the enrolled population.

Measures for Adults

Nonsurgical Ongoing Periodontal Care for Adults with Periodontitis

One commenter recommended including CDT code D4346 (*scaling in presence of generalized moderate or severe gingival inflammation)* in the numerator of this measure. The MDMC agreed that inclusion of this code would be consistent with the intent of the measure 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.*"

Determination: Include CDT D4346 in the set of codes that qualify for numerator inclusion for the measure Nonsurgical Ongoing Periodontal Care for Adults with Periodontitis.

Adults with Diabetes – Oral Evaluation

This measure assesses the percentage of adults with diabetes who received a comprehensive or periodic oral evaluation or a comprehensive periodontal evaluation within the reporting year.

A commenter recommended incorporating stratification based on control (like HbA1c levels) to address that not all diabetics are alike and that some may be periodontally healthy adults. The MDMC appreciates the feedback to incorporate this stratification and will consider for future measure development purpose. However, the MDMC clarifies the intent of this measure is *not to evaluate the severity of diabetes* and its impact on oral health. Rather, the measure is intended to evaluate whether an individual with a diagnosis of Diabetes (including both Type I and Type II), identified from medical and pharmacy claims data, had an oral evaluation. Oral evaluations represent an important entry point into the dental care system. Diagnosis and treatment planning for the prevention as well as the treatment of periodontal disease at these visits offer patients appropriate dental care with the potential to improve diabetes outcomes. The measure currently can be stratified by age, gender, race/ethnicity, and geographic location.

GENERAL COMMENTS ON EXISTING MEASURES

Age Definition

One commenter inquired how the DQA made its age determinations for "children" and "adults."

DQA measures are developed for alignment and use across public and private sectors. When used for comparisons across Medicaid/CHIP programs, the DQA has defined "children" as individuals aged younger than 21 years (<21 years) to be consistent with Medicaid Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) benefit and reporting in the Medicaid Child Core Set Quality Measures. Individuals younger than aged 19 years (<19 years) are defined as "children" for Health Insurance Marketplace reporting to be consistent with the age requirements for Essential Dental Benefit coverage under the Affordable Care Act. Within any particular program, if there are more restrictive age eligibility criteria, the program should include only the ages eligible for program participation in the measure denominator and indicate the age range used when reporting measures. Plans are advised to check with program officials regarding the appropriate age criterion. The age criterion used should be reported with the measurement score.

The DQA uses 18 years as its lower age bound for potential inclusion in adult measures to be consistent with the lower age bound included in the Medicaid Core Set of Adult Health Care Quality Measures and the Health Insurance Marketplace Quality Rating System.

Because age eligibility varies for pediatric and adult dental benefit coverage across the public and private sectors, the age ranges for pediatric measures and adult measures may overlap. Measure specifications between adult and pediatric populations for the same measure concept (e.g., topical fluoride) may be different; therefore, it is important that measure implementers consult the appropriate specifications and not use the same measure specifications across both populations.

PUBLIC RECOMMENDATIONS FOR NEW MEASURES

Preventive and Non-Surgical Periodontal Surgery Service for Adults with Diabetes

One commenter recommended a measure of "Preventive and Non-Surgical Periodontal Surgery Service" that would identify the percentage of adult members with diabetes who have received a cleaning (D1110), periodontal maintenance (D4910), or non-surgical periodontal treatment (D4341, D 4342, or D4346). The MDMC appreciates this feedback and will include it as part of its future measure development plans.

Oral Health Measure for Pregnant Women

One commenter recommended including a periodical dental measure for pregnant women. The MDMC appreciates this feedback and notes that the DQA has identified "pregnant women" as population of interest. DQA has two measure concepts that are under consideration:

Measure Name	Description	Numerator	Denominator
Pregnant Women: Oral Evaluation	Percentage of a. all enrolled women identified as pregnant b. enrolled women who accessed dental care (received at least one service) identified as pregnant who received a comprehensive or periodic oral evaluation within the reporting year	Unduplicated number of all enrolled women identified as pregnant who received a comprehensive or periodic oral evaluation	a. Unduplicated number of all enrolled women identified as pregnant b. Unduplicated number of all enrolled women identified as pregnant who received at least one dental service
ECC advise in Pregnancy	Percentage of all enrolled pregnant women (pre/postpartum) who received advice regarding ECC within the reporting year.	Unduplicated number of all enrolled pregnant women (pre/postpartum) who received advice regarding ECC within the reporting year	Unduplicated number of all enrolled pregnant (pre/post-partum) women

The MDMC will explore feasibility of testing these concepts for validity, reliability and feasibility as part of its future measure development plans.

GENERAL UPDATES TO MEASURE SPECIFICATIONS

RENDERING PROVIDERS - DENTAL SERVICES, ORAL HEALTH SERVICES, and DENTAL OR ORAL HEALTH SERVICES

The following DQA measures have three sets of specifications based on treating provider: dental, oral health, and dental or oral health:

1. Topical Fluoride for Children
2. Preventive Services for Children
3. Utilization of Services for Children

The MDMC specifically discussed the utility of maintaining separate specifications for the Topical Fluoride and the Preventive Services measures based on treating provider. Given an increasing interest in evaluating the performance of programs for health services that are provided as dental or oral health services, the MDMC determined that the separate specifications could be streamlined into a single specification. To that end, MDMC has updated the measure specifications for Topical Fluoride for Children and Preventive Services for Children to include three separate numerators within one specification. The final version will now include all 3 variations of these measures based on rendering provider in a single specification.

Subsequently, MDMC recommends the following separate specifications be retired:

1. Topical Fluoride for Children, Dental Services
2. Topical Fluoride for Children, Oral Health Services
3. Topical Fluoride for Children, Dental or Oral Health Services
4. Preventive Services for Children, Dental Services
5. Preventive Services for Children, Oral Health Services
6. Preventive Services for Children, Dental or Oral Health Services

The MDMC did not discuss revisions to the Utilization of Services measure as part of the 2021 Annual Measure Review. All versions of this measure will be maintained.

CODE UPDATES

In addition to the public comments submitted, the MDMC reviewed and approved several routine updates to the measure specifications. These include code updates and editorial updates. Review of the 2021 CDT Manual code updates did not identify new codes relevant to the measures.

Health Care Provider Taxonomy Codes

The MDMC reviewed the rendering provider taxonomies associated with billed CDT procedure codes using state Medicaid and CHIP data from the Transformed Medicaid Statistical Information System (T-MSIS) Analytic Files (TAF) and the corresponding descriptions of the taxonomy codes from the Health Care Provider Taxonomy code set maintained by the National Uniform Code Committee (NUCC). This review identified five NUCC codes as relevant for identifying "dental" services – those services provided by or under the supervision of the dentist. The MDMC approved inclusion of these codes in the relevant measure specifications. One additional code, 292200000X, *Laboratories: Dental Laboratory* was evaluated, but the MDMC determined that there was insufficient information about how this code is used as well as apparent lack of consistency in use in order to reliably identify services billed with this code as "dental" services. Services billed with this taxonomy code will be included in the "oral health" and "dental or oral health" versions of the measures. The MDMC will continue to evaluate and monitor the use of this taxonomy code.

Measure	**Update**
Applies to measure that contain the NUCC code set to identify "dental" or "oral health" services: • Caries Risk Documentation • Care Continuity • Oral Evaluation • Preventive Services • Topical Fluoride • Treatment Services • Usual Source of Care • Utilization of Services • Follow-up after ED Visits for Dental Caries in Children • Follow-Up after ED Visits for NTDC in Adults • Per Member Per Month Cost of Clinical Services	**NUCC Code Update** The following NUCC codes are added to the identification of "dental" providers for the purposes of distinguishing "dental" services from "oral health" services: • 126800000X Dental Assistant • 261QD0000X Clinic/Center: Dental • 204E00000X Allopathic & Osteopathic Physicians: Oral & Maxillofacial Surgery • 261QS0112X Clinic/Center: Oral & Maxillofacial Surgery • 122400000X Dental Providers: Denturist For detailed descriptions, see Health Care Provider Taxonomy Code Set, Version 21.0, National Uniform Claim Committee: https://nucc.org/index.php/code-sets-mainmenu-41/provider-taxonomy-mainmenu-40/csv-mainmenu-57

CPT Code 99188 for Topical Fluoride

The “oral health” and “dental or oral health” specifications for Topical Fluoride for Children, Preventive Services for Children, and Utilization of Services include the following note regarding procedures that can be counted for inclusion in the numerator: “Services provided by medical providers: In some instances, CPT or other codes are used for reimbursement of oral health services (e.g., medical primary care providers providing oral evaluation, risk assessment, anticipatory guidance or fluoride varnish). Details available at AAP Table . For such states these additional codes must be considered.”

The additional codes include CPT Code 99188: *application of topical fluoride varnish by a physician or other qualified health care professional*. Because this code is specific to topical fluoride (versus generic codes such as 99499 – *unlisted evaluation and management service*), the MDMC determined that this code should be formally included in the list of procedure codes that qualify for inclusion in the numerators for the “oral health” and “dental or oral health” versions of the measures.

Measure	**Update**
Applies to measures that have “oral health” and “dental or oral health” specifications: • Preventive Services • Topical Fluoride • Utilization of Services	Add CPT Code 99188 to the list of procedure codes that qualify for inclusion in the “oral health” and “dental or oral health” numerators.

Appendix A: Measure Development and Maintenance Committee

Measure Development and Maintenance Committee:

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

Frederick Eichmiller, DDS, General Dentist

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

An Nyugen, Chief Dental Officer, Clinica Family Health

Chris Okunseri, B.D.S., M.Sc., Director, Predoctoral Program, Dental Public Health, Marquette University

Bob Russell, DDS, MPH, MPA, CPM, FACD, FICD, 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:

Cary Limberakis, DMD, ADA/ Council on Dental Practice

DQA Leadership:

Tom Meyers, Chair, Dental Quality Alliance

Paul Casamassimo, Chair-Elect, Dental Quality Alliance

The Committee was supported by:

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

Diptee Ojha, BDS, PhD, Director, Dental Quality Alliance & Clinical Data Registry, American Dental Association

Erica Colangelo, 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

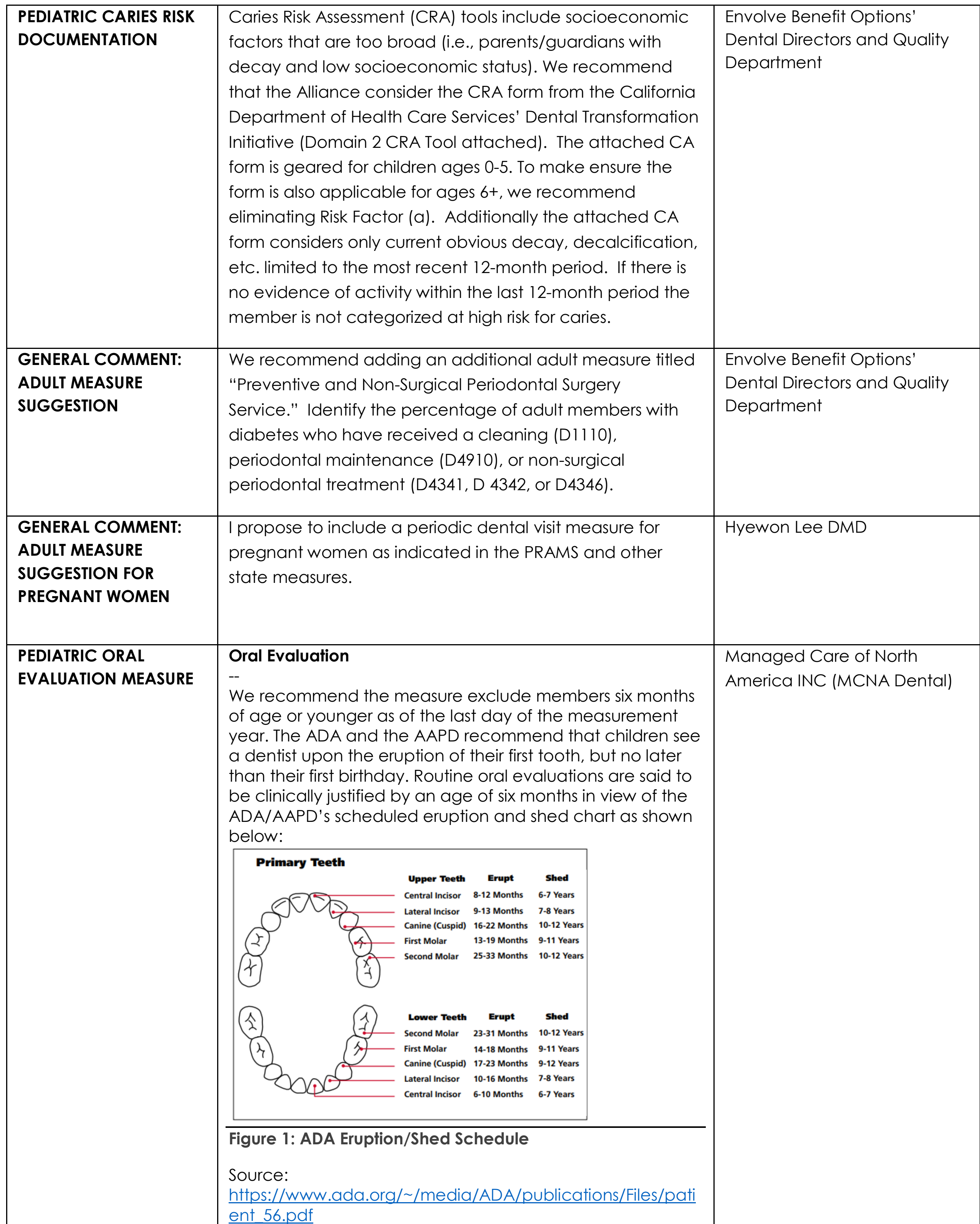
MEASURE	COMMENT	SUBMITTED BY
GENERAL TOPICAL FLUORIDE COMMENT	Back in the early 2000s, I think the CDC said that only water fluoridation and use of fluoride toothpaste were for "all" people/children, and any additional fluoride would be based on risk. So, unless that has changed (and it may have) isn't risk a necessary part of any topical fluoride measure? I will look at our AAPD guidelines again. This doesn't reduce the difficulty of defining risk in the denominator but would focus the use of the measure...	Dr. Paul Casamassimo Chair-elect DQA
PEDIATRIC TOPICAL FLUORIDE	--- We recommend breaking out this measure into two unique measures. One for members aged 1-5 (>=1 and <6) and the second for ages six and older (>=6 and <=20). --Criteria for members aged 1-5: Denominator: All members aged one to five meeting the existing continuous enrollment requirement without regard to risk status. Numerator 1 of 2: Members aged one to five years receiving at least one topical fluoride (D1206, D1208) during the measurement year. Numerator 2 of 2: Members aged one to five years receiving two or more topical fluoride (D1206, D1208) during the measurement year. --Criteria for members aged 6-20: Denominator: All members aged six to twenty meeting the existing continuous enrollment requirement and who meet the elevated risk requirement as specified by the new criteria below. Numerator 1 of 2: Members aged six to twenty years receiving at least one topical fluoride (D1206, D1208) during the measurement year. Numerator 2 of 2: Members aged six to twenty years receiving two or more topical fluoride (D1206, D1208) during the measurement year. ---We recommend expanding the value set of CDT Codes identifying elevated risk criteria to include: 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 **--- see comment A** 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 subjects who do have claims experience in any of the prior three years.) **--- see comment B** OR iii. the subject has a visit with a CDT code = (D0602 or D0603) in the reporting year **OR** **iv. the subject has no history of a dental visit 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	Managed Care of North America INC (MCNA Dental)

	three years for the denominator enrollment criteria; this is a "look back" for subjects consistent with the existing criteria.) **-- see comment C** **Comment A – include the following CDT Codes to the current value set.** D4355, D5211, D5212, D5213, D5214, D5221, D5222, D5223, D5224, D5225, D5226, D5282, D5283, D5284, D5286, D5820, D5821, D5864, D5866, D6985, D8010, D8020, D8030, D8040, D8050, D8060, D8070, D8080, D8090, D8210, D8220 **Comment B – include the following CDT Codes to the current value set.** D5211, D5212, D5213, D5214, D5221, D5222, D5223, D5224, D5225, D5226, D5282, D5283, D5284, D5286, D5820, D5821, D5864, D5866 **Comment C –** ADA Risk Assessment Forms (Links Below) http://www.ada.org/~/media/ADA/Science%20and%20Research/Files/topic_caries_over6.ashx https://www.ada.org/~/media/ADA/Member%20Center/Files/topics_caries_under6.ashx **Comment C commentary:** We recommend adding members to the denominator who do not have a claim history in that the ADA Risk Assessment form includes not having a patient of record, receiving regular dental care in a dental office, as moderate risk.	
PEDIATRIC TOPICAL FLUORIDE	The AAPD recognizes the need for applicability of the denominator in a variety of settings. Users of the measure should choose to use at risk in their denominator or not and modify the measure as needed. We understand this may be the best approach on defining the denominator of the topical fluoride measure.	AAPD
PEDIATRIC TOPICAL FLUORIDE	Using CDT codes and claims to identify caries risk is suspect, since an assumption is made (without validation) that the service that was purportedly provided, was necessary. Do the CDT codes used for confirmation of caries refer to both restorative procedures and the code for application of SDF?	Dr. Stephen J. Canis, DMD National Dental Director United Concordia Dental
PEDIATRIC TOPICAL FLUORIDE	No change to current denomination recommended.	Bob Russell, DDS, MPH, MPA, CPM, FACD, FICD Dental Director & Bureau Chief Oral & Health Delivery System Bureau, Division of Health Promotion and Chronic Disease Prevention / Iowa Department of Public Health

PEDIATRIC TOPICAL FLUORIDE	Texas Medicaid and CHIP Services Quality Assurance prefers running the measure on all eligible children with optional stratification by age and caries risk.	Robyn Smith Senior Quality Analyst Texas Medicaid and CHIP Services Quality Assurance
PEDIATRIC TOPICAL FLUORIDE	1. Current AAPD caries risk assessment categorizes children (age 0-5) as high-risk if the child has frequent exposure (>3 times/day) between-meal sugar-containing snacks or beverages per day. Snacking four times or more is very common for this age group, making most children into high-risk categories (not necessarily candies but also carbohydrates, such as popcorns and organic juice diluted). While the findings of an American Dental Association - American Academy of Pediatric Dentistry Caries Risk Assessment Expert Panel found that current caries risk assessment tools share many common elements to assess risk and affirmed that they have at least dichotomous predictive ability to quantify "low risk" and "elevated risk, the definition of "low risk" should be clearly indicated as a universal definition. 2. History of caries: if a child had one caries during his/her lifetime, it automatically puts him/her high caries-risk. However, those teeth with caries may have already exfoliated and not captured with CDT codes in the system. The measure should include "parents/patient reporting history of caries and/or caries treatment," which may not be identified with CDT codes with different reasons (lack of continuity of care, a tooth with caries have exfoliated or extracted more than three years ago, etc.).	Hyewon Lee DMD
PEDIATRIC TOPICAL FLUORIDE	Recommend Option 1- *No change to the denominator. Monitor for current guidelines updates.* From MCH perspective 1. No change to the denominator. Monitor for current guidelines updates. a. Agree, suggest age change to include children younger than 1. b. The denominator is "Unduplicated number of children aged 1–21 years at "elevated" risk (i.e. "moderate" or "high")". Currently, the common metrics of the NOHIs, the denominator for preventive services, which include fluoride varnish used patients at high risk, which is consistent with this denominator topical fluoride measure. The population age includes 0- 40 months and 6-12 years of age, groups served by the NOHIs 2. Develop a separate specification for children below age 6 with no "elevated risk" criteria applied. Modify the age range of the current measure for only ages 6-20.	Informal feedback from HRSA colleagues for consideration. These comments do *NOT* represent an official position or response from the agency or federal government.

	a. Agree, it may be helpful to develop a separate specification for children below age 6 with no "elevated risk" criteria applied and keep the current measure for only ages 6-20. For the younger group (children below age 6), especially when dealing with vulnerable populations it is important to monitor the use of fluoride varnish more closely whether at high risk or not. 3. Remove criteria for "elevated risk" [from the denominator) and stratify by elevated risks status with recommendations for how to use the stratifications.* a. Disagree, use by the evidence supports and gain better compliance. The alternative (to stratify by risk) sounds convoluted and could interfere with increase knowledge/skill among providers. *As an FYI, Bureau of Primary Health Care does not collected or report data to support Option 3. 4. Any other suggestion/ perspective to the denominator. a. Not specific to the denominator but related to the limitations. It would be worthy to somehow flag charts that do not have a record of care in the past one to three years. Specifically, given case management is an option, such missing reports could trigger outreach to ensure the child is receiving desire preventive oral health care, including fluoride varnish that then will trigger the fluoride varnish measurement. b. The recommendation from the Center for Oral Health Systems Integration and Improvement (COHSII) and its Quality Indicator Advisory Team (QIAT) guided the identification of existing quality indicators to monitor services delivered in public health programs and systems of care to improve access to and quality of oral health care for the MCH population. They selected the current Dental Quality Alliance (DQA) that is endorsed by the National Quality Forum (https://www.mchoralhealth.org/cohsii/indicators/files/indicator-summary-c4.pdf).	
PEDIATRIC TOPICAL FLUORIDE	I would suggest the age to start at 6 months as the lower limit. The rationale for this is that if a patient is coming in at 6 months, it is likely that teeth are already present and the dental provider should be establishing caries risk. Additionally, if the 6 month old patient is not coming in during the measure period, he or she would not be included in the denominator.	Ryan Tuscher, DDS Dental Director, PCC Community Wellness Center
PEDIATRIC TOPICAL FLUORIDE	Re the Topical Fl measure it would be great if we would all work from the same guidelines, but they seem to be under review. When looking at two applications per year the risk stratification does not seem all that important.	Ramona English, DMD Chief Dental Officer Petaluma, Rohnert Park & Coastal Health Centers

	What is more difficult in terms of data collection is measuring the number of FL applications per patient in a time period. We would have to build a report for that. I would change the age group and eliminate the risk stratification to something looking like this: the percentage of children aged 1 – 20 years who received at least 2 topical fluoride applications within the reporting year. Monitor evidence for upper age limit; 16/18/20? Start at age 1 because having two Fl applications before age 1 would be uncommon.	
PEDIATRIC SEALANT MEASURE COMMENT	Is this the measure set which establishes that sealants metrics are judged by retention instead of prevention of disease?	Dr. Jeremy Horst Director of Clinical Innovation DentaQuest
GENERAL COMMENT	Silver diamine fluoride is an excellent alternative to topical fluorides that is more cost effective and requires less frequent application. Please update data collection. Data is available from Elevate Oral Care and recent literature.	Dr. Janet Yellowitz, Director of Geriatric Dental Programs at the University of Maryland, Baltimore College of Dental Surgery
GENERAL COMMENT	Regarding other measures, the age groups need more attention. What is child, what is adult, why does adult start at 18 in the adult Fluoride measure? Some measures should start at 6 months, others at age 1. Why some include 21 for children and others do not? Maybe should stick with age 20 upper limit for children. I also have a hard time with their definition of treatment and preventive. SDF is a preventive code but I see it as treatment. There are other preventive codes that are treating disease. They seem to count only surgical as treatment; restorative and above.	Ramona English, DMD Chief Dental Officer Petaluma, Rohnert Park & Coastal Health Centers

PEDIATRIC CARIES RISK DOCUMENTATION	Caries Risk Assessment (CRA) tools include socioeconomic factors that are too broad (i.e., parents/guardians with decay and low socioeconomic status). We recommend that the Alliance consider the CRA form from the California Department of Health Care Services' Dental Transformation Initiative (Domain 2 CRA Tool attached). The attached CA form is geared for children ages 0-5. To make ensure the form is also applicable for ages 6+, we recommend eliminating Risk Factor (a). Additionally the attached CA form considers only current obvious decay, decalcification, etc. limited to the most recent 12-month period. If there is no evidence of activity within the last 12-month period the member is not categorized at high risk for caries.	Envolve Benefit Options' Dental Directors and Quality Department
GENERAL COMMENT: ADULT MEASURE SUGGESTION	We recommend adding an additional adult measure titled "Preventive and Non-Surgical Periodontal Surgery Service." Identify the percentage of adult members with diabetes who have received a cleaning (D1110), periodontal maintenance (D4910), or non-surgical periodontal treatment (D4341, D 4342, or D4346).	Envolve Benefit Options' Dental Directors and Quality Department
GENERAL COMMENT: ADULT MEASURE SUGGESTION FOR PREGNANT WOMEN	I propose to include a periodic dental visit measure for pregnant women as indicated in the PRAMS and other state measures.	Hyewon Lee DMD
PEDIATRIC ORAL EVALUATION MEASURE	**Oral Evaluation** -- We recommend the measure exclude members six months of age or younger as of the last day of the measurement year. The ADA and the AAPD recommend that children see a dentist upon the eruption of their first tooth, but no later than their first birthday. Routine oral evaluations are said to be clinically justified by an age of six months in view of the ADA/AAPD's scheduled eruption and shed chart as shown below:  **Figure 1: ADA Eruption/Shed Schedule** Source: https://www.ada.org/~/media/ADA/publications/Files/patient_56.pdf	Managed Care of North America INC (MCNA Dental)

ADULT PERIODONTAL EVALUATION	We recommend excluding members from the denominator who, as of the anchor date of the measurement year, received Complete Dentures, Immediate Complete Dentures, Interim Complete Dentures, or Complete Overdentures. The value sets are as follows: Complete Dentures: D5110, D5120 Immediate Complete Dentures: D5130, D5140 Interim Complete Dentures: D5810, D5811 Complete Overdentures: D5863, D5865	Managed Care of North America INC (MCNA Dental)
NON SURGICAL ONGOING PERIO CARE FOR ADULTS WITH PERIODONTITIS MEASURE	We recommend the measure's numerator include CDT Code D4346 (scaling in presence of generalized moderate or severe gingival inflammation — full mouth, after oral evaluation) because, as the ADA has indicated: *"There is no CDT Code available to report therapeutic treatment of patients with generalized moderate to severe gingival inflammation, with or without pseudo-pockets but exhibiting no bone loss – this is the gap by D4346."* As such, the procedure is considered therapeutic for a patient in a diseased state, as noted by the following sentence in the D4346 descriptor – "It is indicated for patients who have swollen, inflamed gingiva, generalized supra-bony pockets, and moderate to severe bleeding on probing." In short, this CDT Code would be a valuable outlet to capture additional numerator compliance because it allows the recognition of non-surgical care when rendered for a member with a history of periodontitis at the point the member has improved in his or her overall oral health. This paints a more accurate picture within the context of population health and real improvement over time. -- We recommend excluding members from the denominator who, as of the anchor date of the measurement year, received Complete Dentures, Immediate Complete Dentures, Interim Complete Dentures, or Complete Overdentures. The value sets are as follows: Complete Dentures: D5110, D5120 Immediate Complete Dentures: D5130, D5140 Interim Complete Dentures: D5810, D5811 Complete Overdentures: D5863, D5865	Managed Care of North America INC (MCNA Dental)
ADULTS WITH DIABETES – ORAL EVALUATION	I agree the measure is too broad. Maybe it should be only diabetic patients with an HbA1C over 9 in the denominator. A stratification seems to be suited for this measure.	Ramona English, DMD Chief Dental Officer Petaluma, Rohnert Park & Coastal Health Centers

ADULT TOPICAL FLUORIDE	----We recommend excluding members from the denominator who, as of the anchor date of the measurement year, received Complete Dentures, Immediate Complete Dentures, Interim Complete Dentures, or Complete Overdentures. The value sets are as follows: Complete Dentures: D5110, D5120 Immediate Complete Dentures: D5130, D5140 Interim Complete Dentures: D5810, D5811 Complete Overdentures: D5863, D5865 ---We recommend expanding the value set of CDT Codes identifying elevated risk criteria to include: 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 **--- see comment A** 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 subjects who do have claims experience in any of the prior three years.) **--- see comment B** OR iii. the subject has a visit with a CDT code = (D0602 or D0603) in the reporting year **OR** **iv. the subject has no history of a dental visit 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 subjects consistent with the existing criteria.) **-- see comment C** **Comment A – include the following CDT Codes to the current value set.** D4355, D5211, D5212, D5213, D5214, D5221, D5222, D5223, D5224, D5225, D5226, D5282, D5283, D5284, D5286, D5820, D5821, D5864, D5866, D6985, D8010, D8020, D8030, D8040, D8050, D8060, D8070, D8080, D8090, D8210, D8220 **Comment B – include the following CDT Codes to the current value set.** D5211, D5212, D5213, D5214, D5221, D5222, D5223, D5224, D5225, D5226, D5282, D5283, D5284, D5286, D5820, D5821, D5864, D5866 **Comment C –** ADA Risk Assessment Forms (Links Below) http://www.ada.org/~/media/ADA/Science%20and%20Research/Files/topic_caries_over6.ashx https://www.ada.org/~/media/ADA/Member%20Center/FIles/topics_caries_under6.ashx **Comment C commentary:** We recommend adding members to the denominator who do not have a claim history in that the ADA Risk Assessment form includes not having a patient of record, receiving regular dental care in a dental office, as moderate risk.	Managed Care of North America INC (MCNA Dental)

PEDIATRIC PREVENTIVE SERVICES MEASURES	---We recommend the measure invokes the same age range as the Topical Fluoride measure (age 1-20) in that this Preventive services measure evaluates Fluoride and/or sealants. As topical fluoride is the only ADA/AAPD recommended preventive service for children with primary teeth, this measure should align with the age criteria for the DQA's Fluoride measure. ---We would also recommend the measure include CDT Code D1355 (caries preventive medicament application – per tooth) as a means for the member to become numerator compliant because it offers the same primary preventive outcome offered by a D1351 in that there is no carious lesion present; offered by D1206/D1208 in that it is primary preventive service. D1355 is not limited to primary teeth. D1355's CDT Code entry describes a discrete procedure for application of a "caries preventive medicament" excluding only topical fluorides. Examples of topical fluorides are foams, gels, rinses, and varnish. Medicaments that would be applied during the delivery of the D1355 procedure include Silver Diamine Fluoride (SDF), Silver Nitrate (SN), thymol-CHX varnish, and topical povidone iodine (PVP-I). The dentist providing this service would determine the appropriate medicament to be applied. -- *Per the ADA:* *"CDT code D1355, effective on January 1, 2021, enables documenting and reporting this preventive "per tooth" procedure. The full CDT Code entry published in CDT 2021 follows. D1355 caries preventive medicament application — per tooth for primary prevention or remineralization. Medicaments applied do not include topical fluorides."* -- *[The Code Maintenance Committee (CMC) agreed with the action request submitter's rationale that a new code was needed to fill a procedure reporting gap:* *"There is a gap in the current code. D1354 covers the application of medicaments for secondary (2°) prevention; that is, interim arrest of caries. But these same materials, particularly silver diamine fluoride, silver nitrate, and chlorhexidine, are used to prevent caries lesions on high-risk tooth surfaces, such as exposed root surfaces in older adults, deep fissures in permanent or primary teeth or around molar bands in fixed orthodontic treatment."]* -- *"Application of a caries preventive medicament (D1355) is one of several preventive services delivered to a patient based on the dentist's diagnosis of the patient's clinical condition. <u>The D1355 procedure is a per-tooth preventive procedure where there is no carious lesion present.</u> Delivery of D1355 may be prompted by findings of a caries risk assessment procedure (i.e., "D0602 caries risk assessment and documentation, with a finding of moderate risk" or ""D0603 caries risk assessment an documentation, with a finding of high risk")."* ---We recommend expanding the value set of CDT Codes identifying elevated risk criteria to include: Check if subject is at "elevated risk": a. If subject meets ANY of the following criteria, then include in denominator:	Managed Care of North America INC (MCNA Dental)

	i. the subject has a CDT Code among those in Table 1 in the reporting year, OR **--- see comment A** 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 subjects who do have claims experience in any of the prior three years.) **--- see comment B** OR iii. the subject has a visit with a CDT code = (D0602 or D0603) in the reporting year **OR** **iv. the subject has no history of a dental visit 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 subjects consistent with the existing criteria.) **-- see comment C** **Comment A – include the following CDT Codes to the current value set.** D4355, D5211, D5212, D5213, D5214, D5221, D5222, D5223, D5224, D5225, D5226, D5282, D5283, D5284, D5286, D5820, D5821, D5864, D5866, D6985, D8010, D8020, D8030, D8040, D8050, D8060, D8070, D8080, D8090, D8210, D8220 **Comment B – include the following CDT Codes to the current value set.** D5211, D5212, D5213, D5214, D5221, D5222, D5223, D5224, D5225, D5226, D5282, D5283, D5284, D5286, D5820, D5821, D5864, D5866 **Comment C –** ADA Risk Assessment Forms (Links Below) http://www.ada.org/~/media/ADA/Science%20and%20Research/Files/topic_caries_over6.ashx https://www.ada.org/~/media/ADA/Member%20Center/FIles/topics_caries_under6.ashx **Comment C commentary:** We recommend adding members to the denominator who do not have a claim history in that the ADA Risk Assessment form includes not having a patient of record, receiving regular dental care in a dental office, as moderate risk.	

Appendix C: Request for Stakeholder Feedback on the Denominator Definition of the DQA Topical Fluoride Measure

The DQA Topical Fluoride measure assess the percentage of 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.

WHAT:
The DQA has focused ***on a subset of children at elevated risk*** to focus measurement on priority populations where evidence of effectiveness is greatest and there is the least uncertainty about

the appropriateness of the intervention. 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. Testing data found that significant performance gaps existed within the elevated risk populations.

"Elevated Risk"
Within the care delivery system, evidence-based guidelines also recommend that **patient-level risk assessment** should drive treatment planning and care delivery. Accordingly, the DQA's approach to performance measurement within the care delivery system is based on these patient-centered decisions instead of using broad population level indicators such as socio-economic status to measure performance. Not every 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 findings of an American Dental Association - American Academy of Pediatric Dentistry Caries Risk Assessment Expert Panel, which reviewed the current state of science on caries risk assessment and developed guidance on risk categorization, found that current caries risk assessment tools share many common elements to assess risk and affirmed that they have at least dichotomous predictive ability to quantify "low risk" and "elevated risk. This review affirms the ability of current CRA tools to distinguish elevated risk from low risk.

ELEVATED RISK DETERMINATION:
The DQA claims-based specifications identify the subset of population at "elevated risk" by evaluating whether the patient has (1) a caries-risk assessment CDT code signifying elevated risk (D0602 or D0603) or (2) past caries history, using a "look-back method" to identify if there is a history of caries-related treatment codes. Both the caries risk assessment codes and past caries history are checked, and if there is *any* qualifying code, the child is identified as being at elevated caries risk. This approach is used to identify children who can be confirmed to be at "elevated risk" for caries using claims data for the purpose of measuring program performance. This method is not intended to identify every child who may be at elevated risk.

LIMITATIONS OF ELEVATED RISK DETERMINATION:
1. As noted above, the purpose is to identify individuals who can be confirmed as being at elevated risk through administrative enrollment and claims data. Since this 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.

2. Given that the measure specifications require looking for specified caries-indicative codes in the reporting year and three prior years, some children who meet enrollment criteria in the reporting year may not have the claims history for prior years. This is especially true for very young children.
3. The USPTF guidelines recommends topical fluoride for all children under the age 5 irrespective of risk. The guidelines are undergoing updates.
4. The ADA Topical Fluoride guidelines are currently being reviewed.

STAKEHOLDER FEEDBACK REQUESTED:
DQA requests stakeholder feedback on the denominator definition for the DQA Topical Fluoride measure-

4. No change to the denominator. Monitor for current guidelines updates.
5. Develop a separate specification for children below age 6 with no "elevated risk" criteria applied. Modify the age range of the current measure for only ages 6-20.
6. Remove criteria for "elevated risk" [from the denominator) and stratify by elevated risk status with recommendations for how to use the stratifications.
7. Any other suggestion/ perspective to the denominator