DENTAL QUALITY ALLIANCE®

Improving Oral Health Through Measurement

DENTAL QUALITY ALLIANCE: 2024 ANNUAL MEASURES REVIEW

REPORT FROM THE DQA MEASURE DEVELOPMENT AND MAINTENANCE COMMITTEE

JUNE 2024

Table of Contents

INTRODUCTION AND PURPOSE

The purpose of this report is to summarize the 2024 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 2024. 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.

PUBLIC COMMENTS TO DQA ANNUAL MEASURE REVIEW

Several of the public comments expressed support for DQA measures in general and for specific measures. One commenter also expressed appreciation for the development of the DQA State Oral Healthcare Quality Dashboard. The following paragraphs summarize additional public comments with feedback on specific measures 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 and Follow-Up after 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. Follow-Up after Emergency Department Visits for Dental Caries in Children measures the percentage of those ED visits for which there was a follow-up visit with a dentist within 7 days and within 30 days, respectively. A respondent to the DQA's annual request for comments commented that although it is a broad measure, the measure of caries-related ED visits is an important measure. The same commenter appreciated the intent of the follow-up measure but noted that it does not identify the nature of the follow-up dental visit and the extent to which that visit focuses on treatment of the specific dental problem or establishment of a dental home. The follow-up measure includes was intentionally designed to be broad based on testing data and subsequent reporting that indicated that only about one-half of caries-related ED visits are followed-up with any type of dental visit within 30 days. The DQA also notes the importance of using measure sets, rather than relying on an individual measure, to understand quality of care more broadly. 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. These measures include ones that allow users to understand at a population level whether children are getting established into ongoing care that includes services that encompass diagnosis, risk assessment, and treatment planning. 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 improvement.

Caries Risk Documentation

Caries Risk Documentation measures the percentage of children who had caries risk documented in the reporting year. One commenter identified this measure as important, but noted the limitations both of a standardized and validated caries risk assessment tool in widespread use as well as lack of reimbursement specifically for caries risk assessment. The DQA appreciates these comments. 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 they have at least dichotomous predictive ability to identify "low risk" and "elevated

"risk". However, there is no evidence that supports one tool over another. As a result, different providers use different risk assessment tools, combined with clinical judgment, to arrive at a caries risk determination. Despite the limited evidence on the relative effectiveness of caries risk prediction using different assessment tools, professional clinical guidelines recommend that providers conduct caries risk assessment 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 caries risk assessment and documentation. In addition, this measure is designed only to document that the enrollee received a risk assessment. This measure is not designed to be used to assess the health state of the population or to create population risk profiles. As the commenter notes, the lack of widespread reimbursement limits the ability to capture a complete picture of the extent to which caries risk assessment is being documented.

Utilization of Services, Dental Services, and Utilization of Services, Dental or Oral Health Services

Utilization of Services is comprised of three measures based on the provider type and measures the percentage of children who received: (1) at least one "dental" (dental provider) service during the reporting year, (2) at least one "oral health" (non-dental provider) service during the reporting year, and (3) at least one "dental or oral health" (any provider type) service during the reporting year. One commenter expressed concern that these measures could add confusion regarding whether a child has a dental home since services delivered by non-dental providers are included. The commenter recognized the measure includes reporting by "dental" services (delivered by dental providers) and "oral health" services (delivered by non-dental providers). The DQA notes that Utilization of Services is not intended to be indicative of whether a child has a dental home. It is designed as a broad measure of access to oral health care. As such, it includes reporting oral health services delivered by dental providers ("dental" services), non-dental providers ("oral health" services), and by any provider type ("dental or oral health" services).

More generally, there is no single DQA measure that is intended to signify the presence of a dental home. However, using a set of DQA measures may be indicative that a child is more likely to have a dental home. For example, the measure of oral evaluation is intentionally restricted to dental providers and looks for a comprehensive or periodic oral evaluation. Visits with those procedures are more likely to be indicative of care that includes caries risk assessment, diagnosis, and treatment planning. A complementary measure is Care Continuity, which looks for a comprehensive or periodic oral evaluation in two consecutive years.

The same commenter suggested emphasizing the following guidance for Utilization of Services, Dental or Oral Health Services: "The 'dental OR oral health' measure is NOT a sum of the 'dental'

and 'oral health' Utilization of Services measures but represents the unduplicated count of children who received a dental or oral health service." **The MDMC recommends adopting this suggestion.**

Oral Evaluation, Dental Services, and Topical Fluoride for Children: Age Stratifications

Oral Evaluation, Dental Services, measures the percentage of children who received a comprehensive or periodic oral evaluation during the reporting year. Topical Fluoride for Children measures the percentage of children who received at least two topical fluoride applications during the reporting year. Topical Fluoride has three rates reported based on the provider type delivering the service: (1) "dental" services, (2) "oral health" services (non-dental providers), and (3) "dental or oral health" services. The method for identifying provider type is described in the DQA User Guide.

These two measures are included in the CMS Core Set of Children's Health Care Quality Measures for Medicaid and CHIP (Child Core Set). One commenter requested DQA consider collapsed age bands that would roll up the current set of age stratifications into fewer categories for Child Core Set reporting.

The MDMC reviewed data that evaluated the measure scores for the current stratifications as well as for different approaches for rolling up the current age stratifications into fewer categories. Based on this review, **the MDMC recommends providing guidance in the User Guide for reporting collapsed age bands for Oral Evaluation, Dental Services, and Topical Fluoride for Children using the following categories: <3 years, 3–5 years, 6–14 years, 15–20 years and total.**

The MDMC further notes:

1. The guidance for how to collapse the existing age stratifications **does not replace the existing DQA measure stratifications.** The more granular stratifications will remain in the measure specifications. The guidance is designed to balance applications where reporting burden is a concern while being careful not to mask important variation.
2. This guidance **only applies to the pediatric measures of Oral Evaluation, Dental Services, and Topical Fluoride for Children**. Any similar guidance for other measures would require separate data reviews and determination.

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 2024 Code on Dental Procedures and Nomenclature (CDT Manual) identified additional codes recommended for inclusion in the code set used to identify individuals at elevated risk for dental caries and in the set of codes used to exclude individuals from the denominators of the sealant measures.

Elevated Caries Risk Code Sets

There are code sets used as part of the methodology to identify individuals at "elevated risk" of dental caries. There is one code set for children and one code set for adults. The application of elevated caries risk and the complete methodology for each population is described in the DQA User Guides. The MDMC identified the following CDT procedure codes to be added to the elevated caries risk code sets:

CDT Code	Child Elevated Caries Risk Code Set	Adult Elevated Caries Risk Code Set	Rationale
D2928 prefabricated porcelain/ceramic crown – permanent tooth	Yes	Yes	Consistent with inclusion of other types of crowns as indicative of a "caries-related treatment code"
D2929 prefabricated porcelain/ceramic crown – primary tooth	Yes	No	Consistent with inclusion of other types of crowns as indicative of a "caries-related treatment code"; applies to primary teeth so added only to child code set
D2934 prefabricated esthetic coated stainless steel crown – primary tooth	Yes	No	Consistent with inclusion of other types of crowns as indicative of a "caries-related treatment code"; applies to primary teeth so added only to child code set
D2976 band stabilization – per tooth	Yes	No	Children: Signifies a child at increased caries risk. Elevated risk identification requires only one code for children. Thus, potential overcounting is not a concern as it is for adults.

			Adults: Less likely to be used, but also concern that if used, it moves an adult to "at least 3" elevated risk codes more quickly because there will also likely be a restoration code so it may result in over-counting caries-related procedures.
D2989 excavation of a tooth resulting in the determination of non-restorability	Yes	Yes	Clearly signifies a caries-related procedure in both children and adults.
D2991 application of hydroxyapatite regeneration medicament - per tooth	Yes	Yes	Although the frequency of this procedure is expected to be very low, it would indicate a caries-related procedure in both children and adults.

Code Set to Identify Exclusions from Denominator for Sealant Measures

The two sealant measures, Sealant Receipt on Permanent 1st Molars and Sealant Receipt on Permanent 2nd Molars, exclude children who have received treatment (restorations, extractions, endodontic, prosthodontic, and other dental treatments) on **all four** molars. The set of exclusion codes includes a series of prosthodontic codes D6205 through D6793. The MDMC determined that **D6794** (retainer crown – titanium and titanium alloys) is also applicable and should be included in the code set to identify exclusions.

Health Care Provider Taxonomy Codes

Review of the 2024 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.

ICD-10-PCS Procedure Codes

Review of the ICD-10-PCS procedure codes identified no new codes relevant to the DQA measures.

CPT Procedure Codes

Review of CPT procedure codes identified no new codes relevant to the DQA measures.

Appendix A: Measure Development and Maintenance Committee

Craig W. Amundson, DDS, Senior Advisor, HealthPartners. Dr. Amundson serves as chair for the Committee.

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

Matthew Horan, DMD, MPH, Dental Director, Office of Oral Health, Massachusetts Department of Public Health

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

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

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

DQA Executive Committee Liaison to the MDMC: Robert Margolin, DDS, ADA

DQA Leadership:

Linda Vidone, DMD, Chair, Dental Quality Alliance

Julie C. Reynolds, DDS, MS, Chair-Elect, Dental Quality Alliance

The Committee was supported by:

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

Erica Colangelo, MPH, Senior Manager, Quality Measurement & Improvement, Dental Quality Alliance, American Dental Association

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

Sean Layman, Coordinator, Dental Quality Alliance & Clinical Data Registry, American Dental Association

Appendix B: Public Comments

MEASURE	COMMENT	SUBMITTED BY
PEDIATRIC MEASURES		
AMBULATORY CARE SENSITIVE EMERGENCY DEPARTMENT VISITS FOR DENTAL CARIES IN CHILDREN	This remains an important measure to assess caries prevalence in a population. AAPD recognizes that the measure does not provide detail suitable for understanding recurrence, disposition of patients, and adequacy of sources of care, among other factors. The measure affords a coarse estimate of care seeking and to some degree, severity of caries across childhood in a community's children.	American Academy of Pediatric Dentistry
FOLLOW-UP AFTER EMERGENCY DEPARTMENT VISITS FOR DENTAL CARIES IN CHILDREN	AAPD recognizes the intent of this measure, but notes that the lack of specificity of the 'dental visit' post NTDP ED visit makes the measure of limited value. A post-NTDP visit to a dentist might be to manage the presenting problem or to establish a dental home. The latter would be consistent with AAPD's objectives for a dental home. The measure's use of both short and long intervals is useful to address indirectly the concerns expressed above about the nature of any subsequent dentist visits.	American Academy of Pediatric Dentistry
CARE CONTINUITY, DENTAL SERVICES	AAPD applauds the inclusion of this measure as an indicator of continuous care and suggestive of a dental home. AAPD has no additions or changes to suggest.	American Academy of Pediatric Dentistry
CARIES RISK DOCUMENTATION	This is an important measure. AAPD recognizes the absence of a widely agreed upon and valid CRA tool, but also recognizes that CRA is not reimbursed uniformly nationally in Medicaid making attainment of a national profile difficult. In a recent policy brief, AAPD noted that Medicaid agencies in 32 states do not independently recognize CRA as a provided service, and only 6 reimburse for the service. The lack of uniformity inhibits this important measure from having a significant impact.	American Academy of Pediatric Dentistry
ORAL EVALUATION, DENTAL SERVICES	This is a useful measure for gross assessment of access and utilization and has utility in monitoring progress in equity and access. AAPD has no suggestions or comments.	American Academy of Pediatric Dentistry
USUAL SOURCE OF SERVICES, DENTAL SERVICES	Excellent measure of dental home placement in a population.	American Academy of Pediatric Dentistry

UTILIZATION OF SERVICES, DENTAL SERVICES	Also, a very coarse measure and may add confusion as to a dental home since it encompasses services by non-dentists that are not able to provide comprehensive care. Given the ability to segment dental services and oral health services, this measure has value in understanding the contribution of non-dentists in the provision of oral health services in the population.	American Academy of Pediatric Dentistry
UTILIZATION OF SERVICES, DENTAL OR ORAL HEALTH SERVICES	If possible, AAPD suggests emphasizing this guidance from DQA: "The 'dental OR oral health' measure is NOT a sum of the 'dental' and 'oral health' Utilization of Services measures but represents the unduplicated count of children who received a dental or oral health service."	American Academy of Pediatric Dentistry
ORAL EVALUATION, DENTAL SERVICES & TOPICAL FLUORIDE FOR CHILDREN **(pertaining to application in CMS Core Set of Children's Health Care Quality Measures for Medicaid and CHIP)**	We would like to propose collapsing age bands. Here is our suggested starting place: o Currently there are 9 age intervals for Topical Fluoride for Children (TFL-CH): 1-2; 3-5; 6-7; 8-9; 10-11; 12-14; 15-18; 19-20 and total. ▪ We propose consolidating the above categories into the following 4 age categories: 1 - 5, 6-11, 12-20 and total 1-20. o Current there are 10 age intervals for Oral Evaluation, Dental Services (OEV-CH): <1; 1-2; 3-5; 6-7; 8-9; 10-11; 12-14; 15-18; 19-20 and total. ▪ We propose consolidating the above categories into the following 4 age categories: <1 - 5, 6-11, 12-20 and total 1-20. The age bands were selected because they consolidated age bands DQA has listed as "recommended" age bands and they align with other measures on the Child Core Set. The only guidance we've provided to states is that only reporting of the total rates for OEV and TFL is required for FFY2024 reporting; reporting by age category is optional. (See the Child Core Set manual - https://www.medicaid.gov/sites/default/files/2024-01/medicaid-and-chip-child-core-set-manual.pdf - section B, "Eligible Population" for each measure) We are open to suggestions from DQA regarding alternative age groups if they believe different divisions would be more suitable. The objective is to decrease the quantity from 9 to approximately 4.	Centers for Medicare and Medicaid Services
ADULT MEASURES		
ORAL EVALUATION DURING PREGNANCY & UTILIZATION OF SERVICES DURING RPEGNANCY	AAPD commends the development and implementation of the pregnancy measures, including the launch of these T-MSIS analyses on the *DQA Dashboard*. This population 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."	American Academy of Pediatric Dentistry

GENERAL COMMENTS		
GENERAL COMMENTS	AAPD regularly uses, cites, and refers others to the *DQA Dashboard*. It is easily navigable, has useful filters, and contains a wealth of information. We thank DQA for its investment in and maintenance of the *Dashboard.*	American Academy of Pediatric Dentistry
	NNOHA would like to thank the Dental Quality Alliance (DQA) for your ongoing efforts to make quality metrics mainstream in dentistry. We believe that the DQA, along with NNOHA and community health centers, are at the forefront of this effort and would like to encourage participation through the public and private sectors. We would like to thank the DQA for the scientific, thoughtful, and rigorous approach taken to develop the 2024 dental quality measures. We would also like to applaud the DQA for the continued effort to engage and encourage feedback from the dental community on these measures. NNOHA would like to continue to support the DQA in the creation, implementation, and adoption of measures clearly tied to evidence and evidence-based practice guidelines, which drive improvements in oral health outcomes. On behalf of our membership, thank you for the opportunity to comment on the 2024 Annual Measure Review of all DQA Measures.	National Network for Oral Health Access