NNOHA
National Network for Oral Health Access

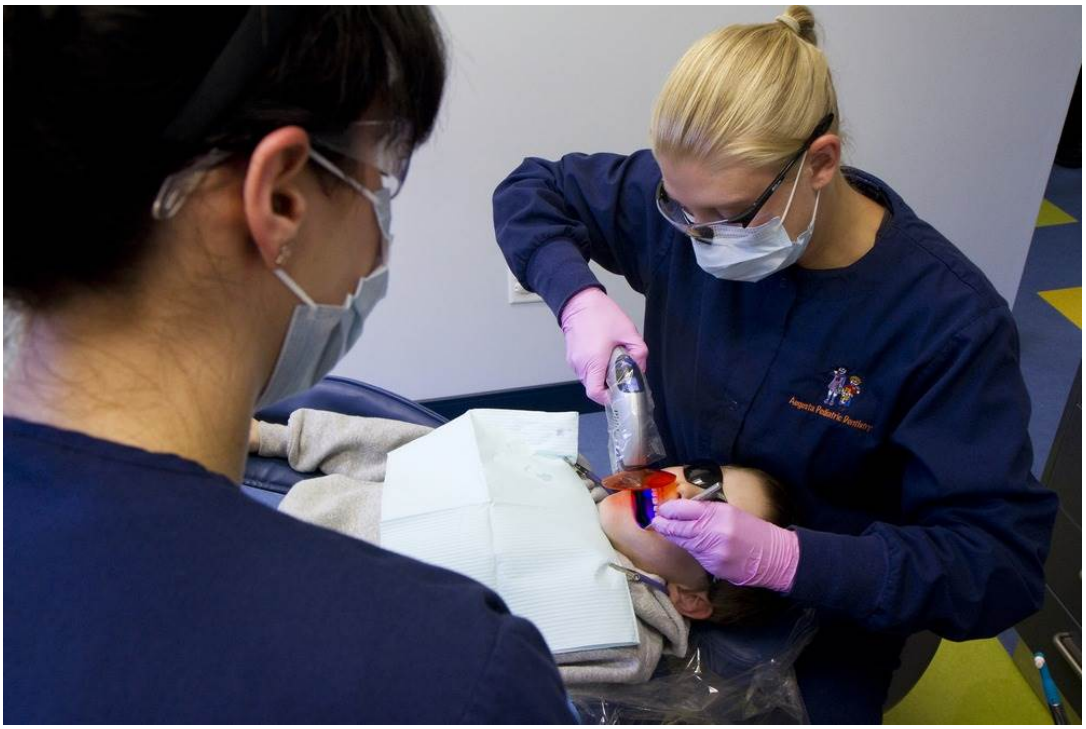
HRSA UDS Sealant Measure FAQ

January 2022

Updated for 2021 Reporting

CONTENTS

Frequently Asked Questions to Assist Health Center Grantees to Submit Data on the UDS Dental Sealants Quality of Care Measure



UDS DEADLINE & ASSISTANCE

Q: What is the deadline for the UDS 2021 report?

A: UDS Reports may be submitted after January 1, 20212 and are due February 15, 2022. Between February 15 and March 31, 2022, health centers work with their UDS Reviewer to identify and correct potential data errors. Final corrected submissions are due by March 31, and changes after this date are not accepted.

https://bphc.hrsa.gov/datareporting/reporting/index.html

Q: Where do we go for help regarding reporting to the UDS?

A: Questions regarding UDS content, such as what data should be included in your UDS report, can be addressed to the UDS Support Line: UDSHelp330@bphcdata.net or via Phone: 1-866-UDS-HELP (1-866-837-4357).

CONTRACTING

Column II of HRSA Form 5A under Service Delivery Method

Q: If a health center contracts dental services out to external dental providers, is the health center expected to collect data for this measure and how would this data be obtained?

A: Health centers providing dental services through paid referral (Form 5A, Column 2) under contract must report dental patients ages 6 through 9 with elevated risk for caries in the denominator count for the dental sealant measure. Please refer to Page 107 of the 2021 UDS Manual. https://bphc.hrsa.gov/sites/default/files/bphc/datareporting/pdf/2021-uds-manual.pdf. Your health center will have to discuss with your contracted providers as to how they will collect data to report on the measure, whether through the Electronic Data Record (EDR) or chart sampling.

SCHOOL-BASED PROGRAMS

Q: What if our school-based dental program is a mobile dental unit that only provides exam, prophy and fluoride treatments in the schools?

A: If the mobile unit is part of an in-scope school-based dental program, and the children receiving exams (codes D0191, D0120, D0145, D0150, or D0180) through this program are health center dental patients (i.e. have a medical record number) then they should be included in the patient population for this measure. If sealants are placed outside of the mobile unit, this should be documented in the patient's chart for inclusion in the measure.

Q: If we do not actually place the sealants in our school-based program but document in our EDR that they are placed do we count them?

A: You should "count" the sealants placed on children that are in the measure denominator for your health center in the measurement year. The children in the denominator should be identified first. So, for example, if a child 6-9 receives an exam at your in-scope school site, then receives the sealant at the home health center dental clinic and you are on a common EDR, then the child will be counted in both the denominator and numerator.

Q: Are there alternatives to codes D0602/0603 for assessing risk level?

A: Ideally, the CPT codes (D0602/0603) should be used to promote standard and consistent data capture. However, your health center may capture these findings through a caries risk assessment template that currently does not record the findings as a CDT code. As long as you have patient-level caries risk assessments recorded in the patient's electronic record that can distinguish elevated caries risk from low caries risk, then those values can be used to identify elevated caries risk.

Q: If high risk of decay is not based on the population level (i.e. low socioeconomic status) on what/how can we base our evidence?

A: This is an individual patient-level measure, so each individual patient should have caries risk assessment performed consistently using standardized risk assessment tools (i.e. American Dental Association, American Academy of Pediatric Dentistry, American Academy of Pediatrics, Caries Management by Risk Assessment (CAMBRA), PreViser, etc.)

Q: What caries risk assessment should we use?

A: A standardized risk assessment tool such as those developed by the ADA, AAP, AAPD, Caries Management by Risk Assessment (CAMBRA), and PreViser, may be used.

Q: What if your EHR does not have built-in risk assessment?

A: In general, the site can evaluate to what extent risk assessment gets captured in paper or electronic format. If it is captured in electronic format, even if not through a specific built-in risk assessment module, it may be possible to map the risk assessment findings to moderate/high risk categories. If it is in paper format, then the site can evaluate what will be necessary (in terms of workflow, resources, etc.) to get it into the electronic system. If risk assessment is not routinely captured, then there is the opportunity to work with the clinical staff to develop a process for conducting these assessments and recording the findings.

Q: What if for 2021, we do not have "formal caries risk assessment documentation" available?

A: Some health centers may not have used the ADA Dental Risk Assessment codes, which were initiated in 2014 or may not have begun tracking caries risk until after January 1, 2021. HRSA has determined that under these situations, an alternate method may be used to determine/estimate the size of the denominator. The steps are outlined below and found on page 177 of the 2021 HRSA UDS Reporting instructions manual:

https://bphc.hrsa.gov/sites/default/files/bphc/datareporting/pdf/2021-uds-manual.pdf

1. Identify all children age 6 through 9 who had at least one oral assessment or comprehensive or periodic oral evaluation visit during the measurement year.
2. Review these records to find 70 records where the dental records or other documentation demonstrate the level of caries risk. *You may need to have providers retrospectively review the records to determine caries risk based on available diagnostic information at that time if the caries risk level is not currently documented in the patient record.*
3. Continue to review charts until 70 charts meet the denominator criteria (dental patients aged 6 through 9 who had an oral assessment or comprehensive or periodic oral evaluation visit during the reporting year with moderate to high risk for caries).

4. Estimate the size of the denominator by:
    a. Dividing the 70 charts that were identified to have met the denominator criteria by the number of records you had to review in order to get to the 70.
    b. Multiply this result by the total number of children age 6 through 9 who had an oral health visit (the value from step 1). The resulting value will be your estimated denominator.
5. Enter the estimated denominator in Column A; 70 in Column B; and the number of the 70 who met the performance standard (received a sealant on a permanent first molar tooth in the measurement year).

Q: Can the 70 chart random sampling methodology be used to compute the UDS Sealants Measure even if the health center utilizes an Electronic Dental Record?

A: Health centers may use the 70 chart random sampling methodology to compute the UDS Sealants Measure even if the health center utilizes an Electronic Dental Record. If the health center has not been documenting risk level by using the CDT codes D0601, D0602, D0603, then providers may retrospectively review the records to determine caries risk based on available diagnostic information at that time. Available diagnostic information may include written notes assigning risk status, previous caries experience, etc.

Q: Does using the chart sampling method effect your HRSA funding?

A: No, using the chart audit sampling method does not affect your HRSA funding. However, please note that chart sampling will no longer be an option for computing the UDS Sealants measure beginning with 2022 UDS reporting, as noted in the 2022 Program Assistance Ltter (PAL). For the 2021 Sampling Methodology for Manual Chart Reviews, please see page 177 of the 2021 HRSA UDS Reporting instructions manual:

https://bphc.hrsa.gov/sites/default/files/bphc/datareporting/pdf/2021-uds-manual.pdf

EXCLUSIONS

Q: Should children that need to have a sealant redo be excluded since they had a sealant done in the past on those molars?

A: A child fulfills all the other denominator criteria and has at least one sealable molar during the measurement year will be included in the denominator. If the sealant was originally placed in the same measurement year, then the child will be in the denominator and numerator for that measurement year, even if the child returns later in the year and the sealant has been lost. If the sealant was initially placed in a previous year, then the child will be included in the denominator again.

Q: Can a child be excluded from the denominator if the parent/guardian declines having sealants placed?

A: No, the child cannot be excluded from the denominator. The only exclusions are "Children for whom all first permanent molars are non-sealable (i.e., molars are either decayed, filled, currently sealed, or un-erupted/missing)". Please refer to page 107 in the 2021 UDS Manual for the exclusions.

https://bphc.hrsa.gov/sites/default/files/bphc/datareporting/pdf/2021-uds-manual.pdf

EXCLUSIONS

Q: Can a child's behavior be used as an exclusion?

A: A child's behavior cannot be used as an exclusion. The only exclusions are "Children for whom all first permanent molars are non-sealable (i.e., molars are either decayed, filled, currently sealed, or un-erupted/missing)". Please refer to page 107 in the 2021 UDS Manual for the exclusions.

https://bphc.hrsa.gov/sites/default/files/bphc/datareporting/pdf/2021-uds-manual.pdf

Q: How can we exclude patients from the denominator if there is no code for a particular exclusion in our EHR (i.e. unerupted teeth) without having to do manual random chart audit?

A: If your current EHR has codes for all the other exclusions (sealed, extracted, filled, carious, fractured molar, etc.) there are several options. One solution would be to create and utilize a SMART/dummy code for unerupted first molars. This would allow you to exclude children without erupted first molars. Another option is to compute the measure with the exclusions you have, understanding that your denominator will be slightly bigger than it actually is (and your final % slightly lower), since there will be a few children without first molars still included. Additionally, you should consult with your EHR vendor, as there may be an upgraded version of your system that allows you to document and report all the exclusion codes.

Q: If we are charting "Partial eruption" where the occlusal surface of the permanent first molar is NOT visible, will that exclude those teeth from the measure calculations?

A: If you are using the vendor solution, it depends on how the vendor solution algorithm is configured, assuming there is a condition code for partial eruption. Usually, any documented condition (i.e. unerupted, missing, filled, sealed) will exclude the tooth from the denominator. Please contact your EDR vendor for instructions on how to code existing conditions for accurate computation of the HRSA UDS Sealants Measure.

Q: How is it taken into account when gathering data that a child can get two exams in a 12-month period? A child could be excluded in the same year as a result of sealants placed earlier in the year.

A: If a child is excluded because they have received sealants in your clinic previously, that will not affect your overall percentage on the measure. A child may be excluded from the denominator at the second exam that takes place in the same reporting year as the first exam and sealant placement, but they should be in the denominator and numerator from the previous visit in the same reporting year.

DENTAL CODES USED TO COMPUTE THE MEASURE

Q: Are children that are only patients in the health center medical clinic included in the sealant measure?

A: No, the UDS Sealant Measure is for children (6-9 years of age) that are dental patients. The standard codes that define an individual as a "patient of record" are CDT (Current Dental Terminology) codes - D0120, D0145, D0150, D0180, D0191.

DENTAL CODES TO COMPUTE THE MEASURE

Q: What dental codes are needed to calculate this measure?

A: To compute the denominator one of five CDT codes is needed to define an individual as a patient of record - D0191, D0120, D0150, or D0180; and one of two CDT codes are needed to define an individual as being at elevated risk - D0602 or D0603. To compute the numerator one CDT code is needed - 1351.

Q: Why is D0145 included when that code is used for patients under 3 years of age?

A: The UDS sealant measure is a standardized national measure. There are standard CDT codes that define an individual as a "patient of record" if that is one of the criteria for computing the measure. The definition of a "patient of record" includes the codes D0120, D0145, D0150, D0180, D0191 regardless of other criteria used in determining the measure.

Q: Are limited exams (D0140) included in the exam portion?

A: No, the D0140 code is not one of the allowable exam codes. CDT code D0140 is defined by the ADA as a *Limited Oral Evaluation - Problem Focused*, for situations of emergency and trauma, so is not the type of examination where it would be expected that a risk assessment would be routinely performed. The appropriate codes are D0191, D0120, D0145, D0150, or D0180.

Q: Can code D0190 be used to establish a child as a patient of record, or does it have to be D0191?

A: No, code D0190 is not one of the codes used to identify a "patient of record" for purposes of computing the measure. Patients to be considered are those with an oral assessment or comprehensive or periodic oral evaluation dental visit. The appropriate codes are D0191. D0120, D0145, D0150, or D0180.

Q: How would we pull data for first molars from all sealants placed?

A: To confirm that a sealant was placed on a permanent first molar, you would look for the sealant code (CDT code D1351) paired with any of the tooth number codes associated with a permanent first molar tooth. For example, if you are using the Universal Number System, the tooth numbers for the permanent first molars are: 3, 14, 19, and 30.

Q: Can Code D1352, Preventive Resin Restoration, be used as a sealant code?

A: No. Only Code D1351 is used to identify sealant placement for purposes of computing the measure.

Q: Should teeth receiving sealant repairs, code D1353, be counted in the numerator?

A: No. Only code D1351 is used to identity sealant placement for purposes of computing the measure. The focus of the measure is on primary prevention. Initial sealant placement for a molar needing a sealant repair would already have been captured by D1351 in a previous visit.

CONSIDERATIONS IN COMPUTING THE MEASURE

Q: What is the DOB for the patients included in the measure for 2021?

A: For the 2021 reporting, the DOB range is between January 2, 2011 and January 1, 2015.

Q: A child is 5 years old at a recall appointment where they are determined to be at elevated caries risk and have sealable first permanent molars. If the child does not get the sealants placed, is it correct to assume that the day the child turns 6 years old, the child is now counted in the denominator? Should we use a sealant exclusion code at the time of this recall exam, when the patient is still 5 years old, so it doesn't count against our sealant measure the day the child turns 6?

A: For the 2021 measurement year, children who were born on or after January 2, 2011, or on or before January 1, 2015 are included in the denominator. This means that the children included in the denominator will be 6 years old on or after January 1, 2021. Because the data for the measure are collected throughout the measurement year, the measure is agnostic as to the order in which the data is collected, as long as all the denominator criteria are documented in the same measurement year. In the above scenario, because the child turns six in 2021, the child will be in the denominator if they are at elevated risk, were a patient of record, and had at least one sealable molar, even if the exam/assessment and the determination of elevated risk occurred when the child was five years old, as long as it occurred in the same year in which the child turns six. To be in the numerator the sealant must be placed in the same year that the child is included in the denominator.

Q: How do we account for uncooperative children (gaggers) that will not allow us to place sealants?

A: The sealant measure is a quality improvement tool. An uncooperative child may be the child at highest risk for dental caries who needs sealants the most. To improve on your baseline in this case, you have to look at the total system of care and the short and long term changes that would allow uncooperative children to get sealants (e.g. training in patient management, improved communication with off-site pediatric dentists, etc.)

Q: Is the measurement exclusively looking at occlusal surfaces? What if the occlusal is restored, therefore ineligible for a sealant, but the buccal pit or lingual groove would benefit for a sealant? Would this tooth be "excluded" or counted as having had a sealant placed after the buccal or lingual was sealed?

A: The measure is specified at the tooth level and not at the surface level. Therefore, a sealant applied to any sealable surface on a permanent first molar would be counted, including buccal pits.

Q: If a patient had a sealant placed somewhere else, from an outside source, or through follow up from an outside pediatric dentist, does the patient count in the numerator?

A: If the patient is included in the denominator and receives a sealant on a permanent first molar by a pediatric dentist or somewhere else during the reporting year, then she/he would also be included in the numerator if that sealant placement was documented in the patient's electronic record. If the child returns to your office within the same reporting year for another exam, where it will be recorded that a tooth that was previously treatment planned for a sealant, has been sealed, the child will be counted in the numerator even if your clinic did not place the sealant.

Q: Do the examination codes have to have been completed within a given timeframe of the sealants having been placed?

A: The examination/assessment codes must take place within the calendar year that is being

A: The examination/assessment codes must take place within the calendar year that is being reported on the UDS.

Q: For the 2021 measurement year, patients that were evaluated in 2020 but did not receive a sealant until 2021, would we count them for 2021 instead of 2020 or how do we count them?

A: No, these patients will not be counted in the numerator for 2020. Patients who had an exam in 2020 and a sealant in 2021 will have been counted in the denominator for 2020 reporting, but not in the numerator. Both the oral evaluation and the sealant must occur during the reporting year. They will be counted in 2021 if the child also has an exam in 2021. Children who receive a sealant in 2021 but do not have an exam in 2021 will not be included in either the denominator or the numerator in reporting for 2021.

Q: If a patient needs 4 sealants will that count as 4 in the denominator?

A: No, this is a patient level measure, not a tooth-level measure, therefore the denominator is the unique number of patients who meet specific criteria, including being 6-9 years old, being at elevated risk for dental caries, and having one, two, three or four sealable molars.

Q: What if a child meets all the requirements except that half of the molars are not erupted? Do we count that patient or not...should we only count those that have all 4 molars exposed and unfilled?

A: A child aged 6-9 is considered for the denominator if they have at least one sealable permanent first molar. It does not matter if there are other permanent first molars that are not sealable.

Q: To have a patient in the numerator - can we have a patient who has only one sealant done in the reporting period?

A: Yes, if a child is in the denominator and that child received a sealant on at least one permanent first molar tooth during the measurement period, noted on pg. 107 of the 2021 UDS Manual.

Q: Can glass ionomer sealants be placed and count towards the UDS measure?

A: The measure does not distinguish between resin based and glass ionomer sealant placement.

PREVENTIVE RESIN RESTORATION

Q: Do you recommend performing preventive resin restorations?

A: The article "Evidence-based clinical recommendations for the use of pit-and-fissure sealants: a report of the American Dental Association Council on Scientific Affairs. J Am Dent Assoc. 2008;139(3):257-68" states that routine mechanical preparation of enamel before acid etching is not recommended.

Q: Should incipient decay be sealed?

A: The article *"Evidence-based clinical practice guideline for the use of pit-and-fissure sealants: A report of the American Dental Association and the American Academy of Pediatric Dentistry. J Am Dent Assoc. 2016 Aug;147(8):672-682"* states that pit-and-fissure sealants should be placed on early (non-cavitated) carious lesions.

MISCELLANEOUS

Q: Why does this measure focus on first molar sealants?

A: Consistent with evidence-based clinical recommendations, the measure is focused on sealants placed on permanent first molars for children 6-9 years. This is also consistent with the Healthy People 2030 objective, which focuses on placing dental sealants on primary and permanent molar teeth.

Q: Is sealant placement a required part of Phase 1 treatment completion for moderate and high caries risk children? Can we mark Phase 1 treatment as complete if all other work has been done and the patient will be coming in later for sealant placement?

A: Sealant placement is a required part of Phase 1 treatment completion for moderate and high caries risk children if a sealable molar is present. Sealants are a preventive dental procedure, and the definition of Phase 1 dental treatment includes preventive procedures. For a definition of Phase 1 treatment see page 21 of the Fundamentals Chapter of NNOHA's *Operation Manual for Health Center Oral Health Programs.*

http://www.nnoha.org/nnoha-content/uploads/2013/08/OpManualChapter1.pdf

Q: Since this measure is only focusing on erupted 1st molars, do we have data on 2nd molar and premolar sealants?

A: There is no national prevalence data on premolar sealants. There is national data and goals for second molar sealants. The New Healthy People 2030 has a revised molar sealant objective. The baseline is 37 percent of children and adolescents aged 3 to 19 years received dental sealants on 1 or more of their primary and permanent molar teeth in 2013-16. The target is 42.5 percent.

https://health.gov/healthypeople/objectives-and-data/browse-objectives/oral-conditions/increase-proportion-children-and-adolescents-who-have-dental-sealants-1-or-more-molars-oh-10/data

Q: Some health centers are starting to use silver diamine fluoride (SDF) applications on first molars as a preventive intervention instead of sealants, lowering the sealant percentage at clinics that have adopted its use. Is there an effort to add SDF applications to the exclusions?

A: This measure is based on evidence-based guidelines for caries prevention. Current guidelines do not recommend SDF as an alternative to sealant placement and note the need for additional research in this area. Guidelines and evidence in this area will continue to be monitored carefully for their implications for measurement.

Q: Any suggestions on how to identify and sort out those that have eligible molars in our specific EDR?

A: Several EDR vendors have developed pathway solutions for obtaining the HRSA UDS sealant measure data. Please consult your EDR vendor.

CREDITS

NNOHA would like to thank the following individuals for their contribution to the development of this fact sheet.

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