Results of a peer review process: the distribution of codes by examining dentists in the Republic of Ireland 2006-2007

Précis: The distribution of codes assigned in 2,991 reports made by examining dentists in the Dental Treatment Services Scheme (DTSS) between 2006 and 2007 are analysed.

Abstract: The Health Service Executive (HSE) appointed 20 examining dentists in April 2006 under contract for one year as part of a probity assurance initiative by peer review in the Dental Treatment Services Scheme (DTSS) in the Republic of Ireland.

Aim: The aim of the study was to analyse the distribution of codes assigned to the reports drawn up by the examining dentists.

Methods: At the end of the year’s contract, each examining dentist forwarded an end of contract report of their activity, including the distribution of codes issued, to the HSE. These were correlated into a national summary of examining dentist activity, from which the data used in the study was extracted. A total of 11 different codes were used, varying from an indication of agreement between the examining dentist and the contracting dentist (code A) to a significant disagreement (code D).

Results: The vast majority (94.5%) of reports on the clinical examination of patients, drawn up by examining dentists, were in broad agreement with the treatment or estimate of the responsible contracting dentists. A total of 622 contracting dentists received such reports. The small minority of reports (4.8%) where there was a significant disagreement related to a small number of dentists (47 dentists).

Conclusions: The study provides evidence that most contracting dentists were not a probity risk. The author suggests that any future probity assurance initiative should focus on areas of high risk rather than random selection of patients/contracting dentists. An enhanced advisory role for the examining dentist is recommended.
the quality of the treatment provided;  
the accuracy of the claims submitted; and,  
the compliance of practitioners with their terms of service.

The authors of the report found that probity assurance arrangements within the DTSS were inadequate and needed to be strengthened through the installation of appropriate governance combined with a quality assurance system.

Appointment of examining/General Practitioner Unit dentists

The HSE appointed 20 part-time examining dentists/General Practitioner Unit dentists (henceforth referred to as examining dentists) in March 2006 for a period of one year as part of a probity assurance initiative in the DTSS. Appointments were made following open competition among private practitioner contractors active in the DTSS. On appointment, examining dentists became part-time salaried employees of the HSE for the 12-month duration of their contract. The time commitment from each examining dentist amounted to two days per month. The examinations of patients by the examining dentists took place in HSE clinics spread geographically throughout the country, with ancillary staff provided by the HSE.

The role of the examining dentist

The primary role of the examining dentist was to ensure the probity of the dental claim, as well as ensuring that the quality of treatment provided met currently acceptable professional standards within the parameters of the treatment schedule (source: Appointment of Examing Dentists, Health Service Executive, 2005: p. 4).

Contracting dentists’ patients selected for referral to the examining dentist were to be identified in ways that included the following:

randomly selected for routine review;  
when variations from the norm or other aberrations were identified by the data analysis and further clarification was needed;  
when prior approval for a more complex treatment had been sought and clarification was required before approval was given;  
patients who had complaints concerning DTSS treatment prescribed and/or received and where the matter could not be resolved without a clinical examination and report; and,  
where a contractor made a request that the examining dentist examine a patient.

The study

The aim of the study is to analyse the distribution of codes issued by the examining dentists for the clinical examinations that they carried out over the 12-month contract period April 2006 to March 2007.

### TABLE 1: The Dental Treatment Services Scheme (DTSS) 2006

<table>
<thead>
<tr>
<th>Year</th>
<th>Number of contracting dentists</th>
<th>Fees paid to contracting dentists</th>
<th>Number of persons treated</th>
<th>Number of treatments</th>
</tr>
</thead>
<tbody>
<tr>
<td>2006</td>
<td>1,213 (at December 31)</td>
<td>€54.46M</td>
<td>256,360</td>
<td>1,095,919</td>
</tr>
</tbody>
</table>

Source: Primary Care Reimbursement Service: Statistical analysis of claims and payments for 2006.

### TABLE 2: Coding instructions for examining dentists’ reports.

<table>
<thead>
<tr>
<th>Code</th>
<th>Coding Instruction</th>
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</thead>
<tbody>
<tr>
<td>A</td>
<td>Treatment as detailed in the contracting dentist estimate has been satisfactorily completed. Minor discrepancies in charting would not preclude an A classification.</td>
</tr>
<tr>
<td>B</td>
<td>The examining dentist disagrees with the estimated or completed treatment but not to a significant degree. Clarification might be required from the contracting dentist.</td>
</tr>
<tr>
<td>C1</td>
<td>Where the examining dentist is satisfied, by examination of the patient and/or inspection of all records, that an outstanding treatment need may have arisen during the interlude between completion of the estimate and the referral examination and/or may be sufficient to necessitate further treatment.</td>
</tr>
<tr>
<td>C2</td>
<td>Where the examining dentist is satisfied, by examination of the patient and/or inspection of all records, that the treatment need could have been identified at the time of the contracting dentist’s examination of the patient and that the patient now requires further treatment.</td>
</tr>
<tr>
<td>C3</td>
<td>Where the examining dentist is satisfied that any failure to complete treatment is as a result of a failure on the part of the patient to complete treatment.</td>
</tr>
<tr>
<td>D</td>
<td>The examining dentist disagrees to a significant degree with the estimated or completed treatment.</td>
</tr>
<tr>
<td>F</td>
<td>The patient failed to attend for the examination.</td>
</tr>
<tr>
<td>R1</td>
<td>The contracting dentist failed to submit the relevant clinical records within the stipulated time. Where appropriate, this code is assigned in addition to codes B, C, D or F.</td>
</tr>
<tr>
<td>R2</td>
<td>Clinical records of poor quality or of limited value. Where appropriate, this code is assigned in addition to codes B, C, D or F.</td>
</tr>
<tr>
<td>X1</td>
<td>Where the contracting dentist has claimed for radiograph(s) but has failed to return these for examination. Where appropriate, this code is assigned in addition to codes B, C, D or F.</td>
</tr>
<tr>
<td>X2</td>
<td>Radiographs of poor quality or of limited or no diagnostic value. Where appropriate, this code is assigned in addition to codes B,C,D or F.</td>
</tr>
</tbody>
</table>

Source: ED6 Examination Form for Examining Dentists, HSE, 2006.

The examining dentist was advised of the date of the examination and was free to attend. Patients who attended for examination received €20 expenses, later increased to €30, from the HSE.

The study

The aim of the study is to analyse the distribution of codes issued by the examining dentists for the clinical examinations that they carried out over the 12-month contract period April 2006 to March 2007.
Methods
On completion of the clinical examination of the patient, a report of the findings was drawn up by the examining dentist with a code or codes ascribed. A copy of this report along with the code(s) was supplied to the contracting dentist. Table 2 gives the coding instructions for examining dentists’ reports.

At the end of the year’s contract, each examining dentist forwarded an end of contract report on their activity to the HSE. These were correlated into a national summary of examining dentist activity, which is the source of the data used in the study.

Results
Table 3 gives the distribution of codes issued by the examining dentists.

A total of 2,993 patients were appointed, of whom 1,229 patients attended for examination, representing an attendance rate of 41%. Some 74% of the patients who attended for examination by the examining dentists were assigned code A. These patients had claim forms submitted by 446 contracting dentists. If those patients whose examinations were assigned the codes B, C1 and C3 were added to those who were assigned code A, then 94.5% of reports on clinical examinations of patients were assigned codes that indicated broad agreement with the examining dentist. A total of 47 contracting dentists received such reports. The majority of code Ds were given for lack of evidence that the treatment claimed was carried out. Fewer code Ds were given for quality issues. Codes R1 or R2 represented <1% of appointed patients. Codes X1 or X2 represented <1% of appointed patients.

In summary, 94.5% of reports on clinical examinations of patients were assigned codes that indicated broad agreement with the examining dentist. This represented the claims/estimates of 622 contracting dentists. In general, the examining dentists reported the quality of the contractors’ work to be very good. However, 4.8% of reports on clinical examinations were given codes indicating that the examining dentist disagreed to a significant degree with the estimate or completed treatment of 47 contracting dentists.

Discussion
The examining dentist process was a peer review process. The examining dentists were both professional and geographic peers of the contracting dentists whose patient they examined. Appropriate issues for peer review are quality of care, appropriateness of care and issues surrounding fees. Because of the expertise required to provide needed services effectively, patients are by definition unable to objectively assess the work of their professional service providers because of asymmetry of information. For this reason, peer reviewers should be practising dentists, even if practising on a part-time basis. The profession is thus required to assess itself, which means that individuals must be willing to review their peers and to submit themselves to peer review. Each professional acquires tremendous practice experience in the course of his or her career from which peers can surely benefit. The DTSS uses a fee per item remuneration system. Cost containment can be a problem with fee for item payment systems. In order to counteract any adverse side effects of the financing system, focus should be placed on the individual dentist in relation to ethics, norms and quality control.

Conclusions
Efforts should be directed towards identifying areas where the small minority of contracting dentists who received ‘negative’ reports appear to have difficulty. An enhanced advisory role for the examining dentist could have a key function here. It is suggested that any future probity assurance initiative should focus on areas that are identified as high risk, rather than random selection of patients/contracting dentists, as the most efficient use of resources.

The vast majority of reports contained a ‘positive code’, providing evidence that most contracting dentists were not a probity risk. They offer a strong affirmation of the professionalism of the majority of contracting dentists in the DTSS.

References