Morgannwg
Local Dental Committee

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GDS Contractual Grey Areas

Further to my email request for examples of grey areas of the regulations I have received a number of emails expressing concerns. I list these below and have anonymised them. I will add to this following the meeting tomorrow and send to Dick Birkin and Gareth Lloyd.

Email 1

I did have an email exchange with ****** about the clash of claiming an exam when it wasn't due (conflicting with our NICE guidelines) vs the advice given on the "update to the regulations" evening which stated "an exam must be claimed for every band 2 or 3 treatment!"

He suggested that if you didn't claim an Exam you should only claim a band urgent ie 1.2UDA's for doing a restoration "between courses of treatment". Seems complete madness to sometimes get 3 uda's and sometimes only 1.2 for doing the same thing! The recent legal (powys?) judgement said we do not need to claim an exam for each course?

I tend to claim an "assessment and advice" and do any treatment necessary if a patient comes in having problems between scheduled exams otherwise it messes up the recall system and the agreed recall period.

I'm just wishing for a very early retirement!

Email 2

Hi Rog, Just one example for the 'grey areas' discussion.

A patient is examined and the treatment plan is to extract eight remaining periodontally involved upper teeth. A full immediate denture is provided and fits well. Treatment is completed and the FP17 submitted. Patient re-attends after six weeks complaining(surprise surprise!)that the denture is loose. Probably every dentist in practice has encountered this scenario but I don't know of any guidelines that agree that it would be acceptable to open a continuation band 2 claim ,with the attendant extra 3 UDAs ,or whether the dentist would have to bear the lab costs of the reline because it would be deemed to be part of the initial course of treatment. Stop me if you've heard this one before!

Email 3

Dear Roger,
At the rules and regs lecture in Oct we were told that we couldn't claim treatment of infected sockets unless it was done by another dentist (different contract holder) but i've found nothing in the LHB rules about that. I had a meeting with ***** and he suggested that non-urgent treatment I.e a fractured cusp with no decay should wait until exam is due for the restoration and then charge 3 udas or charge privately.
Will keep thinkng
Kind Regards

Email 4

Roger Pratley,
Morgannwg Local Dental Committee

Thursday 12th March 2015

Dear Roger,

This is a response to your request for examples of situations where the current interpretation of the dental contract adopted by the Health Authority is incompatible with primary general dental practitioners' frontline delivery of dental care.

I hope it is of value to you in your consideration and debate at the Local Dental Committee meeting.

The context is set in terms of viewing a situation Prospectively or Retrospectively. Is a clinician expected to behave as a fortune teller and predict the future?
I am sure the examples are of everyday situations we all face when trying to meet the challenges presented to us by our patients.
It is not helpful when Health Authority personnel and others higher than them accuse us of wrongful behaviour when we apply modern dental care principles based on prevention, minimal intervention and encouragement to attend regularly, to our patient care.

Examples:

1. A patient attends for routine examination and following assessment is considered healthy and at low risk of more dental disease. The COT is completed and an FP17 is closed. The patient pays the Band 1 charge. An appropriate recall is agreed and organised.
One month later the patient returns with a fractured cusp. A detailed examination is deemed unnecessary as one has been recently undertaken. A filling is provided to restore the tooth, a COT is submitted claiming Band 2 and the patient is charged appropriately. The recall is moved forward one month with the patients' involvement and agreement.

2. A relatively new patient attends for an examination when it is considered by the clinician that previous health promotion has effectively converted the disease status of the patient from Disease Active to Disease Inactive. In this context many early lesions are being monitored as encouraged by the principles of minimal intervention.
The patient returns in one month complaining of sensitivity and one of the early lesions is recommended for restoration. The event is used to re-enforce the patients' responsibility in fulfilling preventative advice. A restoration is provided and a COT submitted claiming Band 2 and the patient pays the appropriate NHS charge, making it clear that prevention is cheaper than repair.

3. A patient attends for examination with pain which at the time is not severe and difficult to diagnose with accuracy. The clinician decides to apply desensitising agents to teeth showing signs of toothbrush abrasion in the area from which the pain originates. A COT is completed and Band 1 is claimed and appropriately charged. A suitable agreement for recall is organised.
One month later the patient returns with pain which again is not severe but sufficient to trigger a request for an appointment. The clinician decides to restore the teeth originally treated with desensitising agents with buccal fillings. A Band 2 COT is completed and submitted and the patient is charged appropriately. Recall is suitably adjusted.
One month later the patient returns again with pain in the same area which is now more severe and associated with a particular tooth. Following appropriate assessment a clinical decision is made to root treat a tooth over the required number of appointments. A continuation Band 2 is claimed and submitted involving no charge to the patient and the recall is re-arranged appropriately.
One month later the patient returns again with pain in the same area and the patient is referred to secondary care for an opinion and treatment. A 1.2UDA claim is made and submitted for Assessment and Advice with referral.

4. A patient attends for examination and following assessment is considered low risk for future disease. A small symptom free fracture on a lower incisor is noted by the clinician but considered not indicating

intervention. Following discussion with the patient it is agreed to leave the tooth untreated. A COT is completed for a Band 1 claim and charged to the patient appropriately and a recall is agreed and organised.
One month later the patient returns requesting a restoration in the fractured tooth. The restoration is provided under a submitted Band 2 course of treatment and the patient happily provides the NHS with the related patient charge.

5. An older, regular, low risk, disease inactive and long standing patient with a history of annual attendance attends an examination and reports discomfort. The pain is not severe and a specific diagnosis cannot be achieved at the time. Due to the heavily restored dentition a diagnosis is difficult. Minimal intervention is applied in order to await development with regard to symptoms. A Band 1 COT is claimed in hope that the symptoms ease.
One month later the patient returns with more severe pain associated with a particular tooth and an attempt is made to root treat the tooth. During the treatment both the clinician and the patient decide that an extraction is the best option and the treatment is provided. A Band 2 COT is claimed and charged.

6. A regular, long standing patient attends for an examination with no pain but numerous carious teeth that the patient does not wish to have restored nor removed. The patient refuses to follow preventive advice (e.g. declines to use fluoride toothpaste, preferring 'natural' remedies). Following discussion with the patient regarding the state of the Mouth, the Teeth and the Gums a decision is made to monitor the disease activity together. A Band 1 COT is claimed and appropriately charged.
One month later a carious tooth becomes symptomatic and the patient returns requesting extraction. The treatment is limited to this one troublesome tooth by the patient. A Band 2 COT is claimed and charged to the patient who is happy to pay, providing patient revenue to the health service.

7. A regular patient with long standing periodontal disease and multiple mobile teeth attends for an examination and is advised to consider full dentures. The patient is extremely anxious about the transition to artificial teeth and following discussion it is decided to adopt a staged approach tackling one arch first to assess acceptability. A lower immediate denture is constructed and a Band 3 course of treatment submitted and charged appropriately to the patient.
One month later an upper incisor is lost due to an accident and the patient is forced to consider an immediate denture in the opposing arch. The denture is constructed and fitted and a Band 3 COT is submitted and charged appropriately to the patient.

The above seven scenarios are common place in general dental practice. A Dental Reference Officer undertaking a paper audit of record cards retrospectively may be of the opinion that all these scenarios demonstrate the splitting of COT's. However, a clinician operating prospectively cannot know what the future holds in terms of the consequence of disease or patient choice. If we as clinicians are to apply contemporary modalities of patient care, considering patient informed choice and encouraging patient responsibility, then these examples must be recognised and we as a profession must not allow retrospective views to prevail. We hope that these scenarios are helpful in addressing the 'grey' areas of interpretation. It seems to us that the presence of a detailed examination for any Band 2 or Band 3 COT is not a prerequisite in the above examples. Clearly, the presence of a formal examination or not does not affect the time interval between bands of treatment. It is therefore more valid to monitor the time interval between Band 2 or 3 claims rather than whether an examination is present or not.

Yours sincerely,

Email 5

Hi Roger

Two examples of grey areas that spring to mind:

1. Treatment of dry socket following an extraction - included in the Band 2 COT for the extraction or a new 1.2 Urgent?
2. Ease of a denture that has recently been provided - Urgent 1.2 or included in the BAND 3 treatment when you provided the denture?

We have been told by an ABM dental advisor that in his opinion we are not to raise a new claim in either of these scenarios.

I have found no such guidance at all in any of the regulations so we have decided to ignore his OPINION.

When a COT is transmitted and completion date added it can't be changed in retrospect with the benefit of hindsight. Any new NHS activity is by definition a new course of treatment.

The Regulations are very detailed in most areas apart from clinical ones! If they wanted such rules they should have laid down detailed guidance when they had the chance. You can't reverse engineer a legal document, adding amendments that you wished you'd have included in retrospect, without presenting us with a new contract to sign!!!