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AUSTRALIAN DENTAL ASSOCIATION

22 June 2018

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By email: submissions.ihpa@ihpa.gov.au

Dear Anne,

Re: Consultation on Australian Refined Diagnosis Related Groups Classification Version 10.0

Thank you for providing the Australian Dental Association (ADA) the opportunity to provide comment on the Independent Hospital Pricing Authority's (IHPA) consultation on AR-DRG V.10. Brief responses to specific questions included in the Consultation Paper on which the ADA has a view are provided further below.

In addition, there are other issues pertaining to how dental procedures are treated within the AR-DRG classification system that are not specifically raised in the consultation paper that the ADA would like to take the opportunity to bring to IHPA's attention.

As a preface to these responses, the ADA makes the following comments in support of its contention that a complexity split should be introduced for DRG D40Z *Dental extractions and restorations*.

In its document *Pricing Framework for Australian Public Hospital Services 2018-19,* the IHPA states that the structuring of AR-DRG classifications is supposed to underpin pricing and funding decisions that support the following principles, amongst others:

- ***Timely Quality Care:*** *Funding should support timely access to quality health services.*
- ***Fostering clinical innovation****: Pricing of public hospital services should respond in a timely way to introduction of evidence-based, effective new technology and innovations in the models of care that improve patient outcomes.*
- ***Minimising undesirable and inadvertent consequences****: Funding design should minimise susceptibility to gaming, inappropriate rewards and perverse incentives.*
- ***Patient-based:*** *Adjustments to the standard price should be, as far as is practicable, based on patient-related rather than provider-related characteristics*.

The ADA submits that the current "catch-all" structure of DRG D40Z is not achieving these objectives for a growing number of paediatric and special needs patients who urgently need dental treatment under GA. Many dental patients are not being allocated the theatre time and hospital resources needed to deal with the complexity of their individual cases because the DRG's and NEP erroneously assume that all dental cases can be dealt with efficiently and provided with quality, up to date models of care in a short period of time.

Dental treatment under GA in a hospital facility is commonly more extensive, more resource intensive, and more complex than that performed in dental practice rooms. This is even more evident in difficult to treat paediatric and adult patients for a myriad or reasons. These cases are much more complex than patients needing their wisdom teeth out, or emergency dental extractions.

The following examples illustrate the variations in time that may be required to accommodate variations in the complexity of different episodes of care:

- A single tooth extraction in a simple non-complex case may take less than 30 minutes in the operating theatre, from time in to time out.

- Extracting sixteen to twenty teeth, an all too common occurrence, in a non-complex case may take as little as 45 minutes.

- Increasing the level of surgical complexity to surgical removal of four impacted wisdom teeth likely brings the total time in the operating theatre to around 60 minutes.

Some cases are so complex that for a variety of reasons a simple examination and radiographs cannot be performed other than in the operating theatre. This creates the problem that it is not possible to accurately assess required theatre time before hand, and if the hospital is willing to schedule an operating slot for the patient at all, they may be be slotted into gap in a theatre list which is too short to allow completion of all necessary treatment.

Where a dental examination and radiography must be performed under general anaesthetic in addition to restorative treatment, the minimum theatre time may be 60 minutes, and the maximum theatre time 240 minutes, with a typical treatment time between 120 and 150 minutes.

- Longer duration cases will typically be associated with more complex procedures such as periodontal therapy, endodontic therapy, surgical rather than simple extractions, or complex crown and bridge restorative treatment.

- Placement of dental implants can take 1 to 3 hours depending on patient factors affecting dental complexity and medical comorbidities. Additional complexity occurs where bone grafting and guided tissue regeneration are required. Bone grafting complexity varies depending on whether bioresorbable exogenous materials are used, or whether autogenous grafts involving significant surgical donor sites are required.

- Placement of stainless steel crowns and pulpotomies can take 30-45 minutes per tooth, and as some paediatric cases often involve 4-8 teeth, 2 to 3-hour GA cases are not uncommon in the very young

- Children with rare developmental defects of the dentition such as Amelogenesis Imperfecta, Dentinogenesis Imperfecta, Cleidocranial Dysplasia, or cleft lip and palate, will typically require 180 to 240 minutes in the operating theatre.

Coding conventions and hidden data

The IHPA suggests that to date, it has rejected calls for a complexity split within D40Z because hospital data does not support the view that there are sufficient variations in the complexity and costs of episodes of dental care provided to clinically distinct groups of patients to warrant a split.

However, hospital statistics on the time and costs associated with D40Z are not presenting an accurate picture of the number of episodes of care that are associated with complexities of either a medical or a dental nature, or both, nor of the costs and time involved in providing quality dental treatment that will improve patient outcomes.

The experience of dentists providing care under GA is that in many hospitals, coders are not translating information contained in clinical notes regarding comorbidities that may affect either dental complexity, or complexities associated with pre-operative assessment, anaesthetic management, airway management and post-operative care, into hospital coding management systems.

The ADA is aware that in some public and private hospitals, the convention is that for DRG's ending in "Z", comorbidities are not coded. ADA has been informed by Special Needs specialist dentists that hospital coding staff may simply ask dentists what work was performed, without referring to dental notes that record "complexities" associated with this work.

Such patients often have multiple comorbidities such as several chronic conditions (e.g. epilepsy, cardiovascular problems, muscular dystrophy or cerebral palsy to name a few) in addition to anatomical abnormalities that complicate intubation, anaesthesia and airway management[1]. These complexities do not appear to be making it into hospital data because they are not being coded.

Many patients with intellectual or cognitive disabilities also have irregular dentition and a need for complex restorative, endodontic and periodontal treatment that often cannot be diagnosed in full because radiography cannot be undertaken until they are under anaesthetic.[2]

For patients with special needs and complex medical issues, the process of obtaining third party consent to treatment, undertaking pre-operative assessment, and providing post-operative care may be complex due to communication and behavioural issues in addition to medical comorbidities. Any of these factors may lengthen the required hours in hospital even where an overnight stay is not required.

With further respect to dental complexity, although data specifications for coding include provision for entry of ADA Schedule and Glossary treatment item codes (the output) under "miscellaneous service codes", the ADA is informed that in some hospitals, computer coding systems do not have all relevant item codes, and/or coders are not aware of them.

[1] Ting Lim, M. & Borromeo, G. L. (2017).' The use of general anesthesia to facilitate dental treatment in adult patients with special needs', *Journal of Dental Anesthesia and Pain Medicine,* 17(2), pp. 91-103.
[2] Desai et. al. (2001). "A study of the dental treatment needs of children with disabilities in Melbourne, Australia', *Australian Dental Journal*, 46 (1), 41-50.

More importantly, the notion of complexity used within the AR-DRG system appears to be based purely on a medical model, which is inappropriate when it comes to episodes of dental care.

Although the "K" series ICD-10-AM diagnosis codes capture certain elements of dental diagnoses, they do not necessarily capture the complexity of required *dental procedures.* So even where ADA Schedule and Glossary treatment item numbers are coded, it appears that the varying levels of episode dental complexity otherwise implicit in the ADA Schedule item numbers required are not formally incorporated into algorithms that calculate the complexity of any episode of dental care.

Cases coded as DRG D40Z are far from being a homogenous group. There are clear differences in the complexity of procedures (outputs) and the resources consumed (inputs) that make it statistically inappropriate to lump all of these cases together, but these differences simply cannot be seen, in part because current coding practices are not capturing them.

The other reason that differences in complexity are not being captured in the hospital data is that the inadequacy of activity based funding allocations and private health insurance benefits for dental services provided under GA are having the effect of reducing access to care, or curtailing the length of episodes of care for patients who need longer, more complex dental treatment in hospital.

Inaccurate data leads to restricted funding and restricted access to care, particularly for patients who need longer or more complex episodes care

National Efficient Price determinations do not only affect public hospital funding. Given that they are held up as a benchmark of the costs of efficient healthcare delivery, they also influence the minimum hospital benefits (second tier default rates or basic default rates) that private health insurers are required to pay under the *Private Health Insurance (Benefit Requirement) Rules 2011.*

Many private health insurers are unwilling to negotiate reasonable benefit contracts with private hospitals for dental services provided under GA.[3] In part, this is because the DRG (Diagnosis Related Group) classification system that underpins the NEP and minimum default benefits that insurers must pay for same-day or overnight services of this kind does not factor in the variations in operating theatre time that may be required in individual cases and underestimates the reasonable costs of more complex procedures.

This means that health funds can argue that hospitals who wish to negotiate contracts that reflect these genuine costs are simply inefficient, and that second-tier rates or basic default rates are all they are willing to offer.

Dental services under GA are classified as Band 1, Type B procedures for the purposes of the *Private Health Insurance (Benefit Requirement) Rules*. There are four Type B bands, and of these, Band 1 requires the lowest default benefit payment, on the assumption that procedures included in Band 1 are relatively simple, relatively short, and vary little in time and cost.

For example, medical procedures included within the Band 1 classification include the provision of an ultrasound, or cauterisation of a cherry birthmark—procedures usually of short duration, that vary relatively little in complexity, and that do not require additional staff with dental training.

[3] Day Hospitals Australia. (2017). *Submission to ACCC Report to the Senate on Private Health Insurance.* https://www.accc.gov.au/system/files/Day%20Hospitals%20Australia%20-%2013%20March%202017.pdf

Where private health insurers will only offer second tier or basic default benefit rates for D40Z procedures, it becomes financially unviable for many patients to seek treatment in a private facility, and economically unviable for many affected private hospitals and day care facilities to schedule dental procedures compared to other specialties. Accordingly, many facilities have restricted or shut down dental lists, and/or impose time limits on dental procedures.[4]

The same appears to occur in some public hospitals. Because DRGs relevant to hospital-based dental procedures are limited in scope and specificity, and do not adequately reflect the resources or time required to provide treatment under general anaesthetic for anything but shortest, most simple of cases, the result is that the more complex services required by many patients who can only be safely treated in hospital are economically "inefficient" and unattractive for hospitals to provide.

The grouping of short and longer cases under the one DRG is producing distortions to funding, to perceptions of what is efficient, and to needs-based allocation of hospital resources. Like inadequate private health insurance funding for dental procedures in private hospitals, inadequate activity-based funding for longer, more complex episodes of dental care gives public hospital administrators an economic incentive to give operating theatre time to short dental cases, or to medical specialties in preference to longer dental cases that reflect the same level of clinical need.

The result is that the existing DRG categorisation disadvantages dental patients compared to patients with other surgical and medical conditions for which the AR-DRG system has acheived a more appropriate grouping of procedures and complexities.

This is disadvantaging some of the most vulnerable members of the community. For example, the case mix for special needs patients often consists of almost exclusively long, complex restorative, endodontic and periodontal treatments on patients with complex preoperative and postoperative management issues. Typically there are only one or two patients per operating list. However, under the national efficient price for D40Z it appears that the break-even point for hospitals is 4-5 cases per list, or 45 minutes per case.

For this reason, the management of many hospital facilities either refuse to take on provision of oral health services for these special needs patients, or allocate dentists who treat them with operating time slots that are too short. All too often, this means that only extractions are done, when it would have been possible to conserve teeth, and thus acheive a far better outcome for the patient, with an adequate allocation of theatre time.

The reality is that although many dental procedures under GA can be relatively short, time-limits being placed on care mean that the need for longer, more complex procedures is not being accurately reflected in hospital statistics.

This problem is one of the factors that lies behind the relative lack of variation in the cost profiles of different episodes of dental care that show up in hospital statistics.

Hospital data on which preliminary decisions about a complexity split for D40Z have been based is also skewed because high out-of-pocket costs restrict patient consent to urgently required treatment

Another reason that the true extent of the variations in dental care needed under D40Z and associated costs are not appearing in private hospital statistics is that out-of-pocket costs to patients may mean they cannot afford to undergo the complete course of several urgent procedures they require under GA.

[4] Ibid.

Dentists report that cost is often the key factor that affects the consent of patients, parents or carers to treatment recommendations made by a dentist who has nevertheless communicated his or her concerns about the oral and general health risks associated with delaying that treatment.

Patients with urgent and extensive dental treatment needs who are ineligible for public dental treatment or suffering too much pain to sit on public dental waiting lists may opt to undergo treatment in a private hospital or day care procedure facility if they can access one. (It is important to note that even special needs patients with major medical comorbidities who are eligible for publicly funded dental treatment can wait many months on waiting lists for treatment, in distress and at considerable risk to their general health.[5])

However, low or non-existent rebates for dental treatment under extras insurance policies (on top of any out-of-pocket costs for the hospital admission that may apply) often result in patients asking the treating dentist to treat only the most urgent dental problem that is causing the most pain or distress, even if they have other urgent treatment needs that would ideally be treated immediately, under the one anaesthetic.

This further skews the hospital data on which IHPA is relying to make decisions about dental DRG splits away from longer procedures, and towards an apparent relative homogeneity in terms of costs. Ultimately, it is also grossly inefficient to the health system, in terms of the preventable need for readmission (most likely to a public hospital), and the increased risk that untreated dental problems will have a serious negative impact on the health of the patient.

Ways forward

- A more equitable manner for calculating the National Efficient Price and National Efficient Cost based upon accurate coding and costing of "dental" complexities needs to be developed. To ensure timely access to quality care based on patient rather than provider characteristics, it is essential to remove the current perverse incentive under Activity Based Funding for hospital administrators to privilege theatre access for some medical procedures over dental procedures that reflect the same level of clinical need.

- D40Z needs to be stratified by the medical comorbidities, the need for diagnostic procedures under anaesthetic, the number of teeth treated and then weighted for the complexity of the dental treatments provided.

- It is recommended that the IHPA engage with organisations that represent oral health services for paediatric, adult and special needs populations, to establish the precise parameters for a complexity split for D40Z. In addition to the Australian Dental Association, the Australian and New Zealand Society of Paediatric Dentistry, the Australasian Academy of Paediatric Dentistry, the Australia and New Zealand Academy of Special Needs Dentistry, the Australian Society of Special Care in Dentistry and heads of hospital-based dental units have enormous expertise in this area of service delivery.

[5] See evidence provided by the Australian Academy of Paediatric Dentistry to the Senate Community Affairs References Committee Inquiry into Private Health Insurance at a public hearing in Sydney on October 31 2017. http://parlinfo.aph.gov.au/parlInfo/download/committees/commsen/3b23c6f6-d3fd-4704-8149-ef27c15e55af/toc_pdf/Community%20Affairs%20References%20Committee_2017_10_31_5710_Official.pdf;fileType=application%2Fpdf#search=%22committees/commsen/3b23c6f6-d3fd-4704-8149-ef27c15e55af/0000%22

Consultation Paper Questions[6]

1. ***Are there diagnoses proposed for exclusion that are considered significant in contributing to the complexity of treating a patient in an admitted episode of care that should remain in the complexity calculation for AR-DRG V10.0?***

   Yes. The ADA submits that the proposed exclusion of all dental diagnoses K00.0 to K14.9 from assessment of complexity is unwarranted and will simply compound the current bias within the DRG classification system which ignores the existence of *dental/oral conditions* that contribute to the complexity of providing dental treatment.

3. ***Do you support the introduction of stabilisation methods to the AR-DRG complexity model?***

   The ADA notes the IHPA's statement that as part of its proposed stabilisation methods, it is further refining the splitting criteria to ensure there is a strong evidence base in the data before a complexity split is introduced or removed.

   As discussed above, the ADA believes that in the case of DRG D40Z, reliance on existing data to provide a "strong evidence base" is problematic. It is crucial that the IHPA consult dentists who have expert knowledge of the complexities that often arise in admitted episodes of dental care under D40Z, and examine actual coding practices on the ground, in addition to the impact of the practices of private health insurers and current NEP pricing models when considering complexity splits.

10. ***Do you support reassigning episodes with osseointegration interventions of the digits and limbs to ADRG I28 Other Musculoskeletal Procedures?***

    Yes, it is not appropriate that osseointegration interventions of the digit and limits be assigned in the same clinical grouping as cranio-facial osseointegration procedures.

11. ***Do you agree with the recommendations that no change be made for AR-DRG V10.0 for acute rheumatic fever, personality disorders, involuntary mental health patient episodes, alcohol and drug disorders, dental extractions and restorations, endovascular clot retrieval, transcatheter aortic valve implantation, repetitive transcranial magnetic stimulation and stereo electroencephalography?***

    No, as discussed above, further consideration should be given to introducing a complexity split for DRG D40Z dental extractions and restorations.

12. ***Do you foresee any system issues with the increase in characters of the AR-DRG version number with the introduction of AR-DRG V10.0?***

    No.

[6] Responses are provided only to those consultation paper questions that are relevant the concerns of dentists and their patients

Should you require any further information, please contact Dr Fiona Taylor, Senior Policy Officer, on 02 8815 3334 or fiona.taylor@ada.org.au

Yours sincerely,

Dr P H Sachs
Federal President