Senate Finance & Public Administration Committees

Parliament House

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SENATE SUBMISSION RE CDDS

04/04/2012

Dear sirs,

I would like to submit the following information and commentary to your Senate committee inquiry into the Medicare Chronic Disease Dental Scheme.

My reasons for taking part in the above scheme are numerous.

Firstly the professional commitment to offer dental services to the public to improve dental and oral health is the reason I became a Dentist. I have also been always happy to help those most in need, and those who are disadvantaged, and for such patients a reduced fee and time payments have been part of my outlook on the supply of dental services since I graduated in 1974.

Secondly the moral/religious imperative to help all who are in need wherever possible and the structure and intent of the scheme was to offer dental treatment to the chronically ill, and although the scheme was not in any way means tested the overwhelming number of patients I saw where elderly people with little disposable income. My working class upbringing has led me to feel at home in the suburban dental practices that I have always been involved in, and I feel a strong bond to all the patients that I treat.

Thirdly the cultural and linguistic link I have to the overwhelming number of patients whom I have seen via this scheme. My parents, with me in tow, escaped to Australia as refugees fleeing persecution in post war Yugoslavia. The emotional and social support that we received from fellow countrymen was indispensible to our settling in this country. Any help from the wider Australian community was also greatly appreciated. My fluency in Croatian has helped me throughout my life and when a new larger wave of refugees started arriving after the breakup of Yugoslavia (1991-1995) a significant number of Croats, Serbs, Bosnian Muslims and others came to me for their dental needs primarily because of being able to communicate in their native language.

It's hard to describe the issues such people face, I for one "feel their pain" and offer them the support they need in the same way that it was offered to us decades ago. The emotional trauma that such uprooted people endure, and the battle to establish their existential needs having lost all they previously had, creates dental patients with their own unique treatment needs.

Fourthly there is a personal factor in treating people on this scheme. Many of the patients are from ethnic backgrounds whose views of the world are diametrically the opposite to my own. Their readiness to place their trust in me and my professional competency, despite my own ethnicity, was very gratifying and also helped me to see in all these people our common humanity. It helps us all to appreciate that despite whatever differences exist, we can still find areas where we can help each other.

Fifthly the financial aspect is also an issue. I was not prepared for the success that the scheme came to exhibit. Initially the people in our practice believed that seeing a few more patients was not a financial problem as the Medicare allotment matched our own discounted rate for pensioners.

Medicare information

The information that medicare provided at the commencement of the scheme was scant. In fact I can't remember whether the main piece of documentation was addressed to me personally or to my practice. There was no further information provided that I am aware of for a number of years.

The "Medicare Benefits Schedule – Dental Services" booklet we received at the start of the scheme in late 2007. The most used and referred to part was the "checklist for Dental Practitioners" on page 16, which was used by all of us at our clinic as a "quick start" guide, and we simply assumed that the information was reliable and accurate.

In retrospect, with regards to the compliance requirements of section 10 of the determination, it needs to be pointed out that this checklist on page 16,

a) Does **not** state that a written itemised quote must be given to a patient. It does state that "a dental treatment plan, including an itemised quotation of proposed charges provided to the patient". "Written" or "printed" **do not** appear, and clearly a given quote can be verbal, and in dentistry this is often still the case. Such a verbal quotation where the provider is bulk billing would also cover all item numbers, and reassure the patient that they will not need to pay anything. This for many was a very important issue they wanted cleared up on the first visit.
b) Does **not** state that these compliance steps need to be carried out "prior to the commencement of treatment".
c) On page 13 of the same booklet. In section 6. It states that a "written quote **or** cost estimate" must be provided prior to commencement of treatment. The apparent alternative cost estimate does not need to be written presumably as it is **not** stated as "or written cost estimate".

d) This booklet also **nowhere** states what was written in a letter from Medicare addressed to me in October 2011, to whit

> "provide the eligible patient, in writing, a plan of the course of treatment, a quotation for each dental service and each other service(if any)in the plan"
> This is apparently in the "Health Insurance (Dental Services) Determination 2007", yet nowhere is this wording found in the only significant document supplied to us by Medicare.

e) In retrospect this document

- does not clearly state exactly what providers are expected to do.
- gives conflicting accounts of what providers are expected to do.
- does not give the exact wording that is in the determination of 2007 re compliance for section 10 .
- does not give any warnings of recovery if section 10 compliance issues are considered not met. In fact with the current threat to reclaim all monies paid out to providers who are found not to be fully compliant – red printing would be very welcome.
- nowhere is it stated that using dental auxiliaries is prohibited. The use of auxiliaries ensures the highest standard of dental care. This includes the use of dental assistance, Oral hygienists, Oral Therapists, Laboratory technicians, radiologists etc. Why would any Dentist assume that "best practice" doesn't apply to the chronically ill? If Medicare insists on second rate dentistry for CDDS patients, they should make it public - not keep it a secret.

Previous Medicare exposure

Like most Dentists i have had no professional experience with Medicare at all. The only experience comes from visiting my G.P. whereby i came to understand the term "bulk billing" and "need to pay a gap". It needs to be stated that the transition from not having anything to do with Medicare to incorporating this Medicare scheme into our practice is best described as chaotic. Prior to the Hicaps access for Medicare payments, when everything was done manually via vouchers, and batched and posted etc proved to be extremely time consuming and complicated. It took a reasonable amount of time to familiarise all our staff with the new billing concepts and other procedures that needed to be followed. Like most practices, we spent alot of time on the phone to Medicare seeking directions, clarifications and support. It didn't help at times when Medicare itself gave us conflicting and sometimes conflicting or even wrong advice.

It is indeed a great pity the Government of the day didn't see fit to employ a liaison officer to visit each surgery personally, to ensure that everyone was fully aware what the requirements of the scheme are. Should any similar or expanded scheme be introduced in future this would be an extremely valuable aid, and would not be of any great expense compared to the costs of these audits and legal costs that the Government is now incurring. It is noteworthy of course that from early 2008 the Government of the day had openly stated its hostility to the scheme, and had vowed to close it as soon as it could. One assumes there is less stress on insuring compliance under these circumstances.

Other Government schemes

I have been in a number of practices since graduating and have been involved in two other Government run schemes. These are

A) The Federal Government Department of Veteran Affairs (DVA).
B) The South Australian Dental Scheme (SADS)

These schemes also have their own somewhat complicated and bureaucratic compliance issues. The DVA has become more streamlined over the last decade, and is far more in line

with its use of dental item numbers, essentially adopting the definitions of the 8th edition of the Dental glossary. SADS still hangs on to some of its itemisation peculiarities, and Medicare reflects some of these. Eg 311 becomes 316 for 2nd and subsequent whereas everywhere else its multiples of 311. Also the 316 item doesn't even exist in the 8th edition. Medicare also chooses to add two numbers to all three digit item numbers, creating a five digit item number. This has complicated life for a lot of Dentists, as some dental software programs can't easily incorporate the five digit item number without serious programme modifications. The persistent threat by the Government to close the CDDS scheme, initially by Nicole Roxon MP, the then Health Minister, ensured that some dental software companies chose a patch type temporary solution, rather than spend considerable funds for a major overhaul of their program. This made it much harder for Dentists with such software to easily incorporate Medicare 5 digit item numbers in treatment planning and quoting.

The experience of our practice with the other two schemes is quite a different one to that with Medicare. Both are far more cooperative and helpful with us and the information is reliable. Errors and omissions in paper work are simply sent back to us to sign. There is no threat of repayment of monies for work clearly done, and they are reliable in their information. Sometimes it's easy to correct payment inaccuracies over the telephone rather than constantly have to resubmit the whole account (with yet again another signature from the patient). I am unaware of any provider who has found himself in the position that many now find themselves in with respect to Medicare.

Seeking Help from Medicare

Medicare assistance has been a bit perplexing and contradictory over time. There seems to be an enormous number of people one gets to talk to and they can give you misleading or incorrect information. The people are always friendly but don't seem to know much about dentistry. The following examples occur commonly.

a) Confirming that a Medicare plan is in place, it's not uncommon to be told that it is in fact "not yet in place". Yet if one phones again it's not uncommon to find that now the plan is in place.
b) Amounts remaining to fund a patient aren't always correct.
c) Different amounts available for the same patient. E.g. "..still has $302.00 from the old plan". A further telephone call gives you "yes, the new plan is in place for the full amount of $4.250.00".
d) Being told on numerous times what needed to be done to claim amounts that weren't paid. This cannot be done over the phone, but corrected payment requests need to be resubmitted. When these resubmitted requests were also not paid, which happened from time to time, a different set of instructions was given.
e) In mid 2008, in discussing a procedure carried out by one of our Oral Therapists, that wasn't paid, I made a point of confirming that Hygienists and Therapists were able to carry out work under dentists supervision (standard procedure). The Medicare representative confirmed that this was fine. It would in fact be bizarre were it to be not so as this is considered best practice worldwide, and all health funds, and the other two Government bodies acknowledge this. However in 2011 we were advised

that this is “not clear” according to the ‘Determination”. Apparently best practice does not apply for Medicare patients, and in this case why wasn’t I correctly informed in 2008?

f) Errors that Medicare makes are not corrected by them as a general rule, until you resubmit your claim. But even when they err, one still may not get paid. The best example of this from my practice was when a married couple with the same surname as well as first names starting with the same letter, were erroneously deemed to be the same person? The vouchers were correctly filled out (this was before Hicaps claiming), the Medicare details were all correctly filled in. They were both having upper and lower partial dentures (co/cr), so four partials in all. Medicare paid us for only two as they believed they were the same person. All attempts to retrieve the approximately $2,500 were in vain, even when we included the lab statements.

g) Errors also occur because Medicare personnel don’t seem to fully understand their own rules. E.g if two partial dentures are constructed, Medicare places a maximum number of teeth for each Partial (12). However that is 12 teeth per base (per denture). Even today one is likely not to be paid for say 16 teeth on an upper and a lower denture each having say eight teeth. You are more likely to get paid for just 12. After which we must once again resubmit the original invoice when Medicare already has the correct information but misunderstands its own rules.

Current situation

In October 2011, I received a request for a self audit. My overall attitude to the whole issue of the CDDS, and to the way the Government of the day has handled it, I can only describe as incredulous and appalling. The draconian and punitive, and one must stress greatly delayed, action of Medicare in enforcing compliance to administrative procedures is what one might expect in many other countries in the world but not from Australia.

I have spoken to a number of Dentists at different stages of the audit process, and all are similarly horrified by the heavy handed approach to Medicare’s insistence on administrative paperwork compliance. All of us are naturally under considerable stress, as are our families and our staff. The attitude of Medicare that any non-compliance will lead to full recovery of monies paid, could place many dentists in grave financial hardship if not bankruptcy. The several Government inspired Media releases in which dentists are accused of “rorting” the system, are seen as setting the stage for what has already been called a “witch hunt” against Dentists. This is despite Medicare acknowledging to the Senate recently that with all the audits so far not one case of actual fraud or rorting has been uncovered.

There have been demands made on Dentists already, and some I believe have paid. I know of one colleague who has left the country as a consequence of receiving a demand to repay Medicare.

I had sought the advice from my Federal member of parliament, Andrew Southcott MP, well before my audit request. He was similarly dismayed by what I explained Medicare was doing in relation to the scheme. He stated that if the work “has been done in good faith” he couldn’t see how anyone could expect to have to repay any amount back to Medicare. He

stressed that I should be absolutely compliant with all aspects of the scheme. The ADA has given the same advice, with ever increasing urgency, since the beginning of last year. He also stated that in cases of outright fraud, each provider should be fully aware that this becomes a criminal matter. This is however the commonly understood view that I and my colleagues, and the ADA all share already and none would have any sympathy for any provider who might do such a thing. The great concern for Dentist is that because of innocent administrative errors that serious repercussions may follow.

Myself, my colleagues and my hygienists and Therapists, all of whom have treated a large number of chronically ill, generally elderly patients under this scheme, and have done so in good faith, are appalled and very apprehensive as to the outcome of the compliance issues and also of any punitive steps that may be taken by Medicare in light of this.

Benefit of CDDS to patients

That the scheme has been of enormous benefit to those who were eligible is beyond doubt. Australia wide some 11,500 Dentists were able to treat a very large number of patients and to deliver some 11,500,000 services. In my own practice it was an extremely helpful scheme, assisting for the most part mainly elderly pensioners and people with chronic diseases that often did not render them fit for any work, essentially the lower economic level in our society. The funding amount of $ 4,250.00 for a two year period was a generous amount, especially in 2007. With this funding it was possible to develop comprehensive treatment plans with which one could adequately sort out most patients dental needs. Patients were able to have holistic treatment, to ensure that the proposed treatment delivered them a stable mouth that would, with preventive care, last well into the future. Occasionally the funding didn't cover the patient for the most ideal treatment, but even for these an acceptable compromise was achieved.

That they benefited from the scheme is very clear. The patients that are returning after several years, generally require mainly preventive work, and don't really need a great deal of any new plan that's in place. There are of course some failures, as one finds in general dentistry. There will always be a small minority who fail to look after the achieved result, despite our best efforts. They are few and treatment options need to be revised accordingly.

I am in fact quite proud of the success that we have achieved with this group of patients and the fact that many will see me after their scheme has ended is very gratifying.

The specific group that I tend to mainly look after, as I have already mentioned, are the refugees from the conflict in the former Yugoslavia. As a group they have many issues common to all who have been involved in and displaced by conflict. These include but are not limited to, a range of psychiatric disorders from post traumatic stress to depression and anxiety states. Despite appreciating all that Australia has done for them , many still have a deep seated resentment at having been uprooted from their homes and living their lives in a foreign land. They do generally require more patience and understanding, and are generally more difficult to handle than most other categories of patients.

I was pleased to be able to help nearly all of these patients and had very few with whom I could not establish adequate rapport, and in these few it reflected their unrealistic expectation of what their specific treatment could achieve.

Patients adversely affected by any non compliance?

I cannot think of a single patient of the more than six hundred or so patients treated by our clinic who were in any way affected with any possible non compliance that may have occurred.

Despite the claims by two health ministers that this compliance is crucial, in reality it cannot have any impact what so ever. No patient can possibly be at greater risk where treatment is started for example and a letter has not been dispatched on time to the referring G.P. The reason is simple – there is absolutely no requirement for the G.P. to have to read the letter/treatment plan and in some way react to it. There exists only a requirement to send (by email or fax) the treatment summary, after which the Dentist is compliant, however whether the referring G.P. is on holiday for a week, doesn't see the letter , or doesn't read the letter, or doesn't understand the letter- has no bearing on the treatment agreed to between the Dentist and the patient. There is no requirement for the G.P. to ever send back a response stating that he approves the treatment. This particular exercise has no merit at all. Neither I nor any of the colleagues that I have asked has ever had a response to such a letter. Never.

In fact the reverse is true, and occurs as needed. The enormous cost of training dental surgeons to be competent in their assessment of patients is money well spent. We are trained to be able to assess our patients overall health with respect to dental treatment. Where we do have any doubts about the impact of dental treatment on a medically compromised patient we promptly telephone the G.P. and discuss the treatment plan and other options, and noting the advice, reservations and prohibitions that the G.P. might offer. I would suppose that perhaps 20 patients from the scheme were handled in this way, and had their dental treatment tailored to suite their overall health needs. In fact there are cases that such discussions occurred with the G.P. well after the letter had been sent. The letter produced no response; the telephone discussion however changed the way treatment was carried out.

Any issues with quoting and compliance having an adverse affect on the patient don't really apply. We were until recently a bulk billing practice, patients were well aware that they were not required to pay a gap. On the odd occasion where we may have exceeded the maximum available funding, and this could occur where unexpected problems complicated the original treatment plan, it was a case of discounting that amount for the patient.

In conclusion I would just like to recount a social meeting I had with a group of G.P. who do refer CDDS patients to me. The first one greeted me with "why do you keep sending me all these letters? I keep getting all these letters from you!" My reply that I had to send them a treatment plan led me to ask whether any of them actually read the letters. There was some

shaking of heads and when I asked whether they just filed them, one went through the motions of screwing up a bit of imaginary paper and throwing it into a bin. The horrified look on my face was met with “No we file them-you’re doing what you have to do”

I have not met a Dentist or a G.P. who treats this process as anything but a bureaucratic exercise.

Medicare auditors

I have as yet never met anyone who has claimed to be from Medicare for any reason whatsoever, whether to offer educational material or otherwise. A liaison person did speak to my receptionist earlier this year, on my day off, to explain that something she called “easy claim” was available. This ensured that patients didn’t have to bring large sums of money to meet their agreed full payment amounts. They apparently can claim the Medicare amount via Hicaps and settle the gap at the front desk. However as this is clearly not in the booklet as a payment option, and I don’t have anything in writing to say that it’s compliant we as yet are not prepared to do this. It would of course have been very helpful to have such Medicare liaison people from day one of this scheme.

I personally have not received any educational material since the booklet of 2007.

CDDS experience and future Medicare schemes

The impact of this CDDS scheme has been initially chaotic and bureaucratic yet from a dental treatment point of view was generous and comprehensive in its scope. The Medicare rebate was in 2007 very close to what we as a suburban dental practice charged our socially disadvantaged group of patients. So bulk billing was a logical step to take. However year by year as cost rose it became harder to continue bulk billing and our practice in mid 2011 charged a gap of some 15%, probably a year later than we should have.

At the same time the Government of the day has consistently threatened to close the scheme down and this made it a lot harder to plan patients’ treatment. Also the issue of compliance at the beginning of 2011, led to dental specialists, then dentists and other providers in my practice and elsewhere choosing not to treat patients under the scheme. This created greater hardship both for patients and for me. It’s very frustrating for patients who have been approved for the scheme and who clearly require treatment and they are finding it harder to be seen by anyone.

The paperwork has been addressed for quite a while now, though of course this does create a lot more work. Unfortunately I have had to restrict the number I see on the scheme per day as I feel I have not being looking after my former non CDDS patients. There have been those who have left to seek treatment elsewhere, as they were unable to be seen promptly. On the other hand CDDS patients are becoming unhappy as their treatment is been stretched out further into the year.

The question about any future Medicare funded dental scheme is of interest to many of us. The Greens are committed to a comprehensive Dentacare scheme. The Labour party has its own version, but also has been negotiating with the Greens since March 2011, for a more comprehensive Medicare scheme closer to what the latter envisage. Finally the Liberals have indicated that they're not opposed in principle to such comprehensive schemes or ones focusing on the lowest socioeconomic group. This would indicate that in the future we may well expect a continuing relationship between Medicare and the Dental fraternity in some form.

The experience with Medicare CDDS has been an unpleasant one for many dentists, primarily because the Government of the day has been intent from day one in closing the scheme down by any means. This has been publically stated many times. It seems too many of us that their attitude is one of if the opposition brought it into law it must be bad. The compliance issue is seen by G.P.s and Dentists alike as an obstructionist strategy to downgrade the schemes appeal, since the Senate is not prepared to close the scheme down outright.

Any future scheme would need to reassure future providers that they will not be demonised and harassed for essentially political reasons. Dentist will remain focused on delivering quality dental care to their patients. They will by and large be more than happy to help the disadvantaged in our community to obtain good quality dental care, and they don't much care which party does what to meet these goals.

It would be very helpful for any future Medicare /Dental schemes to ensure liaison officers are available to properly and constructively educate the providers of the schemes requirements. The emphasis should be overwhelmingly on education, rather than punishment. The administration should be more streamlined and more direct means for correcting any errors that will always occur should be developed. Medicare staff should be familiar with dental terms and practice.

Where errors of omission occur under any scheme and are of a clearly administrative or clerical nature, it's hard to understand why a savage punitive response is even permitted. No future Medicare scheme should have such an option. If work is done in good faith, then it's natural justice that people are payed accordingly. Where a government body becomes aware that compliance to its "determination" is poor, then surly it's a case of the department having not educated and guided the providers adequately. In fact it's clear from the result of the current auditing process that full complaints is quite rare, thus underlining the departments failure to successfully educate providers.

In such cases the only civilized path to take is to increase liaison with providers, directly and actively. By this I recommend direct e-mailing, telephone calls and visits by Medicare personnel to practices, to amicably point out where they may not be meeting their compliance standards. Also Medicare should liaise better indirectly with the respective Associations to help in achieving their compliance. Only after continued failure to comply should Medicare take further steps. Perhaps a written personnel warning that providers may be unable to treat Medicare patients for a certain time (or ever) would be reasonable.

It's very important that this, and any other, Medicare scheme be user friendly, straightforward, logical and in harmony with the norms of the Dental health industry. The need to get greater input from the representative professional bodies in designing the scheme is paramount. In would avoid the current anomalies with different branches of Government. One good example of this is that AHPRA registers a variety of Dental Auxillaries to provide the delivery of world class dental treatment to patients, whilst the DVA and Medicare , each having the same wording in their determination, are at odds, the DVA agreeing with AHPRA and Medicare disagreeing.

The impact of the CDDS audits has, as I have stated before been negative, and has frightened off many providers from continuing to treat patients under the scheme. The possible advent of a future Medicare scheme, or even the continuation in some form of the current one, means that Medicare will have to do much to regain the confidence of the profession. The above comments are the main issues which if addressed adequately would certainly encourage me to continue working with Medicare in the future. I would just like to add that the time given to adequately organise this submission has been somewhat short, and perhaps has not allowed me the time to present my views as fully and as coherently as I might have, however I do feel that I have covered all the main points that concern me on the matter.

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