AUSTRALIAN DENTAL ASSOCIATION INC.

Australian Dental Association Inc.

Inquiry into the Health Insurance (Dental Service) Bill 2012 [No.2]

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Authorised by
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1. About the Australian Dental Association

The Australian Dental Association Inc. (ADA) is the peak national professional body representing over 13,000 registered dentists engaged in clinical practice and dentist students. ADA members work in both the public and private sectors. The ADA represents the vast majority of dental care providers.

The primary objectives of the ADA are to:

• Encourage the improvement of the oral and general health of the public and to advance and promote the ethics, art and science of dentistry; and

• To support members of the ADA in enhancing their ability to provide safe, high quality professional oral healthcare.

There are ADA Branches in all States and Territories other than in the ACT, with individual dentists belonging to both their home Branch and the national body. Further information on the activities of the ADA and its Branches can be found at www.ada.org.au.

2. Executive Summary

The Senate, on the recommendation of the Selection of Bills Committee, has referred for inquiry the Health Insurance (Dental Service) Bill 2012 [No.2] (the Bill) by the Standing Committee on Finance and Public Administration Legislation Committee. The ADA welcomes this review and seeks to make representation to the Inquiry in writing and in person.

For a number of years, the ADA has been seeking a mutually-agreeable resolution to the range of issues that have arisen from the audit processes undertaken by Medicare Australia (MA) as part of the compliance requirements in relation to the Chronic Disease Dental Scheme (CDDS).

This submission presents a case to **support** the changes sought in the Bill.

The key issues this submission will address are:

- The CDDS was introduced without adequate consultation with the profession and without adequate education of the profession which had not previously been significantly exposed to providing services under MA.
- Advice provided to dentists from MA has been inconsistent.
- MA did not advise dentists of the penalties that would apply for non-compliance with the administrative requirements of the CDDS until almost two years after the CDDS had commenced.
- Despite stating that that their compliance approach included an “appropriate mix of education, support, deterrence and enforcement in order to encourage maximum levels of voluntary compliance”, MA have shown little or no flexibility in making demands on dentists to repay moneys provided – even when treatment has been carried out to the satisfaction of patients.

The ADA would be happy to provide additional case studies of individual dentists' experiences with the auditing process if required.

3. Introduction

The CDDS provides eligible patients with access to subsidised dental care. The legislation that underpins the CDDS is the Health Insurance (Dental Services) Determination 2007 (the Determination).

Most dentists registered to practise in Australia have participated in the CDDS and have provided good and appropriate dental care services to a large number of patients. In providing that care, some dentists have not understood the necessity to comply with specific administrative procedures that are a feature of the CDDS. This is in part due to:

- Lack of consultation with the profession before the CDDS was implemented;
- The communication processes and education approach taken by the Department of Human Services (DHS, but previously MA) to dentists when the CDDS was introduced;
- A lack of recognition within the CDDS's construction of dental practice and procedures;
- Provision of inconsistent advice to participants in the CDDS;
- Dentists not understanding the need to seek further information; and
- The fact that once issues were identified with dentists' non-compliance, procedures were not put in place to assist dentists to familiarise themselves with the CDDS.

Dentists are accused of being at fault and of rorting due to non-compliance and are being made to pay back MA rebates received for services provided to patients in good faith. The penalty – requiring repayment of the entire amount claimed because of a failure to comply with certain administrative requirements (when patient care has been provided) – is grossly out of proportion to the offence.

The finger cannot be pointed at any single entity to attribute all of the blame.

The intention of the Health Insurance (Dental Services) Bill 2012 [No.2] is to address the inequities and unfairness that have arisen from the compliance operations under the CDDS.

The ADA supports any moves to ensure equity and fairness for dentists who, when audited, are found to have made administrative errors under Section 10 of the Determination.

The ADA wishes to strongly make the point that it does not, nor ever will, condone fraud or poor dental practice and thus is supportive of any claim for recovery or prosecution that may be made by MA in respect of practitioners found guilty of such action.

This submission presents the facts as understood by the ADA. It presents a case to support the passing of the Bill. It demonstrates the gaps in implementation of the CDDS that have led to poor compliance by the profession.

4. Consultation with the profession was non-existent

The CDDS was introduced without broad consultation with the dental profession.

Up until the commencement of the CDDS, dentists within Australia had very limited experience dealing with claims involving government rebates or MA and its rules. Their major exposure to such processes was limited to the program administered by the Department of Veterans' Affairs (DVA). In terms of familiarity with MA, dentists were no better prepared to understand MA processes than the general public; as dentists, like the general public, would only have had experience as users of the CDDS in obtaining general health benefits for their own medical treatment.

The complexity and importance of meeting the administrative requirements under the CDDS – as a health provider – were therefore new. Dentists have not, as compared to medical practitioners, had years of experience in participating in MA as health practitioners.

In 2010, the Australian Government included nurse practitioners as a recognised provider for the purposes of the Medicare Benefit Schedule (MBS). The ADA is aware that prior to implementation of this initiative there was extensive discussion between nurses, nurse organisations, medical practitioners and other key stakeholders regarding the scope of their inclusion into MA; the items that would be eligible for rebates and the education that would be required by the profession to ensure that nurse practitioners understood how MA operated and the compliance requirements of providers.

There was no similar program for dentists when the CDDS was introduced in 2007. The ADA had, prior to the commencement of the CDDS, outlined its concerns with government; unfortunately this was not heeded. Had the profession been adequately consulted, many of the issues with compliance that have been identified by the audits could have been avoided.

5. Education of the profession was not comprehensive

Since its inception, the ADA has raised concern with the lack of education provided to dentists participating in the CDDS.

Using the nurse practitioner example as a comparison, the Department of Health and Ageing worked closely with MA and stakeholders to ensure that a suitable education program was in place so that the nursing profession was fully informed about the processes for nurse practitioners to participate in the new arrangements; including what services were eligible to be claimed and the audit processes undertaken by MA to ensure compliance.

With regard to the CDDS, the only interaction with the profession was delivery of a letter and a copy of the Medicare Benefits Fee and some reference to website information. Many dentists suggest they did not receive this information and report that the first time they became aware of the CDDS was when patients brought it to their attention.

It was not until the ADA's recognition, in early 2010, of the deficiencies in the education program provided by MA that any form of comprehensive education program was undertaken. At that time the ADA arranged for a representative of MA to be interviewed on its *ADA Dental Files* educational CD distributed to members; articles to be published in the

ADA *News Bulletin* and provision of MA advisories to be included in its publications – both hard copy and website.

Since that time the ADA has regularly updated its members on compliance issues.

The ADA suspects (and internal Departmental material may substantiate this) that the history of the CDDS has impacted on the Department's investment in the education of dentists regarding the CDDS. It is strongly felt that the constant reference to imminent closure of the CDDS (there having been two unsuccessful attempts to do this) caused the Department to not invest in education as it saw the CDDS to only have a limited life and that the financial investment in education was not warranted.

6. Information about the CDDS was confusing and inconsistent

Section 10 of the Health Insurance (Dental Services) Determination 2007 requires two prerequisites be satisfied for there to be an eligible MA service, namely:

1. A plan of the course of treatment and a written quotation for each dental service be provided to the patient; and
2. The provision of a written summary of the treatment plan to the referring general medical practitioner.

The ADA accepts the claim by the DHS that they developed and distributed advice regarding the CDDS. However, the ADA has been notified of many occasions where dentists have reported that they never received any correspondence from MA regarding the CDDS, its requirements, and the penalties that would apply should they not comply.

While Section 10 of the Determination clearly imposes steps that need to occur before a dental service can be considered a valid MA service, these were not clearly set out in either the *Medicare Benefits Schedule Dental Services* Book (the Booklet); the *Information for Dentists and Dental Specialists – Dental Services under Medicare for People with Chronic and Complex Conditions* fact sheet (the Fact Sheet) placed on the Department's website, nor in any other communication sent to dentists.

The ADA holds a copy of a letter purportedly sent to dentists by the then Health Minister, the Hon. Tony Abbott, which is believed to have been sent on 5 October 2007. This letter refers to the then new scheme and makes reference to the fact that patients are to be informed about the cost of any recommended dental services but makes no comment on any requirement to provide a written quote or to provide general medical practitioners with a copy of the proposed plan of treatment. Furthermore, Mr Abbott's letter likens the new scheme to the services provided under DVA. It would be fair for the reader of this letter to infer that the CDDS would therefore operate in a similar manner to the DVA scheme.

The DVA scheme (with which the dental profession was very familiar) requires healthcare providers to formulate a written care plan following the first patient consultation and this plan must include, among other things, "the planned treatment regime, including the anticipated type, number and/or frequency of services." The *Notes for Allied Health Providers* issued by the DVA go on to say that "the entitled person's Medical Practitioner, as the care coordinator, **may** request a copy of the patient's care plan. DVA may also request a copy of the care plan."

It should be noted that there is no requirement under the DVA scheme to provide a medical practitioner with any information regarding the services provided to veterans before, during or after the provision of any services, it is only required on request. Nor is there any requirement to provide the patient with a written quote.

The message that the CDDS would operate along similar lines to the DVA scheme was further reinforced in the Booklet which took effect on 1 November 2007.

On page 8 of the Booklet, explanatory notes (N.1) provide advice on how to use the Medicare dental items. This advice states:

> *"One of the key differences from the DVA dental arrangements is that under Medicare dental practitioners are free to set their own fees for services …*
>
> *Unlike the DVA arrangements, prior approval by a dental adviser is not required for any of the Medicare dental items."*

Given the substantial differences between the administrative requirements of DVA scheme and the CDDS, it would have been prudent for MA to specifically point out the list of technical administrative differences of consequence rather than confine the advice to the fees applicable. Reading these comments at that time would leave the dentist under the clear impression that while the CDDS may have differed somewhat from the DVA scheme, the differences were only minor – as outlined. The consequences of this misconception may well have been the foundation of the problems that later developed. Certainly this has been borne out in subsequent unfortunate cases of non-compliance.

If the information under paragraph 5 (of this submission) was not enough, the Booklet provided to dentists highlighted key text boxes as a means of pointing out the essential pieces of information regarding the CDDS. None of the text boxes made specific reference to the requirements under Section 10 of the Determination. Nor did the Booklet in any way advise readers of the consequences of non-compliance with Section 10 requirements. This is concerning considering that most findings uncovered to date by audits relate to Section 10 breaches.

The ADA is prepared to go so far as to say that any messages that were provided in these documents were also internally inconsistent. These discrepancies and ambiguity within the Booklet itself have been a substantial factor in poor compliance by dentists.

For example, the Booklet (at page 13) refers to the need to provide patients with "a written quote or cost estimate" prior to commencing a course of treatment. It is unclear as to whether this provides the dentist with an option to provide "a written quote" or "a cost estimate" This is not made clear, nor is what may constitute a "cost estimate" made clear. Established dental practice has always sought to provide for the delivery of informed financial consent but this has never necessitated provision of written quotes. The precise extent of dental care that is required to be delivered to a patient cannot always be predicted with certainty and thus costing associated with it is not something that can be provided absolutely. A "cost estimate" provided verbally is the dental custom and was thus the interpretation given to the phrase by dentists under the CDDS.

It is not until the reader reaches page 17 (Explanatory Note N.2) that mention is made of the need to provide a copy or summary of the patient's treatment plan to the referring medical GP. Even then, the Booklet refers to the need to provide such a plan on commencement of the treatment, not before treatment commences. It was not until the 2011 version of the Booklet was released that additional text was added to this paragraph to clarify this, so that it now reads:

> *"Dental practitioner must provide a copy or summary of the patient's treatment plan to the referring (medical) GP at the commencement of the course of treatment (ie following an examination and assessment of the patient, including any diagnostic tests), but before commencing treatment."*

This ambiguity is now one of the key measures against which dentists are being found to be non-compliant.

Examples of such inconsistencies are further demonstrated when one considers the advice in the Checklist for Dental Practitioners included in the Booklet (page 16). While it refers to the two prerequisites mentioned in Section 10 of the Determination, it does so in a much more relaxed (and non-specific) context.

In the Fact Sheet, the following two items are identified as required:

a) Dental Treatment Plan (including an itemised quotation of proposed charges) provided to the patient;

b) Copy or summary of treatment plan sent to referring GP (may be emailed).

It should be pointed out that this Checklist, when read alone, makes no reference to the need for any written fee estimate to be provided, nor does it stipulate the time at which those requirements have to be met. While included, these matters are not listed as being prerequisite conditions for a valid MA service as indicated in Section 10 of the Determination. That is, the real significance of these requirements to make the services eligible to receive MA payments is not outlined clearly.

The logic behind the need to send letters back to the referring Doctor to better manage the patient's chronic condition was never fully explained. Indeed, in many cases the ADA has been approached by medical GPs for an explanation as to why the treatment plan was sent to them by the dentist. When advised as to why they were being sent, the response was that the details in the treatment plan made little sense to the medical GP and could the practice stop. This response from medical GPs would suggest that education of the medical profession was as lacking for them as it was for dentists.

The ADA reiterates that that while there was information indicating the necessity for these prerequisites to be satisfied, it has not been made abundantly clear in documentation. A simple statement setting out the Section 10 requirements as prerequisites may have alerted dentists to the importance of the requirements and significantly reduced the rates of administrative non-compliance identified by the audits.

7. Consequences of non-compliance were never explained

The ADA has identified that the first advice to the dental profession regarding MA's Compliance Program was a letter dated 4 September 2008 which included a copy of the brochure entitled, *Medicare's National Compliance Program 2008-09.* This was almost a year after the establishment of the program.

While MA did not request this advice be further disseminated, the ADA took it upon itself to provide a copy to members via the ADA website.

In December 2009, the ADA was advised by MA of their concerns that dentists were not complying with the requirements of the CDDS. Following this discussion, the ADA issued advice to its members about the likelihood that individuals could be required to repay monies paid by MA for services dentists performed if all requirements of the CDDS had not been met. This was the first time that such concerns were raised; two years after the CDDS commenced. We now know that many of the dentists found to be non-compliant, were non-compliant during this time of the CDDS's operation.

ADA also distributed communiqués from MA to its members and continued to dispense further information regarding the CDDS as further information came to hand (see earlier comments in Section 5).

The ADA has reviewed all of the correspondence which MA purportedly sent to all dentists. This evidence was tabled in the Senate on Monday 31 October 2011 in response to an order for production of documents by Senator Fierravanti-Wells. The only reference that the ADA could find prior to this date as to the consequences of non-compliance with the CDDS is in the last sentence of the 2007 version of the Booklet (page 23). Here it states:

> *"Where a Medicare benefit has been inappropriately paid, Medicare Australia may request recovery of that benefit from the practitioner concerned."*

Further re-issued versions of the Booklet also fail to make any reference to the penalties that would apply if all requirements of the CDDS were not met adequately. This is still not addressed in the current fact sheet dated November 2011.

8. Action taken for non-compliance is extreme

MA's National Compliance Program document states that its approach to compliance includes an *"appropriate mix of education, support, deterrence and enforcement in order to encourage maximum levels of voluntary compliance."*

The document contains a diagram to provide a visual explanation of the compliance model.

Diagram 1—The compliance model

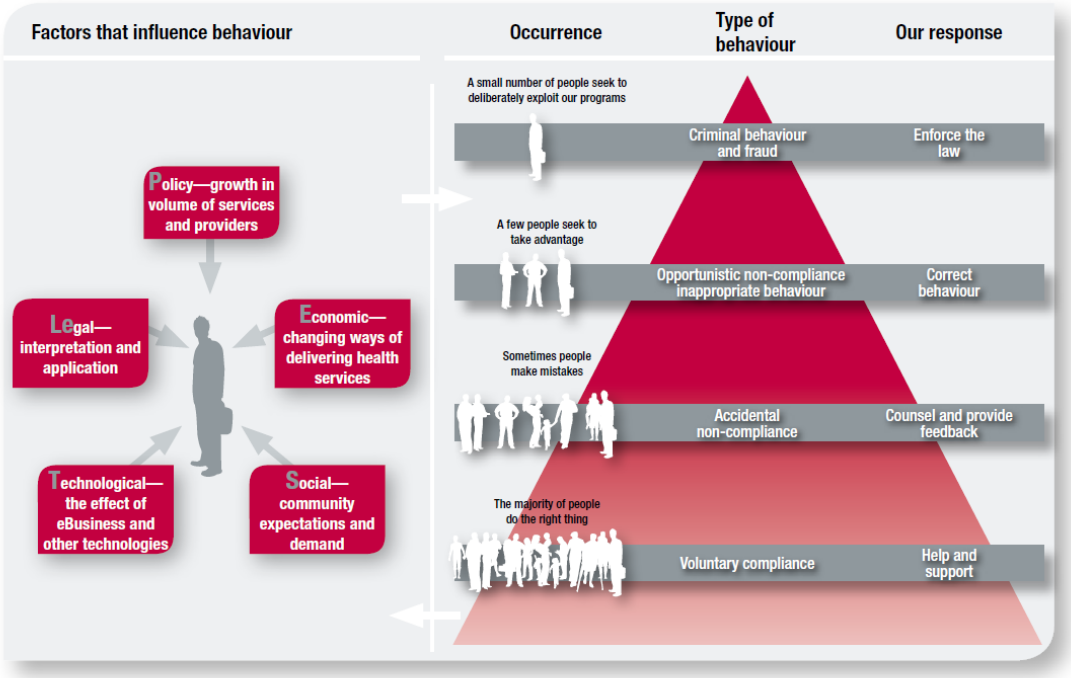

Diagram 1 illustrates the factors that influence behaviour (PESTLe framework) and the compliance triangle.

This diagram indicates that where non-compliance is accidental, MA will counsel and provide feedback. The level and seriousness of action by MA then escalates matching the level of non-compliance. This is a suitable program approach. The ADA would argue that the compliance program model articulated by MA has not been followed with respect to its audits of dentists. MA appears to have decided to sparsely adopt the educational approach to address those dentists found to be administratively non-compliant. The proportional and reasonable approach suggested by the Compliance Model is not being applied in practice by MA.

The ADA would like to provide evidence of how MA has not followed its own Compliance Model:

Case Study – Queensland

In one case known to the ADA, MA alleged a Queensland dentist did not provide services to patients based solely on their investigator's telephone conversation with a small number of the dentist's patients. This advice was acted upon by MA in pursuing recovery without conducting any form of independent clinical examination; asking the dentist if he provided the services or even checking his records.

Such disregard to the professionalism of dental practitioners is indicative of the MA approach of ruthless pursuit of recovery of benefits wherever possible.

Case Study – Dr Wilma Johnson

An audit of this dentist's records took place. Extracted below are sections of the Audit findings.

Summary of Audit findings:

"All patients treated had a valid referral from a general practitioner prior to the beginning of treatment.

All services billed were found to have been provided.

Some services provided are yet to be billed, or Dr Johnson chose not to bill for the service.

Thirty-one (31) patients were found to have treatment plans and quotes/cost estimates which are dated after the treatment commenced or after the treatment had been completed.

Three patients did not have a treatment plan or quote/cost estimate in their patient records. However, two of these patients only had initial services and the other patient was initially treated by another dentist before treatment was taken over by Dr Johnson.

Patient treatment plans were provided to referring GPs after the commencement of dental services.

No additional gap was charged to bulk bill patients.

The total for all CDDS services billed by Dr Johnson for the audit period 01/11/2007 to 31/10/2009 is 34 patients (240 services) for $34,495.85 in Medicare benefit.

The potential MA recovery of non-compliance by Dr Johnson is approx. $30,000 to $33,000 (exact recovery calculations cannot be provided – awaiting directions from the CDDS Taskforce on final item number exclusions from the schedule other than 85011-85013 arid 85022 - 85039).

The exceptional circumstances needing to be considered prior to making final recommendation are that Dr Johnson was first selected for Information Gathering Purposes under the CDDS 20 Dental Enquiry Strategy and as such was not advised or provided with:

- A letter outlining the purpose of audit/visit;
- Advice that this was voluntary audit/visit;
- The Information she provided could be used against her; and
- An outcome letter detailing any issues identified regarding her claiming under the CDDS.

MA Compliance Officers have been conducting an audit of Dr Johnson for well over a year. This has caused great distress and anxiety to Dr Johnson. As a result, Dr Johnson has advised she will not be treating any more CDDS patients.

All patient referrals and actual services rendered by Dr Johnson are compliant. If recovery action is taken by MA over administration aspects of Section 10 of the CDDS, Dr Johnson could seek recovery from patients for services she has provided. This could cause patient and political backlash as patients could end up covering the costs for the services provided.

The recommendations for the audit treatment of Dr Johnson are:

(a) Educational letter be sent to Dr Johnson and NFA.

Or

(b) Recovery action taken for all services identified as non-compliant which is approximately $30,000."

MA has pursued the second recommendation. Such action is indicative of the very hard and inflexible line adopted by MA.

9. Advice to dentists from DHS has been inconsistent

ADA members repeatedly report difficulty getting consistent advice from MA staff. One of the best examples of this is the advice provided to members regarding the provision of services by dental hygienists. Dental hygienists are registered dental practitioners who work under the supervision and direction of dentists. They play a significant role in the provision of preventive services to patients in a large proportion of practices.

ADA members have sought advice from MA as to whether services provided by dental hygienists under supervision and on behalf of a dentist are eligible for claiming under the CDDS. MA Service Centre operators have advised some dentists that hygienists could provide services yet others have answered negatively to the exact same question.

The ADA has now confirmed that services provided by hygienists are not covered under the CDDS.

Another example where advice was inconsistent with MA's own documentation is demonstrated by the following situation. In general terms the discussion between the practice manager and the MA officer was as follows:

Case Study – Questions to Medicare Service Centre

A dental practice manager called MA to ask if a treatment plan for patients was required if the practice was bulk billing or whether it was sufficient for the patient to sign the electronic billing form.

The MA officer indicated she could not see why provision of a plan would be necessary if the dentist was bulk billing them. She indicated that if the patient wanted a breakdown of services and what was being charged then the patient was entitled to this. When asked what was required if the patient did not ask, the officer replied it was not necessary to supply it. On further questioning this advice was repeated.

The Practice manager also sought clarification of the provision of a treatment plan to the medical GP. The advice provided was along the lines that you should exchange treatment plans or reports in relation to the patients. For instance, it was suggested that maybe at the halfway mark of the treatment plan being delivered, the dentist should inform the GP of what was being done.

When asked if the medical GP needs to know what is happening even before the treatment commences, the officer replied that the situation was variable and that some GPs have requested that the dentists supply them with a treatment plan before the treatment starts. Others have asked for it midway through the plan; others have asked for a final copy of the completed plan. It was generally a matter for the GP.

With this variation in advice from the published materials, it is not surprising that dentists have not complied with the letter of the law in many cases.

10. Agreements with ADA have not been upheld

The ADA would also like to bring to the Committee's attention an excerpt from a letter from the Hon. Tanya Plibersek, former Minister for Human Services, to the ADA dated 29 July 2011. This letter acknowledges that the ADA advised the Minister that dentists were not fully aware of the requirements under the CDDS until the ADA and MA worked together to advise the profession in early 2010. The letter also suggests that MA will provide some flexibility in how it deals with dentists being audited.

> "*Dr Fryer and you (Mr Robert Boyd-Boland, ADA CEO) have also raised concerns that most dentists were not aware of the administrative requirements of the CDDS prior to the joint communication activity of the ADA and DHS in April 2010. To address this concern assurance has been provided by Medicare that dental practitioners selected for the next round of audits will continue to be sampled from claims made in the 12 months preceding the commencement of the audit. I am advised that as such, Medicare will be considering claims made after April 2010. Where the dental practitioner is found to be generally compliant with the requirements of the CDDS, this will generally be the end of the audit. If however, the audit indicates a pattern of significant non-compliance by the dental practitioner, the audit may then proceed to consider claims made in previous periods."*

The ADA believed that they had an agreement with MA that if dentists got their house in order, they would be some reasonable flexibility shown in relation to audit findings and recommendations. This has not proven to be the case. An example which demonstrates that MA has not shown any such consideration is outlined below:

Case Study – Dr X, general practitioner, Western Australia.

Dr X was audited by MA in March 2010 and asked to self-assess services rendered to 21 patients between November 2007 and October 2009 under the CDDS.

In all cases, Dr X had provided to the patient the services claimed but while he had provided a quote and treatment plan to the patient, he was unaware of the need to provide a copy of the treatment plan to the medical practitioner.

Reimbursement amount identified by MA for the 21 patients – $31,847.05.

Dr X was then advised that he would be the subject of a full audit on all services claimed for the period 1 November 2007 to 31 October 2009. This audit demonstrated that **all patients** had been provided with the services claimed. However, Dr X and his staff had failed to submit a copy of the treatment plan to the medical practitioner. As a result, MA is now seeking recovery of funds amounting to $654,142.05.

Since being made aware of the requirements under the CDDS, Dr X has complied with all administrative requirements necessary pursuant to the relevant Determination.

MA has not taken into consideration that Dr X has:

a) Provided the services;

b) Paid staff wages, laboratory costs; and

c) Used and paid for materials and supplies for those services.

Dr X is unable to pay back the funds to MA and will need to declare bankruptcy due to the fact that dental practices operate at a 65-70% expense rate, thus only 30-35% of gross revenue is retained by the dental practice. His surgery will close and his staff will be unemployed.

11. Audits show non-compliance is substantially of an administrative nature

The DHS responded to questions on notice regarding the CDDS at the Senate Additional Budget Estimates on 16 February 2012. In particular, the DHS has provided details regarding the number of audits undertaken as at 31 December 2011 and the type of non-compliance resulting in requests for reimbursement of funds.

At that date, 540 audits were underway and 89 had been completed. 26 of the closed cases were found to be compliant with a further 63 non-compliant. Of those 63, 17 were provided with education and no recovery of funds was sought. 12 audits suggest that services had not been provided to patients. Of the remaining 34 cases where the DHS are seeking recovery of funds, all 34 were non-compliant as they failed to provide a treatment plan and or quote. In other words, they failed to meet administrative requirements only.

It should be noted that the DHS reported that there have been no incidences where they have referred dentists to the Dental Board of Australia (DBA) for the dentist's conduct under the CDDS. The ADA is concerned that at the heart of the matter the majority of identified non-compliance relates to the administrative requirements of the CDDS and that patients had received the treatment they sought in full.

The ADA does not condone provision of poor dental treatment. If it has been provided, the ADA will support appropriate action being taken against the provider.

12. Recovery of benefits paid.

The ADA would like to raise two issues here that again reflect a poor appreciation of dental practice:

1. The ability to recover benefits paid to dentists where there has been non-compliance with the requirements of Section 10 has a further unforeseen ramification for dentists. In many cases of treatment, the dentist will engage a third party to provide a service such as the construction of a denture or bridge. While this product will be delivered by the dentist, it will have entailed the dentist paying an out-of-pocket expense to the dental clinic. Such expense will be included in the MA claim and when MA seeks recovery, the recovery will in fact require the dentist to repay for services delivered by the third party. The dentist has then paid the provider and been required to reimburse MA.

2. Related to this is the CDDS's failure to adopt recognised dental billing practices. As indicated in many cases, the dentist needs to obtain the assistance of a third party to provide dental appliances to the patient (crowns; bridges; dentures). These services are required to be prepaid by the dentist. It is a recognised business practice in dentistry that in such circumstances the patient is billed for the provision of the service so that the dentist is not out-of-pocket should the patient later abandon the treatment. Under the CDDS, pre-billing in such cases is not possible.

   This has led to:

   a) Where the dentist has billed for the service (as is the custom) the dentist is identified as having billed for services which have not been rendered and thus is in breach of the CDDS.
   b) Where the service has been partially provided but not completed, the dentist has not been able to bill for either the services rendered or for those services outsourced. Should the patient not return for completion of the treatment plan then the dentist is left out-of-pocket.

Significant financial ramifications can follow.

Conclusion

Through this submission the ADA has demonstrated significant deficiencies in the way in which the CDDS was introduced and has also demonstrated how later implementation and administration was extremely poor.

As such, in many cases dentists should be excused for their non-compliance with the administrative requirements of the CDDS.

There is no doubt that utilisation of the CDDS has exceeded the Government's expectations and has caused budgetary problems for Government. The early advice to Government from the ADA pointed this out and as well as the significant level of unmet dental need in the community.

These budgetary problems for Government have no doubt lead to decisions that have required the implementation of the tough approach taken by MA in recovery of benefits for services. While economics might justify this, the ruthless pursuit of dentists is not in the ADA's view the way to address the problems confronted.

As a consequence, the ADA sees dentists as being made the scapegoats for these failures. This is unjust and thus the ADA strongly supports the changes sought to the administration of the CDDS as detailed in the Bill.

F Shane Fryer
Federal President
Australian Dental Association Inc.
13 April 2012.