AUSTRALIAN DENTAL ASSOCIATION INC.

Australian Dental Association Inc.

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

ADDITIONAL DOCUMENTS PRODUCED.

1 May 2012

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HEALTH INSURANCE (DENTAL SERVICES) BILL: Finance and Public Administration—Legislation Committee

Australian Dental Association Inc. (ADA)

Documents tendered on 1 May 2012.

Correspondence:

1. 19 March 2010: Letter ADA to Kathy Dennis-Medicare Australia.
2. 30 March 2010: Letter Kathy Dennis to ADA.
3. 29 April 2011: Specimen letter agreed between ADA and Medicare Australia (MA) sent to dentists.
4. 17 June 2011: Letter ADA to Chief of Staff Minister for Human Services.
5. 29 July 2011: Letter Minister for Human Services to ADA.

Articles and news items to ADA members:

6. ADA News Bulletin (ADANB) article: February 2010. (Author Kathy Dennis (MA))
7. ADANB article: April 2010.
8. ADA President's Comments: ADANB July 2010.
9. ADANB article August 2010.
10. ADANB article September 2010.
11. ADANB articles (2) February 2011.
12. ADANB article April 2011
13. ADA President's Comments and ADANB article May 2011.
14. ADA President's Comments August 2011.
15. ADA President's Comments, ADANB article and reproduction of Minister's letter of 29 July 2011 September 2011.
16. ADANB article October 2011.
17. ADA President's comments December 2011.
18. ADA President's Comments and ADANB article April 2012.
19. ADA Dental Files Educational CD-item 3.
20. Summary of ADA Survey 2012.

AUSTRALIAN DENTAL ASSOCIATION INC
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19th March, 2010

Ms Kathy Dennis
Medicare Australia
PO Box 1001
TUGGERANONG ACT 2901

Dear Kathy

RE: CHRONIC DENTAL DISEASE SCHEME

The Australian Dental Association Inc (ADA) would like for thank Medicare Australia (MA) for the co-operation that it has extended to the ADA in relation to the Medicare Audits being conducted pursuant to the Chronic Dental Disease Scheme (Scheme).

Discussions to date:

As raised at our last meeting on 15 March, 2010 the ADA is looking to seek a form of resolution to the audit processes that are being embarked upon by MA in relation to utilisation of the scheme by dentists. Resolution would be designed to both meet the needs of MA and accommodate dentists that are genuinely providing valuable treatment to Australians pursuant to the Scheme.

It is generally agreed that there are three categories of concern identified in the evaluations carried out to date and they are in respect of:

1. Dentists that have billed and been paid by MA for services as having been finalised, but which were not in fact performed prior to completion of "treatment" of patients i.e. services claimed to have been performed in a completed treatment when they were not provided.
2. Dentists that have billed and been paid for services by MA, but treatment paid for is still to be completed as part of ongoing treatment.
3. Dentists that have breached Section 10 of the Health Insurance (Dental Services) Determination 2007 which requires two prerequisites be satisfied for there to be an eligible Medicare service, namely:
   i. a plan of the course of treatment and a quotation for each dental service be provided to the patient, and
   ii. the provision of a written summary of the treatment plan to a general practitioner.

The ADA understands that in respect of each category dentists providing such services can be found liable to repay MA for monies received for services in certain circumstances. In some circumstances more punitive punishment can occur.

Proposal- Way forward:

In respect of the first category, the ADA is happy to provide whatever assistance MA needs to prosecute dentists within this category. The ADA does not, nor ever will, condone fraud and thus is supportive of any claim for recovery or prosecution that may be made by MA in respect of such practitioners.

In respect of the second category, it is conceded that Medicare Australia has always required that services in respect of which Medicare claims are made are not able to be pre-billed and must only be billed after completion of the treatment. As we have advised, this practice is not one always adopted by dentists in their customary practice and some do pre bill for services yet to be rendered. For example, such methodology is often adopted where services to be provided involve the dentist in incurring a liability to a third party for services to be rendered by that party such as a dental technician constructing a crown.

MA has indicated in discussions that it will forego any claim for refund of fees paid for those non rendered services in these cases provided such services are rendered within three months.

The ADA would like to express its gratitude to Medicare Australia for this indulgence granted to dentists.

In respect of the third category, the ADA recognises that MA has said that where administrative oversight has resulted in ineligible claims (due to non compliance with Section 10) being paid, MA will not seek an automatic recovery of such fees in every case but will consider each case on its merits.

You have indicated that MA will use its discretion in dealing with the question of recovery of benefits. In exercising its discretion the ADA would hope that Medicare would take account of the appropriateness and necessity of treatment received and if it finds that the treatment was appropriate and necessary then regardless of the administrative oversight it will not, in the public interest, seek recovery of payments.

The ADA recognises that no hard and fast rule can be adopted by Medicare in these circumstances. The ADA would ask MA to agree to take account of the mitigating factors listed below in determining the application of its discretion in reviewing individual situations.

Should Medicare require any assistance in any determination of issues in respect of any situation, the ADA would be happy to assist. The ADA has expertise in this area, and would be happy to make this available to Medicare Australia in the hope that this will resolve the issues between MA and the relevant dentists.

Mitigating factors:

The ADA does not dispute that information as to the administrative requirements of the Scheme was conveyed by MA to members.

Without wishing to attribute or point blame elsewhere for the failure on the part of dentists to comply with the requirements of the Scheme, it is relevant to point out the following in mitigation of the conduct adopted by members in making claims for services upon Medicare under the scheme:

I. Up until the commencement of the scheme, dentists within Australia had very limited experience of dealing with claims involving Medicare and its rules. Most dentists would be familiar with the Department of Veteran Affairs' procedures which although administered by MA differ in some relevant respects from the Medicare claiming model used for the Scheme. Most members' familiarity with the Medicare scheme would have been through their own participation in obtaining general health Medicare benefits for their own medical treatment. Most would therefore have been unaware of any administrative requirements and are not used to the involvement of GPs.

II. Whilst Section 10 of the Legislation clearly imposes prerequisites before a dental service can be considered a Medicare service, the clear cut nature of that prerequisite was not clearly set out in the Medicare Benefits Schedule Publication, the Information for Dentists and Dental Specialists documentation placed on the Department's website, nor in the letter of instruction from the Minister to dentists.

It is conceded that messages similar to those set out in Section 10 were provided, but the messages were not consistent and some discrepancy and ambiguity in requirements for compliance have arisen. MA and more specifically the Department of Health and Ageing seem to concede that the education program to dentists in respect of this scheme was not as comprehensive as it would have liked. This has arisen no doubt in part due to political attempts to close down the scheme and to replace it with an alternate Commonwealth Dental Program. It would seem that the Department (and to some extent this Association) knowing this, did not perhaps embark upon as comprehensive an education program as it could have otherwise undertaken.

Without wanting to go into too much specific detail, examples of some inconsistency can be seen when you examine the checklist on page 16 of the Medicare Benefits Schedule Booklet. It refers to the two prerequisites mentioned in Section 10, but does so in a much more relaxed (and non specific) context.

In the booklet, 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 documentation to be provided, nor does it stipulate the time at which those requirements have to be met. Whilst included in a checklist, these matters are not listed as being pre requisites of a valid Medicare service as indicated in Section 10.

Whilst emphasising again that clearly that there was information indicating the necessity for these prerequisites to be satisfied, it has not been made abundantly clear in documentation.

The 'Information for Dentists and Dental Specialist' document summarises in coloured highlighted boxes the key elements of the scheme. Nowhere in those highlighted sections are the prerequisites identified. Whilst the document stipulates dental practitioners "to provide a copy or summary of the patients treatment plan to the referring GP at the commencement of the course of the treatment" and requires dental practitioners "to provide a written quote or cost estimate to the patient prior to commencing a course of treatment", those comments are inconsistent with the checklist and fail to stipulate the absolute necessity to comply with Section 10. This document still makes it unclear whether it is absolutely necessary for a written treatment plan or written cost estimate to be provided.

A simple statement setting out the Section 10 requirements as pre requisites may have alerted dentists to the importance of the requirements.

III. It should be noted that non compliance with these administrative requirements does not automatically mean that the services rendered by dentists to eligible patients were not in fact provided. In many instances essential and necessary treatments were provided. It would seem inappropriate, and unjust, if dentists were required to reimburse fees (appropriately rendered but for administrative oversight) for genuine services required to be received by a patient to restore dental health.

IV. The requirement to provide a treatment plan to the treating medical GP has always been seen by participants in the Scheme (medical GP, dentist and patient) as a formality with the medical GP being in no real position to question the quality of appropriateness of treatment plan provided. Anecdotally, GPs spoken to by representatives of the ADA have always provided comment along these lines and have often questioned the worth of this requirement.

Whilst you are no doubt already acutely aware of this, the goodwill of the dental profession's participation in this Scheme and other Government funded Schemes may be tested if recovery actions are implemented in cases where valid and appropriate treatments were provided to patients under the Scheme. Many dentists may see such action as being unfairly penalising the provider of services.

The ADA has not heard of any suggestion of this but feels it would be remiss of the Association to not point this out.

Going forward:

In respect of the future, the ADA would be more than happy to assist MA in embarking upon a proper and comprehensive education program to members. The facilities and communication channels available through ADA and its Branches will be made available to you.

Yours faithfully,

RN Boyd-Boland
Chief Executive Officer

Australian Government
Medicare Australia
If not delivered return to PO Box 1001 Tuggeranong DC ACT 2901

30 March 2010

Mr Robert Boland-Boyle
Chief Executive Officer
Australian Dental Association
PO Box 520
ST LEONARDS NSW 1590

Dear Robert,

Re: Chronic Disease Dental Scheme

Thank you for your letter dated 19th March 2010 in relation to the compliance activity being undertaken by Medicare Australia on the Chronic Disease Dental Scheme.

In terms of your proposal of a way forward I make the following comments:

Whilst Medicare Australia is adopting the position that it will not look to recover benefits paid for claims made prior to services being provided where those services are provide within 3 months, we are looking for providers to change their billing behaviour moving forward. I note that we have provided some words for your next newsletter in relation to this issue. We are happy to continue to work with you to communicate this message.

In relation to claims where the provider has failed to meet the requirements of section 10 of the *Health Insurance (Dental Services) Determination 2007*, I would like to highlight that the requirements of section 10 are integral to the scheme and are not purely administrative. Section 10 requires that the patient is fully informed as to the treatment being provided and the full cost of that treatment. It also ensures that the referring practitioner is aware of the treatment being provided to the patient.

Whilst Medicare Australia will be taking all of the circumstances of each individual case into account when determining whether recovery of monies is appropriate, it is not Medicare Australia's role to determine whether the treatment itself was appropriate or necessary.

I note the mitigating factors I – IV outlined in your letter. We will give these due consideration prior to determining our action on individual cases.

At present Medicare Australia is continuing to interview dental providers. Until such time as all these interviews are complete we will not be in a position to determine our position on each case. We had expected to have all initial compliance activity finalised by the end of March, however, there have been some delays as some providers have sought legal assistance.

I will continue to keep you informed as to progress and thank you for your co-operation and assistance in relation to this matter. If you have any further questions please contact me on 02 6124 6376 or 0434 606 216.

Yours sincerely

Kathy Dennis
Branch Manager
Compliance Strategy, Intelligence and Design
Compliance and Business Services Division
Medicare Australia

2

Australian Government
Medicare Australia
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29 April 2011

Phone: **02 6124 6300**
(Call charges may apply)

<Title> <Name> <Surname>
<Address 1>
<Address 2>
<SUBURB> <STATE> <Postcode>

Our reference: <reference>

Dear <Title> <Surname>

Increased Audit of Chronic Disease Dental Scheme

In June 2010, Medicare Australia wrote to all dental practitioners who were participating in the Chronic Disease Dental Scheme about a compliance project being undertaken in relation to the scheme. In that letter, Medicare Australia outlined concerns about dental practitioners claiming under the scheme and provided information about the legal requirements. These matters were drawn to your attention to give you the opportunity to ensure your claiming practices are compliant.

Since that time, Medicare Australia has undertaken a program of audits of dental practitioners who have made claims under the scheme. In the conduct of these audits Medicare Australia has found that 41% of practitioners complied, or made genuine attempts to comply, with the requirements of the scheme. I acknowledge the effort and professionalism of dental practitioners who have sought to comply with the scheme. I also appreciate the efforts of the Australian Dental Association which I note has been making information available to members about the scheme since October 2007.

While many dental practitioners are claiming correctly, these audit findings have also shown a high level of non-compliance with the legal requirements, particularly the requirements of section 10 of the *Health Insurance (Dental Services) Determination 2007* (the Determination). In addition, Medicare Australia has received hundreds of complaints from patients about dental practitioners claiming under the scheme. The results of these audits have given rise to significant concern about the use of the scheme across the dental profession.

The purpose of this scheme is to improve the health outcomes of sufferers of chronic disease. The section 10 requirements go to the core of the scheme and are essential to fulfilling this purpose. The requirements of section 10 of the Determination are as follows:

- Dental practitioners must provide patients with a written quotation for each dental service and each other service (if any) in the plan prior to commencing the course of treatment. This is to ensure patients give full financial consent to the services.
- Dental practitioners must provide patients with a written plan of the course of treatment prior to commencing the treatment. Dental practitioners must also provide referring general practitioners with a copy or written summary of the treatment plan prior to commencing the course of treatment. This is to facilitate appropriate communication

between health professionals to ensure adequate and appropriate care. It also ensures that the patient is aware of the full course of treatment.

These two requirements are explicitly about patients' rights and placing the referring general practitioner in an informed position to manage the overall health of the patient. This is not red tape. Failure to notify the referring general practitioner represents a serious level of non-compliance that undermines the integrity of the scheme, does a disservice to sufferers of chronic disease and potentially puts patients' health outcomes at risk.

In addition, there are specific requirements for any claim or billing under the Medicare program. For example, health professionals may only claim Medicare benefits after the service has been rendered and the service must meet the relevant Medicare Benefits Schedule item descriptor.

A range of information has been provided to dental practitioners and is available to explain the requirements of the scheme. In particular, the Medicare Benefits Schedule Dental Services Book was sent to dental practitioners who were members of the Australian Dental Association at the commencement of the scheme. If you have not already done so, you should make yourself aware of the content of the explanatory notes as well as the item descriptors. The Medicare Benefits Schedule Dental Services Book continues to be available on the website of the Department of Health and Ageing, along with a fact sheet for dental practitioners.

It is the basic responsibility of all health professionals who bill or claim benefits under the Medicare program to acquaint themselves with the requirements and to ensure their claims are fully compliant.

Medicare Australia has taken a fair and reasonable approach to conducting audits under the scheme. Audits have generally been confined to a two year period rather than the three years of claiming under the scheme. Medicare Australia has considered all information provided by dental practitioners that could potentially demonstrate compliance with the requirement to provide a treatment plan to patients and referring general practitioners. Medicare Australia has and will continue to accept standard industry practice of what constitutes a dental treatment plan. Medicare Australia has also focused primarily on those cases where the section 10 requirements were not met in relation to any of the claims made.

It is Medicare Australia's obligation to ensure the integrity of the programs it administers and that taxpayer funds are spent correctly. As a result of the findings, I am writing now to inform you that Medicare Australia is increasing audits of dental practitioners claiming under the scheme. A Chronic Disease Dental Scheme Taskforce that was established in June 2010 will be expanded to undertake this extra work.

Medicare Australia will continue to be flexible in our audit approach, but will seek recovery of benefits where there is a clear pattern of serious non-compliance with the core requirements of the scheme. Medicare Australia considers that clear and unambiguous information about the scheme's requirements is available to dental practitioners and expects that all claiming under the scheme strictly adhere to these requirements.

It is also clear that many dental practitioners have been less than cooperative in responding to Medicare Australia's audit activity. I urge you to cooperate with Medicare Australia's audit activities. You should be aware that, if insufficient information is provided by a dental practitioner in the course of an audit, given the seriousness of failure to comply with the requirements, patients and referring general practitioners will be contacted to determine each dental practitioner's level of compliance. Medicare Australia is seeking significant recoveries

from a number of dental practitioners who have been found to be non-compliant on the basis of information provided by patients and referring general practitioners.

I also draw your attention to the recently passed *Health Insurance Amendment (Compliance) Bill 2010*. The new law enables Medicare Australia to compel health professionals to produce documents to substantiate claims, enables the recovery of claims that are not substantiated, and introduces financial penalties for health professionals who do not comply with the law. These provisions will only apply to services rendered after the Bill becomes law, however Medicare Australia will continue to pursue recovery of incorrectly claimed benefits that were paid in relation to past services where serious non-compliance is found.

As indicated above, information about the requirements of the scheme is set out in the Medicare Dental Services Book. This is available on the website of the Department of Health and Ageing at **www.health.gov.au >Programs & Campaigns >Programs & Initiatives >Dental Health**

I urge all dental practitioners to review their claiming under the scheme to check that all the legal requirements are met. This will ensure the scheme operates optimally to improve the health outcomes of chronic disease sufferers. Where dental practitioners can show that efforts have been made to rectify non-compliance, Medicare Australia will take this into account when considering what action to take when non-compliance is detected.

If your claiming is compliant with the legal requirements of the scheme, you need not be worried about Medicare Australia's compliance activities. However, if you have any concerns about the requirements of the scheme or about your claiming under the scheme, I urge you to contact Medicare Australia to discuss your concerns as soon as possible. You can write to Medicare Australia by email at **Compliance.CDDS.Taskforce@medicareaustralia.gov.au**

Yours sincerely

Lynelle Briggs
Chief Executive Officer
Medicare Australia

AUSTRALIAN DENTAL ASSOCIATION INC.

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17 June 2011

The Chief of Staff,
Minister for Human Services
PO Box 6022
House of Representatives
Parliament House
Canberra ACT 2600

Dear Ms Wood,

The Australian Dental Association Inc. (ADA) would like to thank you and the Hon Tanya Plibersek MP, Minister for Human Services, for meeting with us to discuss the ADA's concerns regarding Medicare Australia's (MA) audit processes relating to dentists' treatment of patients under the Medicare Chronic Disease Dental Scheme (the Scheme).

It was our understanding following the meeting that a genuine attempt would be made by all parties, as the Minister directed "to sort something out" regarding the issues discussed. However, the ADA remains very concerned with reports it is receiving from members regarding the behaviour of MA in their audit reviews.

Since the initial meeting with yourself and Minister Plibersek, the ADA has met with representatives from MA in person and held a number of discussions electronically. The ADA believed a way forward had been agreed to with the satisfaction of all parties. This resolution involved the development of a protocol which, was felt (by us at least), would recognise that many dentists had provided valuable and essential treatment to patients but did so while innocently overlooking the administrative requirements of the Scheme. I emphasise that the ADA's focus in this matter has solely been on those dentists that provided these valuable services but in non-compliance with the administrative aspects of the Scheme. The ADA does not condone any fraud that may have occurred under the Scheme and repeats its offer to assist MA in the prosecution of all such claims.

Both MA and the ADA then worked upon a communication plan that would inform dentists of the action that they needed to take to become compliant with the Scheme and to avoid liability to refund monies paid by MA where innocent non-compliance had occurred.

I attach two documents that were prepared following that meeting:

i) A copy of the President's Comments that were published in the ADA's May 2011 edition of its News Bulletin. These comments were vetted and amended at Medicare's direction prior to publication and were therefore endorsed by MA.

   I draw your attention to the highlighted sections of the article and, in particular, those sections highlighted in yellow.

ii) A copy of the letter of 29 April 2011 sent out to dentists by MA. Again, your attention is drawn to the highlighted sections of the letter and, in particular, those sections highlighted in yellow.

It was our clear understanding from the meetings that there was recognition of the fact that despite assertions to the contrary, most dentists were not aware of the administrative requirements of the Scheme prior to the joint communication activity of the ADA and MA in early 2010. In view of this, it was understood by the ADA that where there was evidence of non-compliance prior to April 2010, but then later evidence of compliance post April 2010, that account of this would be taken and the earlier non-compliance excused and in most cases, recovery of benefits paid to patients would not claimed by MA. In explanation, MA would exercise the discretion referred to in the correspondence.

Any reading of the above documents would bear this out.

Information now received by the ADA from its members is that MA is not acting in accordance with the direction of the Minister, nor within the spirit of the agreed protocol. In virtually all instances of non-compliance, claims for recovery are being made. No account is being taken of the compliance activities of members from April 2010. The ADA feels it has been misled. Other data suggests that information supplied by MA to the Minister in the meeting about there being 50% compliance with the administrative requirements by dentists was grossly misleading. Later advice from MA told us that this level of compliance was overstated.

The Scheme is one that the ADA has never supported. It was ill-conceived and badly designed. The ADA has supported the Government in calls for its closure and the introduction of a scheme targeting the disadvantaged. Notwithstanding this, Australian dentists, who have provided dental services to chronically-ill Australians are now being penalised due to their failure to comply with administrative requirements which were never clearly communicated. I would refer you to the attached letter from the ADA to Kathy Dennis of 19 March 2010 that dealt with the relevant issues. It was not until the time of this letter that any detailed requirements of the Scheme were presented to dentists through the ADA's communications (News Bulletin/Website/E-newsletter and Educational CD).

Dentists are being made the scapegoat for the Scheme's failures. The conduct of MA in their ruthless pursuit of recovery has only served to create distrust and suspicion among dentists with Government schemes. Significant financial hardship leading to bankruptcy in some cases, closure of surgeries in others has and will continue to occur – all attributable to administrative non-compliance with a scheme that delivered needed services to the chronically ill.

Action needs to be taken urgently to ensure that MA immediately instigates protocols that are more reflective of the sentiments expressed in our meetings and the above correspondence.

At this stage, there is absolutely no evidence that:

> *"Where dental practitioners can show that efforts have been made to rectify non-compliance, Medicare Australia will take this into account when considering what action to take when non-compliance is detected".* (Medicare Australia letter 29 April 2011.)

Further, there is no evidence that members' actions, in response to the MA endorsed ADA President's Comments, have been given the consideration that had been indicated by MA where he stated:

> *"So, in summary, all practitioners who have been involved with the CDDS should get their house in order, review their records and correct all administrative discrepancies. If you are the subject of an investigation or audit by MA now or in the future your ability to demonstrate a change in your administrative behaviour with respect to the CDDS will hold you in good stead and allow MA the option of exercising some discretion in your favour when they are reviewing your CDDS compliance level."* (ADA News Bulletin, May 2011 – President's Comments)

We ask that we be given an immediate meeting with the Minister and MA to clarify this situation so that a greater degree of fairness and equity is provided to dentists.

Yours faithfully,

Robert Boyd-Boland
Chief Executive Officer.

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The Hon Tanya Plibersek MP
Minister for Human Services
Minister for Social Inclusion

Mr Robert Boyd-Boland
Chief Executive Officer
Australian Dental Association
PO Box 520
ST LEONARDS NSW 1590

Dear Mr Boyd-Boland

I refer to your letter dated 20 June 2011 and the meeting on 13 July 2011 with you and Dr Fryer representing the Australian Dental Association Inc. (ADA) and senior representatives from the Department of Human Services Medicare Program (DHS). I thank you and Dr Fryer for your attendance at the meeting which I consider clarified a number of matters associated with the audits being conducted on the conduct of the Chronic Disease Dental Scheme (CDDS).

At this meeting and in your letter the ADA raised concerns about the manner in which DHS is managing situations where dental practitioners have retrospectively rectified non-compliance with CDDS requirements by providing treatment plans and quotes after the provision of services to the patient.

Dr Fryer was particularly concerned that the comments provided by him in the ADA News Bulletin of 11 May stating in summary that "dental practitioners should get their house in order, review their records and correct all administrative deficiencies and that such actions will hold them in good stead if they are subject of an investigation or audit" were now being shown to be inaccurate in view of the actions of DHS.

I can assure you that this advice to the members of the ADA was accurate and was greatly appreciated by me and DHS. This advice stands. As I am advised and was mentioned by DHS at our meeting, once an audit by DHS has been notified or commenced such retrospective action would be unlikely to be taken as compliance with the requirement of the CDDS, however, DHS does consider such circumstances on a case by case basis. I can confirm that there have been a number of instances where DHS has used its discretion in relation to dental practitioners' compliance with the CDDS requirements and has provided education and not sought recovery, due to the particular pattern of non-compliance identified.

Dr Fryer and you 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

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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 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 high billing category of audits to be conducted includes dental practitioners identified as high billers of the Scheme with a high benefit claimed per patient average when compared to their peers.

Where tip offs or complaints are received about dental practitioners compliance with the CDDS , DHS is obligated to assess the concerns raised in the complaints and will conduct its audits by examining records from the dates relevant to the complaints, which may be prior to April 2010. To date the majority of audits undertaken by DHS have related to tip offs or complaints but will be now complemented by the high billing category audits.

I would like to reiterate that the legislative requirements associated with the Chronic Disease Dental Scheme are aimed at assisting patients suffering from chronic disease. These requirements are essential and facilitate appropriate communication between the patient, the treating general practitioner and the dental practitioner to ensure adequate patient care is provided. In addition, the requirements are necessary to ensure that patients fully understand the treatment they are receiving and the cost of that treatment, regardless of any out of pocket expenses. As well Medicare is required to conduct assurance activities to ensure that the public funds expended on the CDDS are being used in accordance with legislative requirements.

I would ask that you pass on to the members of the ADA that while each audit involving a dentist is considered on an individual basis and the dentist's current and retrospective efforts in complying with the requirements of the CDDS are taken into account, there is no scope for DHS to not follow through on recovery action when warranted.

I have been advised that shortly a further meeting will be arranged between senior representatives of Medicare and the ADA to continue discussions on these and other issues relevant to the ADA.

I would like to assure you that I have asked DHS to continue to work in close partnership with you and I appreciate your efforts in ensuring that dental practitioners have all the information they require to successfully operate within the requirements of the CDDS.

Yours sincerely

Tanya Plibersek

29.7.11

CHRONIC DISEASE DENTAL SCHEME ADVICE FROM MEDICARE

Medicare Australia has completed phase one of a two-phased compliance project to determine the level of compliance with requirements of the Chronic Disease Dental Scheme.

Findings of phase one of the compliance project have identified concerns that a number of dental practitioners have:

- Failed to meet the requirements of Section 10 of the *Health Insurance (Dental Services) Determination 2007* to produce a treatment plan and provide informed financial consent; and lodged claims for benefits prior to completing the services.
- Lodged claims for benefits prior to completing the services.

These concerns were identified through an internal assessment and analysis of claiming data, information supplied to the Medicare fraud tip-off line, complaints by State law agencies, and interviews with a number of dental practitioners.

Under phase two of the compliance project, Medicare Australia will examine these issues through a series of targeted audits. Medicare Australia will be contacting a number of dental practitioners and making enquiries about their compliance with the requirements of the Scheme commencing in January 2010.

WHAT DOES AN AUDIT INVOLVE?

A compliance audit currently involves notifying a practitioner that there is an identified concern in their claiming history, and seeking an explanation or evidence to support the claims that have been made.

It is important to distinguish between a compliance audit and a criminal investigation. Audits are primarily aimed at addressing incorrect claims that have resulted from misunderstanding, carelessness or recklessness. Criminal investigations commence when there is a suspicion or evidence of intentional fraud or deliberate non-compliance.

To respond to an audit request, a provider can make copies of the relevant documents or electronic files that they feel adequately demonstrate their compliance with the item descriptor. On some occasions, we may also invite the practitioner to take part in a phone or face-to-face meeting to discuss the concerns identified.

The majority of Medicare Australia audits went with our concerns being addressed and no further action being taken. In other cases, the documents show that the claim was not eligible. When this occurs Medicare Australia seeks recovery of the benefits paid.

Kathy Dennis
Branch Manager
Compliance Strategy, Intelligence and Design

DRAFT STANDARD FOR EXCHANGE OF DENTAL FEES INFORMATION (DeIDC)

Every year the ADA sends each of its members a request for information to enable preparation of the ADA Dental Fee Survey. This is a paper based questionnaire where members record the standard fees they charge for each service. The response is provided to the ADA and the data analysed and the ADA Dental Fee Survey prepared.

The ADA is encouraging suppliers of practice management software to implement a direct data upload facility so that a member can select an option to automatically and anonymously upload the data directly from their computer system. This should be much quicker and easier than completing the survey entirely manually. This is known as **DeIDC** or **De-identified Data capture.** Adoption of this method of data provision should simplify the process for members.

The ADA has prepared a draft technical specification of how this will function for consideration by practice management software vendors (and others). It is located here: www.ada.org.au/filestore/deidc/DeIDC_data_specification.zip

Members of the ADA should note that use of the automated DeIDC system is entirely optional; no data is uploaded without the member explicitly requesting it, and the fees survey form can still be completed manually if preferred.

A high level description of DeIDC suitable for interested members can be found here: www.ada.org.au/filestore/deidc/DEIDC_information_for_members.docx. It describes what information is collected electronically, what use is made of the information, and how members' privacy is protected.

Both documents provide contact details should you wish to comment or need further information.

Robert Boyd-Boland
Chief Executive Officer

UPDATE ADVICE TO MEMBERS MEDICARE-CHRONIC DISEASE DENTAL SCHEME AUDIT

Following on previous notices placed on the ADA Members website on 22 December, 24 December 2009 and 1 March 2010, members are advised that Medicare is continuing their audits relating to the Medicare chronic disease dental scheme.

Medicare has confirmed that they are currently investigating 28 dentists – 24 in NSW and four in Victoria and following these additional audits may be undertaken.

There are three major areas being investigated by Medicare and they are those dentists that have:

1. Failed to comply with Section 10 of the Health Insurance (Dental Services) Determination 2007 which states that before an eligible dental service is a service under the Medicare scheme the dentist must provide:

   i) the eligible patient, in writing, a plan of the course of treatment and a quotation for each dental service and each other service, and

   ii) a written summary of the plan to the referring general practitioner.

2. Billed Medicare and been paid by Medicare for services that had not yet been rendered.

3. Billed for services as having been delivered, but which were not performed.

The ADA would like to advise all members that it is in discussions with Medicare with a view to identifying how the audit process can best be completed to the satisfaction of members.

Members who have any concern with compliance issues regarding the Scheme should visit the Department of Health and Ageing website located at: **http://www.health.gov.au/internet/main/publishing.nsf/Content/Dental+Care+Services**

Whilst the ADA has opposed the 'universality' of the Scheme, it recognizes that many disadvantaged Australians have received much needed dental treatment under it. The ADA maintains its position that governments must focus their funding to the disadvantaged.

Should members be contacted by Medicare, they should contact their Branch or ADA National Office on 02 9906 4412.

Please be assured that we are doing everything we can to solve this issue.

Robert Boyd-Boland
Chief Executive Officer
11 March 2010

THIS MONTH IN THE DENTAL FILES

In addition to our audio interviews, this month's disk includes an on-demand lecture with Professor Grant Townsend on the 'Inferior alveolar nerve block'. You can access the file from the disk or via the ADA's website.

Orofacial Pain

We begin our program with another in a series of interviews recorded at the American Dental Association's Annual General Meeting held in Honolulu, Hawaii. Dr Henry Gremillion is Dean of the Louisianna State University School of Dentistry and former Director of the Orofacial Pain Center at the University of Florida. In this interview with Dr Kareen Mekertichian, Henry discusses one of the most challenging aspects of dental practice – diagnosis and treatment of orofacial pain.

Professional Ethics

Dentists today face working in a litigious society with a real potential for legal issues arising out of everyday practice. Ms Jane Walton is a lawyer, ethicist and presenter who specializes in helping professionals maintain positive relationships and avoid complaints and litigation. This interview is the first of a two-part talk with Jane and Dr Patrick Meaney.

Dentine Hypersensitivity

Professor Mark Wolff is Associate Dean and Chairman of the Department of Cariology and Comprehensive Care at New York University College of Dentistry. One of Mark's chief research interests has been dentine hypersensitivity. In this interview with Dr Sarah Raphael, Mark discusses the aetiology of the condition as well as new options for treating the problem.

Fire Safety

Starting as a fire fighter and rising through the ranks, Mr Clinton Demkin has over 26 years of experience with the NSW Fire Brigade. In this interview with Dr Patrick Meaney, Clinton talks about some of the essential elements of implementing a fire safety plan for your surgery.

Immediate Implants

Dr Georgios Romanos is Professor of Clinical Dentistry Director of the Unit of Laser Dentistry at the Eastman Dental Center, University of Rochester, Rochester, NY. He is also Associate Professor of Oral Surgery and Implantology, University of Frankfurt. On a recent visit to Australia, Professor Romanos kindly took time to speak with our interviewer, Dr George Alexopoulos. We would like to thank DENTSPLY Australia for their support of the interview.

Infection Control Update

The ADA has recently updated their publication of standards and guidelines for infection control in dentistry. One of the people responsible for helping to develop the ADA *Guidelines for Infection Control* is Dr Liz Coates of the University of Adelaide. In this conversation with Dr Patrick Meaney, Liz highlights some of the recent changes to recommended infection control protocols.

Patrick Meaney

president's comments

Neil Hewson
Federal President

"To help comply with the third requirement, [to keep a record of CPD activities] I recommend to members the very good system the ADA has on its website where members can record their CPD experience."

MEDICARE AUDIT

Recently, all members should have received a letter from Medicare Australia regarding participation in the Chronic Disease Dental Scheme (CDDS) and their audit process. Medicare Australia is responsible for paying benefits under the Medicare Benefits Schedule and can audit practitioners. This letter was sent in response to the ADA suggesting to Medicare it should better inform dentists as to their responsibilities under the Scheme.

Audits of dentists have revealed that dentists are in error in three areas and to avoid these errors and so not be liable to repay claimed money dentists must:

1. Provide patients with a written (printed) dental treatment plan including an itemised quotation of proposed charges;

2. Provide a copy of summary treatment plan to the referring medical GP; and

3. Only claim for completed treatment.

Note that points 1. and 2. must be done ***before*** starting reatment. However, approval of the treatment plan by the referring medical GP is not required. The patient, of course, must consent to the treatment.

Members must ensure their claiming practices comply with these rules and so not be liable to repay any incorrect claimed amounts.

A fourth area of non-compliance has also been exposed. Unfortunately, some dentists have claimed for treatment they have not done; such fraudulent behaviour is unforgivable and the ADA will not support those dentists.

More information on the CDDS can be found on the ADA website www.ada.org.au and the Department of Health and Ageing website http://www.health.gov.au/.

It is essential that all dentists participating in the CDDS are fully conversant with the requirements as ignorance of the rules will not be a defence to charges of incorrectly obtaining money from Medicare.

DENTAL BOARD OF AUSTRALIA

Members, other than those in Western Australia, will now be registered nationally with the Dental Board of Australia (DBA) and have to practise under the National Act and the DBA's Standards and Codes. These can be found at the Australian Health Practitioner Regulatory Agency website http://www.ahpra.gov.au and clicking 'Dental' to go to the DBA section. I urge all members to familiarize themselves with them. Also I have received reports that some members' details on the register are incorrect and advise all members to check that their details are correct. The May *News Bulletin* provided a good summary. This and other DBA material can also be found on the ADA website. For many there will be substantial changes, while for those who reside in Victoria and the ACT less so.

One of the substantial changes is the mandatory CPD requirements and so from 1 July 2010 dentists will have to:

- Complete 60 hours of CPD every three years;
- Have a minimum of 80 per cent of their CPD hours as scientific material; and
- Be responsible for keeping records that validate that they have met this requirement.

To help comply with the third requirement, I recommend members use a facility I have used for a few years now – the very good system the ADA has on its website where members can record their CPD experience.

To use this recording system:

- Log in as a member;
- Next click the 'Edit My Profile' button;
- Then click 'Manage CPD';
- After that it is easy to enter the details; and
- Subsequently you can see your totals of scientific and non-scientific hours for any time span you specify (see page 24 for more details).

VISIT

Late last month, the CEO and I met the British Dental Association National President, Dr Amarjit Gill when he visited the ADA. Many common dental issues were discussed; of particular note was the fact that now in the United Kingdom over 60 per cent of dental treatment is being done privately. This further indicates the failure of the National Health System and why, in Australia, a universal dental scheme should not be introduced.

COME ON BOARD AND BE PART OF THE TEAM

Opportunities now exist for you to join your colleagues and contribute to your profession by nominating for ADA Inc. Standing Committees. All those who have served on ADA Inc. Standing Committees have found the experience most rewarding and have enjoyed meeting and working with their colleagues from other Branches. See which committee suits your interests and expertise and nominate now.

NOMINATIONS FOR ELECTION TO ADA STANDING COMMITTEES

At the meeting of the Federal Council to be held on 18/19 November 2010, election of members to the Standing Committees of the Association will be conducted. It is open to any member to lodge nominations for election to these Committees.

How to nominate: Appropriate nomination forms should be used and these will be available from Branches. It should be noted that By-Law VI [Committees] requires that the nomination form "...shall provide details of the nominee's experience and offices held and shall indicate willingness of the nominee to act if so elected..."

Timing: Completed forms should be in the hands of the Chief Executive Officer no later than four weeks prior to the meeting, i.e., by **Monday, 11 October 2010**.

Nominations are required for the following Standing Committees:

- Constitution Committee
- Continuing Professional Development Committee
- Dental Instruments, Materials and Equipment Committee
- Dental Therapeutics Committee
- Dental Workforce and Education Committee
- Infection Control Committee
- Oral Health Committee
- Policy Committee
- Schedule and Third Party Committee

Members who are considering making a nomination to a Committee are advised that access to the terms of reference for each Committee (By-Law VI & VII of the Federal Constitution) are available on the ADA website.

If this is impractical, the Federal office will willingly supply photocopies of the relevant sections. Please telephone the Council and Committee Services Manager, Sharon Reid on 02 9906 4412 or email: nom.stand@ada.org.au

Robert Boyd-Boland
Chief Executive Officer

CHRONIC DENTAL DISEASE SCHEME AND DENTAL SPECIALISTS

Medicare Australia has made considerable efforts to alert dentists as to their administrative requirements under the Chronic Dental Disease Scheme (CDDS). It has advised that in respect of each referral under the Scheme, dentists must ensure that prior to the commencement of treatments they provide:

- the patient with an itemised treatment plan, including all financial details (quotation), and
- a copy or summary of the treatment plan to the referring medical general practitioner provider.

Dental specialists need to be aware that if a patient is referred to them by the treating general dental practitioner (GDP) then the dental specialist has the same obligations.

Medicare was recently asked two questions. The questions and answers are set out below:

Q. If a patient is referred to a dental specialist by a general dental practitioner (GDP), do they have to write to the general medical practitioner (GMP) to advise of treatment?

A. Yes, a dental specialist must provide a written summary of the treatment plan to the referring GDP and GMP before beginning the course of treatment. This requirement is in Section 10 (2) of the Health Insurance (Dental Services) Determination 2007. The referring dentist is instructed by the Medicare Benefits Schedule (Dental Services) in its 'Checklist for Dental Practitioners' and in its explanatory notes that a copy of the GMP referral form be included in all referrals between dental practitioners. This instruction is also included on the GMP referral form. The copy of the referral will have the referring GMP's details for reporting purposes.

Q. Will the specialist be deemed section 10 non-compliant if they don't write to the GMP?

A. As above, in order to comply with requirements of Section 10 (2) of the Health Insurance (Dental Services) Determination 2007, a specialist must provide a written summary of the treatment plan to the referring GDP and GMP before beginning the course of treatment, as well as providing the patient with appropriate treatment plans and quotations.

Robert Boyd-Boland
Chief Executive Officer

Update:

MEDICARE CHRONIC DENTAL DISEASE SCHEME

Members will have noted regular reports published in various ADA publications on activity associated with dentists' use of the Medicare Chronic Dental Disease Scheme (CDDS).

Since late 2009, when the ADA was first advised by Medicare Australia (Medicare) of audit processes being implemented surrounding the CDDS, the ADA has been in constant communication with Medicare as to their actions. Through its publications, the ADA has kept members informed as to dentists' requirements and obligations for work done pursuant to the CDDS.

It was evident from early meetings with Medicare, there were two very distinct concerns being addressed:

- Abuse and exploitation of the CDDS by some dentists; and

Technical non-compliance with rules applicable to the CDDS.

The ADA made it clear to Medicare that it would not condone fraud and would assist Medicare in dealing with such cases.

A major concern to Medicare (and the ADA) was that in many instances where treatment had been provided under the CDDS, dentists had not been fully compliant with the administrative requirements. Two major administrative requirements not being observed were the need to:

- provide a treatment plan for the dental treatment to be undertaken to the Medical General Practitioner (MGP); and

- advise the patient of the anticipated cost of the treatment to be undertaken.

ADA felt it was important for Medicare to be made aware of dentists' lack of familiarity with the CDDS requirements and to alert Medicare that non-compliance with these administrative requirements was in most cases innocent and done out of ignorance of the requirements. Medicare was advised that comments made by the Federal Health Minister advising of immediate closure of the CDDS had also imposed significant pressure on dentists to meet patient needs before closure. These matters lead dentists to inadvertently overlook the technical aspects of the scheme (See: *ADA Member website - Item of interest: 16 July 2010 Exchanges of correspondence between ADA and Medicare Australia*). Notwithstanding this Medicare advised ADA that dentists' non-compliant behaviour under the CDDS was widespread and indicated that a preliminary audit process would begin and depending on what was revealed may escalate into a wider audit process.

During the first half of 2010, Medicare continued to inform ADA of the nature and extent of the audit process. Through contact with members, ADA became aware of a poor lack of appreciation by dentists as to the fundamental importance of compliance with the CDDS administrative requirements. Medicare was advised of this. Regular reports and advice were published in ADA publications. Considerable assistance has been provided by Branches in this process particularly, ADANSW and Dr David Sweeney.

It should be remembered that contemporaneously with this activity was the Government's efforts to implement a Commonwealth Dental Health Program (CDHP) which would have provided funding to States and Territories to bolster public dental services. This legislation was not passed as the Government insisted that the CDDS be closed down as a prerequisite for establishment of the CDHP. The Senate did not oblige and a stalemate has resulted with the continuation of the CDDS.

In mid-year, ADA suggested that Medicare should again alert dentists as to the administrative requirements of the CDDS. This culminated in all practitioners receiving a letter of advice and instruction from Medicare as to the absolute necessity for compliance with its requirements.

At this time, adverse publicity was created which suggested rorting of the CDDS by dentists. Budget blowouts in respect of the CDDS were said to be solely attributable to abuse by dentists. The ADA met this head on and published rebuttals to the press reports. Media releases and discussions with journalists set the record straight that in the vast majority of cases the so

called 'rorting' was no more than an administrative oversight by dentists. The ADA also pointed out that whilst it did not support the Scheme (due to it not being means tested) many Australians had received some worthwhile dental care that may otherwise have not been available to them. Budget blowouts were identified as being attributable to the lack of appreciation by Government in its budgetary process as to the degree of unmet dental need in the community and the the significant uptake of the funds available. (*See Media Release on ADA website, 10 June 2010*).

Cynics might suggest the Government's frustration at their inability to close down the CDDS (due to opposition in the Senate) was being directed at the dental profession.

Following ADA contact with the Minister's office, media releases and numerous media interviews by the ADA President, Dr Neil Hewson, the Honourable Chris Bowen, Minister for Financial Services, Superannuation and Corporate Law and Minister for Human Services was reported as stating that breaches under the CDDS by dentists were in most cases "accidental". The ADA's response was seen as having some impact.

As Medicare were continuing with their audits and finding dentists were non-compliant with the administrative requirements of the CDDS, it was felt a meeting with Minister Bowen may achieve some political or administrative solution to the matter. In late June a meeting was agreed to but cancelled by the Minister. A new date was set for late July but in the interim the Federal Election was called necessitating the cancellation of the meeting as the Government was in 'Caretaker' mode.

Medicare continue their audit process and have now advised ADA that there are a further 300 dentists likely to undergo an audit by Medicare.

Recent ADA *News Bulletins* have provided useful information as to CDDS requirements to be observed and the last edition of ADA *Dental Files* contained a valuable interview with Kathy Dennis from Medicare on how compliance with the CDDS is essential and on how best to deal with a Medicare audit. Members are urged to review this material and those continuing to provide CDDS services must ensure compliance with the CDDS requirements or risk an audit.

ADA has met with AMA to discuss and clarify issues that have arisen under the CDDS between MGPs and dentists.

Following the Election, ADA will immediately re-establish contact with the appropriate Minister to point out the innocent nature of the oversight by dentists and will seek an administrative outcome to the problems arising from this for members.

In the meantime, if you are one of these subject to an audit or you are one of the 300 about to be approached for information or audit, please immediately refer the matter to your Branch for assistance.

If you feel you need further information on the actual mechanisms of the CDDS contact the Medicare provider enquiry line on phone: 132 150 (local call rate) or Mail, Medicare at GPO Box 9822, in your capital city or Email: medicare.prov@medicareaustralia.gov.au.

Robert Boyd-Boland
Chief Executive Officer
10 August 2010

AUSTRALIA DAY 2011 HONOURS LIST

The Australian Dental Association Inc. (ADA) and its members wish to congratulate the following recipients of awards in the Australia Day 2011 Honours List:

Dr Terence Keith Pitsikas AM – Member of the Order of Australia Award granted for service to dentistry, particularly through executive roles with a range of professional organizations, and to education. Members will note that in addition to past roles within the ADA and the ADA WA Branch, Dr Pitsikas is currently a member of the Federal Council of the ADA and is Chairman of the ADA's Schedule and Third Party Committee.

Dr James Alastair Robertson AM – Member of the Order of Australia granted for service to dentistry and to international humanitarian aid through the delivery of dental health programmes in Asia. Dr Robertson is currently Chairman of the ADA's Committee on Dental Volunteers. Dr Robertson has also been engaged in a variety of activities for the ADA Victorian Branch.

Dr Anthony Michael Zahra OAM – Medal of the Order of Australia granted for service to dentistry, and to the community.

Robert Boyd-Boland
Chief Executive Officer

NEW MEDICARE BENEFITS SCHEDULE OF DENTAL SERVICES FOR THE CHRONIC DISEASE DENTAL SCHEME

The Department of Health and Ageing has advised that the new Medicare Benefits Schedule effective 1 November 2010 is now available for viewing.

Consistent with the Government's stated intention to close the Chronic Disease Dental Scheme (CDDS), schedule fees for the scheme are not indexed annually (unlike other Medicare items) and continue as originally set at the scheme's implementation on 1 November 2001.

However, the maximum patient gap between the benefit payable and the schedule fee for out-of-hospital services under Medicare was increased by $2.10 to $71.20 as at 1 November 2010, consistent with previous years.

For all CDDS item fees up to $474.65, the benefit payable is 85% of the schedule fee. For CDDS fees over $474.65, the benefit payable is the schedule fee less $71.20.

Because the CDDS fees are not indexed, but the maximum gap provision is, this results in a small reduction in the benefit payable for dental items with a schedule fee above $474.65. The Maximum Gap Payment amount last year was $69.10, $2.10 less than this year's indexed amount of $71.20. This means that items with schedule fees over $474.65 will generally see a reduction in benefit of $2.10 over last year.

The Maximum Gap Payment provision ensure as patient will receive benefits above 85% of the schedule fee once the fee reaches a certain level (this year $474.65). The maximum gap for out-of-hospital services has increased to $71.20 this year. As an example of the operation of the provision, if the schedule fee for a service is $1000, the patient would receive a maximum benefit of $850 if only the 85% rule applied ($1000 / .85 = $850). However, with application of the maximum gap provision, the patient would receive a benefit of $928.80 ($1000 – $71.20 = $928.80).

AGE AND THE COSTS OF DENTAL CARE

The Australian Institute of Health and Welfare released a new report, *Age and Costs of Dental Care*. This report examines the costs of dental care in the adult (over 18) population. Data has been taken from both the *National Dental Telephone Interview Survey 2004-06 (NDTIS)* and the *Longitudinal Study of Dentists' Practice Activity 2003-04 (LSDPA)*.

Some 14,123 participated in the NDTIS while 962 dentists responded to the LSDPA.

Cost per Visit

Costs of dental care can vary throughout the lifespan. The cost of each service was estimated using the average fee for each service for the year 2005, identified by ADA Item Numbers.

Cost per visit increases with age but then declines in the oldest age group. The mean cost per visit ranged from $212 in the youngest age group (18–34 years) to $366 in the 65–74 years age group. The reason given for this is the number of visits per year goes down in the eldest age category. Other factors that contribute to the frequency of visits include: age; dentate status and number of remaining teeth.

Cost Annually

Mean annual expenditure on dental care increased steadily from $255 in the 18–34 years age group to $562 in the 65–74 years age group. However, it then decreased to $384 in the 75+ year age group.

Edentulism

As expected, edentulism increases with age. However, the number of teeth is not associated with the number of visits in the older age groups. The mean number of teeth in the group aged 18–34 years is 29.4 declining to 17.7 in the group aged 75 years and older.

Number of Dental Visits

The distribution of mean number of visits is an inverted U-shape, with those in both the oldest and youngest age groups making fewer visits than those in the middle age groups.

There were no consistent, statistically significant differences in number of visits by number of teeth within age groups.

The full report can be found at: http://www.aihw.gov.au/publications/index.cfm/title/11916

CHRONIC DISEASE PATIENT REFERRALS FOR MEDICARE

Under the Medicare chronic disease dental scheme (CDDS) a patient is eligible for up to $4,250 in Medicare benefits over two consecutive calendar years. Where further dental services are required to treat a new or existing oral health problem at the end of the patient's two calendar-year period, the patient will need to obtain a new referral from their medical GP.

This is to enable the medical GP to assess whether or not the patient continues to meet the eligibility requirements for the CDDS, i.e., that the patient still has a chronic condition that requires management through a medical GP Management Plan and Team Care Arrangements, and that their oral health is impacting on, or likely to impact on, the patient's general health.

If the patient is referred for a second two calendar year period, they will be eligible for up to a further $4,250 in Medicare benefits.

MEMBERS WANTING TO CHECK ON THEIR DENTAL BOARD REGISTRATION STATUS

You can now check the status of your registration if you have a renewal due on 31 December 2010.

The Dental Board of Australia has advised that for those practitioners wanting to check their Registration status they should visit:
http://www.ahpra.gov.au/Registration/Renewal-Received-Confirmation.aspx

This site is for use by registrants with a renewal due on 31 December 2010.

This search enables those with an application for renewal which was due on 31 December 2010 to check that their application for renewal has been received. The information is updated daily at 9am.

Robert Boyd-Boland
Chief Executive Officer

CORRECTION

Schedule and Third Party Committee Vice Chairman

Please be advised that an error appeared in the December 2010 *News Bulletin*, page 14 – Federal Council election results – the Vice Chairman of the Schedule and Third Party Committee is Dr Gregory Morris. Our apologies for any inconvenience this has caused.

MEDICARE AUSTRALIA UPDATE ADVICE TO MEMBERS

Members are advised that whilst deliberations between the ADA and the Minister for Human Services, the Honourable Tanya Plibersek MP's office continue, Medicare Australia have commenced widening of their audit processes in relation to dentist's utilisation of the Medicare Chronic Dental Disease Scheme.

Branches have advised that further notifications of claims are being received by its members. Medicare Compliance Offices from the Chronic Dental Disease Scheme Taskforce are contacting members initially by phone and then letter to invite voluntary participation in a self-audit of Medicare services under the Chronic Disease Scheme.

The audits are in relation to services now rendered to patients in the period 31 December 2008 to 30 December 2010. When conducted, the audits will review a selection of 20 patients who have received services from the dentist being audited.

As in the past, should members receive contact from Medicare Australia in relation to its audit process of the Scheme, they should immediately contact their Branch and seek advice and assistance. Your Branch is well positioned to provide this.

It is strongly recommended that members not agree to immediate participation in the audit process but to contact their Branch immediately.

For updates refer to ADA member website.

CHRISTCHURCH EARTHQUAKE - DENTAL RECORDS

Dr John Bell, President of the New Zealand Dental Association (NZDA) in a letter to the ADA President, Shane Fryer has advised that ADA members may be required to provide dental records following the devastating Christchurch earthquake in February as some Australian nationals may be among the deceased.

In his letter, he asks that members please endeavour to comply with the NZDA's request adding that "The authorities here in New Zealand would require the original records of the victims but please be aware of the procedure. All requests for records should come through official circles and not from the victim's relatives and records should only be surrendered to the appropriate officials and not to victim's relatives.

Further we recommend that the records are duplicated before being handed to the authorities."

He asks that members be alerted of this possibility and extends the NZDA's sympathy to Australians who have been affected by this tragic event.

NEWS bulletin

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medicare

Chronic Disease Dental Scheme (CDDS)

LATEST ADVICE ON MEDICARE

Chronic Disease Dental Scheme requirements

Strategic Plan 2012–2015

Brisbane Congress

Celebrating over 40 years of publication

president's comments

F. Shane Fryer
Federal President

"...all practitioners who have been involved with the CDDS should get their house in order, review their records and correct all administrative discrepancies."

MEDICARE AND THE CHRONIC DISEASE DENTAL SCHEME 'GET YOUR HOUSE IN ORDER'

You will have seen numerous previous reports of ADA's dealings with Medicare Australia (MA) over the last 15–20 months where the ADA has advised you as to how important it is for you to comply with the administrative requirements and rules with the Chronic Disease Dental Scheme (CDDS).

MA has undertaken an exhaustive investigation of some dentists' claims under the CDDS. These investigations commenced with MA either receiving a tip off about a dentist's treatment or billing, or from a direct complaint by a patient to MA about a dentist's conduct in respect of treatment under the Scheme. Investigations are at various stages from initial informal enquiries to those that have escalated to full blown audits. These investigations initially revealed widespread non-compliance with the administrative requirements of the CDDS and instances of pre billing of services by dentists. Non-compliance from the administrative perspective dealt primarily with a failure to meet Section 10 requirements, which obligates the dentist:

- prior to the commencement of the course of treatment, to provide a written treatment plan to the patient, along with a written itemised quotation for services within the plan, and
- prior to the commencement of the course of treatment, to provide a copy or summary of the treatment plan to the referring General Practitioner (GP).

These obligations exist whether the patient is being bulk billed or not. Provision of advice to the patient is designed to provide informed consent and financial consent for treatment. Provision of the treatment plan to the medical GP is designed to assist them to develop and monitor the overall treatment plan for the chronically ill patient.

If Section 10 of the Scheme was not complied with, the claim against MA for the services rendered is invalid and MA has a right to recover the monies it has paid in respect of those services.

The law is absolutely clear on this.

The ADA has been in frequent dialogue with the Ministers for Human Services, (currently the Hon. Tanya Plibersek), the Department and the Compliance Officers with MA. What the ADA has attempted to do in its approaches to Government is to seek the assistance of the Minister and MA in having the breaches in the CDDS administrative compliance requirements with respect to Section 10 sympathetically dealt with by MA in its recovery actions. The ADA has recognised that in many cases non-compliance was innocent due to lack of familiarity and education with the CDDS. (I want to make it clear that this is not about protecting those few who may have acted unprofessionally in claiming under the Scheme but is aimed at the larger group who may not have completed the administrative requirements in the correct sequence and are therefore in breach of the legislation.)

Initially, it was believed that MA was strictly seeking recovery for all dental benefits paid pursuant to invalid claims, however, after meeting with Medicare and outlining our concerns it is now evident that MA is adopting a more reasonable approach.

Recent dialogue with MA has seen a further slight adjustment in its stance on Section 10 breaches.

Following our most recent meeting with MA officials on Tuesday, 12 April I would like to advise members of the following matters:

- If you receive a request by MA to undertake an examination of your treatment records for patients treated under the CDDS, you should seek advice from your Branch and discuss with the Branch whether you have been compliant with the Scheme both now and in the past.
- As part of standard operating arrangements, MA officials indicate they will engage with you throughout the audit process, this may be by phone, letter and/or face-to-face. These opportunities are used to seek information, keep you informed of progress and allow you to move through the audit as efficiently as possible.
- If in this investigative process you assess or are advised that you have been non-compliant then you should determine in what areas this has occurred and after further consultation with your Branch consider seeking MA's advice as to how to best address the issues identified.
- Cooperation with MA may be in your best interests.

• If you are told to revise your method of dealing with claims under the CDDS then you must immediately take the necessary steps. Failure to comply (which is ill advised) will lead to an audit and the likely receipt of a formal demand for repayment of monies paid by MA. Compliance with MA's directions will only stand you in good stead. It may not result in a claim being avoided but you are more likely to be dealt with sympathetically by MA.

• In the investigation process you should heed MA's advice. If a demand for repayment is made, it would be sensible to promptly enter into discussions with MA to explain the reason for your non-compliance. For example, you may have been innocently unaware of the Section 10 obligations. If you can establish this and this is the only shortcoming in your compliance or claiming then you may be able to demonstrate that remedial action by you to address the administrative oversights will result in overcoming the impact of at least some of your non-compliance.

• If you ignore MA's approaches a statutory demand for repayment to the Commonwealth may be made.

• In either case if a demand for repayment occurs you are able to seek an internal review of the decision within 28 days and this review is conducted by a delegate of the CEO of MA. Following ailure of this your only recourse would be to appeal to or seek some relief from the Commonwealth Minister for Finance.

• It should be noted that once a demand for repayment is made by MA the options available to you are limited.

• If you have not been approached by MA but are now aware that you have been non-compliant, I suggest you review your patient files and see what can be done to rectify any deficiencies with respect to your administrative requirements as soon as possible. Any steps you take in this regard will assist the medical GP to place your treatment in the overall management of the chronically ill patient and will assist the patient to understand their treatment plan and the financial costs associated with it.

You will be receiving a letter from MA shortly. It has been written by MA after our representations to the Minister and the Department. It provides some advice for you to deal with compliance issues under the CDDS. Please read the letter carefully as it sets out what it is you have to do to comply with the CDDS requirements. It is not forgiving you for any liability you may have but is offering a potentially more favourable outcome to you. I implore you to read it and act upon it.

Please heed advice you receive through your Branch or from MA. The consequences of non-compliance have left some members on the verge of bankruptcy.

So, in summary, all practitioners who have been involved with the CDDS should get their house in order, review their records and correct all administrative discrepancies. If you are the subject of an investigation or audit by MA now or in the future your ability to demonstrate a change in your administrative behaviour with respect to the CDDS will hold you in good stead and allow MA the option of exercising some discretion in your favour when they are reviewing your CDDS compliance level.

It is also worth noting that MA is aware of the content of this Presidential Message on the CDDS.

Your attention is also drawn to the article published on page 8 of the *News Bulletin* that deals with changes to the administrative powers of MA when dealing with claims. These changes make it even more imperative that you are fully aware of the rules and are compliant with the requirements.

HEALTH INSURANCE AMENDMENT (Compliance) Bill 2010

The Health Insurance Amendment (Compliance) Bill 2010 (the Bill) was introduced into the Federal House of Representatives on 17 November 2010 and passed through the Senate on 21 March 2011. It will shortly receive Royal Assent.

The Bill amends the Health Insurance Act 1973. It will impose some very strict time limitations for responses to demands that may be made by Medicare Australia. Medicare says the new legislation will provide it with the necessary powers to protect the integrity of the annual expenditure under the Medicare program. It creates a statutory frame work for the auditing of health professionals who provide services that attract a Medicare benefit. It will therefore apply to dentists who provide services under the Chronic Disease Dental Scheme (CDDS) and other Federal government schemes.

The Bill will enable the Chief Executive Officer (CEO) of Medicare Australia to give a notice requiring the production of documents to a practitioner, or another person who has custody, control or possession of the documents, to substantiate a Medicare benefit paid for a service.

The following is a summary of the key points in the Bill. It will:

- Allow the CEO of Medicare to serve a Notice to Produce if the CEO has a 'reasonable concern' that a benefit has been paid that exceeds the amount that should have been paid. A 'reasonable concern' may relate to a particular practitioner or group of practitioners, or a particular service or group of services. This notice will require health professionals to produce documents to substantiate claims made under the Medicare program when provided with a notice by Medicare Australia. If you fail to comply with the Notice to Produce the benefits paid will become recoverable as a debt to the Commonwealth irrespective of whether a person received the benefit. A complete defence to the non-compliance is available if it can be established that the non-compliance was brought about by factors out of the control of the person.
- Allow Medicare Australia to require the production of clinical records where it is necessary to substantiate a claim. The health professional may elect to provide the clinical record to a Medicare Australia medical adviser.
- Require that notices to produce documents only relate to services that were rendered in the two year period immediately before the notice is provided and after the legislation takes effect.
- Set timeframes for certain parts of the audit activity. For example Medicare Australia is required to give a health professional at least 21 days to respond to a notice to produce documents.
- Give greater clarity and certainty to the audit process.
- Require the CEO to take reasonable steps to consult with a relevant professional body about the types of documents required to substantiate a Medicare benefit before commencing a compliance audit. The Minister will, by legislative instrument, declare bodies to be relevant professional bodies for this purpose.
- Require that Medicare Australia contact health professionals in writing at the beginning of an audit as well as advising health professionals in writing of the outcome when the audit has been finalised.
- Prevent Medicare Australia from issuing a debt notice until 28 days after the health professional has been advised of the audit outcome.
- Give health professionals 28 days in which to request an internal review of the audit outcome and allow the health professional to provide further information to substantiate the claims in that time.
- Prevent Medicare Australia from using or providing information that is provided by a health professional in response to a notice to produce to the Director of the Professional Services Review or for any other criminal and civil proceedings.
- Introduce a penalty system to encourage voluntary compliance and deter recidivism. The financial penalty will only apply to debts that exceed $2,500. This threshold reflects the point at which Medicare Australia data indicates that mistaken claims may become routine, or be reflective of poor administration or decision making. (If this threshold had been applied to audits conducted in 2009-10, 60% of practitioners who made incorrect claims would not have received a financial penalty.)
- Provide:
  - A base penalty amount of 20% to be applied to all debts over $2,500. The base penalty amount can be reduced or increased according to circumstances described in the legislation. The reductions are intended to encourage greater voluntary compliance.
  - If a practitioner tells Medicare Australia that an incorrect amount has been paid for a service:
    - prior to being contacted by the CEO, the penalty is reduced by 100%;
    - before a notice to produce documents is issued, the penalty is reduced by 50%;
    - after a notice to produce documents has been issued but before completion of the audit, the penalty is reduced by 25%.
  - On the other hand, if a practitioner:
    - does not respond to a notice, the full amount of the services identified in the notice become repayable and the penalty is increased by 25%; or
    - has been unable to substantiate an amount paid for other services in the previous 24 months, and the total they repaid was more than $30,000, the penalty for the current amount is increased by 50%.

Medicare Australia has advised it will provide more detailed information to health professionals about the requirements and obligations of the new law in the near future. It will also provide a dedicated email address for health professionals to ask us about the new law. Contact details will be provided with the information pack to health professionals.

Robert Boyd-Boland
Chief Executive Officer
April 2011

president's comments

F. Shane Fryer
Federal President

"Please note that there are no absolute guarantees on offer. How you are considered by Medicare Australia, should you be the subject of an audit, will depend upon what you have done to ensure ongoing compliance."

MEETING WITH THE HON NICOLA ROXON MP, THE MINISTER FOR HEALTH AND AGEING

Following this year's Federal Budget announcements pertaining to the dental profession, I, together with the CEO, Robert Boyd-Boland and the Manager Policy and Regulation, Eithne Irving met with Minister Roxon on Monday, 27 June 2011.

Of particular significance with regard to the budget announcements was the Federal Government's funding of dental care and the announcement of the creation of the National Advisory Council on Dental Health.

The importance of the ADA in developing public policy on dental health was reinforced by Minister Roxon and I am now able to eport to you that the ADA has been invited to participate on the National Advisory Council.

I shall keep you informed of further developments.

CHRONIC DISEASE DENTAL SCHEME: MEETING MEDICARE AUSTRALIA AND THE MINISTER FOR HUMAN SERVICES

Members are referred to the ADA members' website and the entry there on correspondence with the Minister for Human Services, the Hon Tanya Plibersek (see www.ada.org.au).

Following submission of the letter, both the CEO and I met with the Minister and representatives from Medicare Australia (MA) to discuss the ADA's concerns with the way it was being reported to ADA that MA were conducting their audits of members regarding the utilisation of the Chronic Disease Dental Scheme (CDDS). During this meeting, I pointed out that there was a considerable discrepancy between the way in which MA were conducting their audits and the intent of the correspondence that had been sent to members by both ADA and MA after our earlier discussions with MA and the Minister. I stated that members had reported a 'hard line' being adopted by MA in their audit processes and that members were anticipating claims for full recovery of fees received by dentists where they had been non-compliant with the administrative requirements of the Scheme. It had been reported that despite member's efforts to rectify defects in their compliance and thus demonstrating a change in administrative behaviour, little regard for this was being paid by MA. I pointed out that this was not in the spirit of the understanding previously reached.

MA responded that it was exercising discretion in cases where the only concern with the claims had been administrative non-compliance and it could see rectification efforts in evidence. Where audits were based on patient complaints or where audits had commenced prior to the delivery of the ADA and MA messages in late April 2011, there could be no exercise of discretion as dentists had been non-compliant and thus had to refund fees where they had not been properly claimed.

Both the Minister and MA stated that since meeting with the ADA, MA had in fact altered its approach to audits. MA indicated that it was now exercising discretion in suitable cases and that if dentists could demonstrate that they were now rectifying their conduct and had commenced this prior to receiving notification from MA that they were going to be the subject of an audit, those practitioners would be looked upon sympathetically and would be likely to have potential claims for refunds avoided.

It was repeatedly emphasised to us that no global statement could be given as to how claims would be considered by MA. Each case would be looked at individually.

All the ADA can do is encourage members to do as I stated in my May 2011 message, namely:

"...all practitioners who have been involved with the CDDS should get their house in order, review their records and correct all administrative discrepancies...your ability to demonstrate a change in your behaviour with respect to the CDDS will hold you in good stead and allow MA the option of exercising some discretion in your favour..."

Please note there are no absolute guarantees on offer. How you are considered by MA, should you be the subject of an audit, will depend upon what you have done to ensure ongoing compliance.

THE WRIGLEY COMPANY FOUNDATION ADA COMMUNITY SERVICE GRANTS

This month, I had the privilege of sitting on the Grant Review Panel for The Wrigley Company Foundation ADA Community Service Grants, alongside Drs Carmelo Bonanno, Peter Alldritt and Michael Foley. Nearly 40 per cent of Australians cannot access dental care when they need it, with the worst affected being low income, single parent families and rural and Indigenous communities. It is a sobering thought that was reflected in the words of one grant applicant, namely that "the Third World exists in Australia."

As dental professionals, ensuring access to dental care for all Australians should be a priority and responsibility for us all, which is why it was so pleasing to see the number and quality of applications that we received in the pilot year of our partnership with The Wrigley Company Foundation. It was very difficult to choose only seven recipients, as all of the submissions showed real merit, but I believe that this year's grantees will make a direct and very real difference to the communities in which they are working.

As oral health professionals, we have the opportunity to help these at-risk communities by forming mutually-beneficial private sector partnerships such as The Wrigley Company Foundation ADA Community Grants program. Please take a moment to read about the fantastic projects that received grants this year on page 9; I know that you will be as inspired by their stories as I am.

ADA DENTAL HEALTH WEEK

By the time you read this, this year's ADA Dental Health Week (ADADHW) will have come and gone. The campaign was again conducted through the efforts of the ADA's Oral Health Committee and was a little different to the campaigns conducted previously. The Committee has sought to engage members through email and the ADA members' website to help you inform your patients and others of the valuable services you provide to them outside of just examining and treating the dentition and of the issues relating to their mouth of which they need to be aware for ongoing good health.

Media coverage has been exceptional. I would like to convey my congratulations to the Committee and those that assisted with delivery of this important national annual event.

I can also commend to you the video that was prepared in conjunction with ADADHW. Professor Camile Farah from the University of Queensland demonstrated an oral health check-up and provided some valuable information on what we should be doing when performing one. This video material is available on both the website and in the August ADA *Dental Files* (attached to the cover of this *News Bulletin*).

president's comments

F. Shane Fryer
Federal President

"...this Council is a significant step and it demonstrates the recognition the Government now accords to the ADA..."

NATIONAL ADVISORY COUNCIL ON DENTAL HEALTH

I am pleased to report to members that I have now received official notification of my appointment to the Federal government's National Advisory Council on Dental Health. As members will be aware the ADA has been advocating strongly to the Federal government for some years that they direct funding to provide for the dental care of the disadvantaged.

The creation of this Council was a major dental announcement in this year's Federal Budget and it signifies an intention by the government to now give the issue of dental care increased focus. For the ADA to be one of the few bodies represented on this Council is a significant step and it demonstrates the recognition the government now accords to the ADA in seeking advice on dental issues. Hopefully, it is a culmination of effort over recent years by my predecessors to raise the ADA's profile with government. It will provide the ADA with an ability to publicly express its views on dental care for Australians and hopefully influence government to introduce meaningful measures to improve the oral health of all Australians.

MEDICARE AUSTRALIA AND THE CHRONIC DISEASE DENTAL SCHEME (CDDS) – CORRESPONDENCE FROM THE MINISTER

Many of you will be aware as I reported in the last President's Comments [August 2011] that in July this year the Chief Executive Officer, Mr Robert Boyd-Boland and I again met with the Minister for Human Services, the Hon Tanya Plibersek MP regarding the CDDS.

During this meeting I expressed concern that my message to the membership in May 2011 may be inaccurate as Medicare Australia's actions appeared not to be in the spirit of the message I had conveyed. Recently, the Hon Tanya Plibersek has written to the ADA expressing her view and more importantly indicating my message to the membership in May this year was accurate.

The Minister states "This advice stands".

This correspondence from the Minister is particularly important to the ADA as it demonstrates that the assurances we have been given (although qualifications are attached) are valid.

There is further information on this matter elsewhere in this *News Bulletin* and the Minister's letter has been reproduced on pages 12 and 13 for all to view.

I would add once again that members should get their house in order, review their records and correct all administrative deficiencies as quickly as possible as such actions will hold you in good stead if you are the subject of an investigation or audit.

AUSTRALIAN DENTAL JOURNAL

It is with pleasure that I announce that this ADA flagship publication has again risen to high levels. I am able to inform you that at the last Impact Factor Survey the ADJ achieved a 2010 impact factor of 1.496. For those that may be unaware of the nuances of this evaluation measure it should be noted that in 2009 the Impact Factor was 1.22. Thus our Journal is now ranked at number 32 in the world. Probably of more relevance to many of us is how the ADJ is rated compared to the *Journal of the American Dental Association* (16), the *Journal of the Canadian Dental Association* (41) and the *British Dental Journal* (54).

Of interest is that the journal that ranked number one from an Impact Factor perspective was the *Journal of Clinical Periodontology.*

On behalf of us all I extend sincere congratulations to Professor Mark Bartold, his Editorial Advisory Board and the ADA Publications team in achieving such a successful result.

2011 AUSTRALIAN DENTAL ASSOCIATION MEMBER SURVEY

The ADA is continually reviewing its direction and focus so as to remain relevant in our ever changing world, contemporary with current practices and worthy of members continuing their relationship with the Association.

With this in mind, members will have received an email requesting them to participate in the 2011 Survey of ADA members. The ADA has developed this year's survey so as to collect feedback on your experience and expectations as a member of the Australian Dental Association.

MEDICARE AUSTRALIA AND THE CHRONIC DISEASE DENTAL SCHEME

The Minister for Human Services, the Hon Tanya Plibersek MP, has written to the ADA following a meeting with the ADA Inc. President, Dr Shane Fryer, CEO, Mr Robert Boyd-Boland, the Minster and representatives from Medicare Australia which was held on 13 July 2011.

Members will recall previous reports regarding discussions and meetings held with the Hon Tanya Plibersek MP and Medicare Australia (MA).

A copy of the letter is published on pages 12 and 13.

The letter refers to the concerns expressed by the ADA as to what it saw as a discrepancy between the understanding that the ADA had taken from earlier meetings with the Minister and MA and what appeared to be happening in relation to MA activities and recent audits.

The Minister's message is clear that she is in agreement with the sentiments expressed by Dr Fryer in his earlier President's comments [*News Bulletin,* May and August 2011] where he said:

"...dental practitioners should get their house in order, review their records and correct all administrative deficiencies and that such actions will hold them in good stead if they are subject of an investigation or audit."

She cautions though that:

"...once an audit by DHS (Department of Human Services) has been notified or commenced such retrospective action would be unlikely to be taken as compliance..."

The clear message is if you have not been compliant with the administrative requirements of the scheme; then immediately take steps to attempt to rectify the situation. Such action may assist you avoiding claims for repayment of benefits. Don't wait until MA or the DHS notify you of an audit to do this – as it will be too late then to enable you to obtain any favourable exercise of discretion by MA.

As yet, no details of any further meetings between senior representatives of MA and ADA have been received. However, it is pleasing to observe that the Minister has directed the Department "to work in close partnership" with the ADA.

Robert Boyd-Boland
Chief Executive Officer
12 August 2011

THE DENTAL FILES QUIZ

Please be aware that the ADA has ceased the provision of the Dental Files quiz. With the establishment of national registration for dental practitioners through the Dental Board of Australia and the changes to the Registration Standard in relation to Continuing Professional Development (CPD) the accumulation of CPD hours is now self-certified.

NEWS bulletin ADA

MEMBERS

READ THE *NEWS BULLETIN* ON YOUR iPAD

As part of the ADA's ongoing program to improve services to members, the *News Bulletin* is now available for the iPad. As with the online version it is available through the ADA web site www.ada.org.au.

No special software is required to be downloaded or installed because the application automatically identifies iPads and loads the appropriate version of the *Bulletin.* To access the iPad version:

- Logon to the members section ADA.org.au using an iPad
- Select 'Publications' and then *News Bulletin*
- Select current issue or any issue required (back to August 2010). The iPad version of the *News Bulletin* will automatically open up on your iPad
- As with the browser based version, instructions on how to operate the *News Bulletin* on the iPad are displayed on the first page.

The Hon Tanya Plibersek MP
Minister for Human Services
Minister for Social Inclusion

Mr Robert Boyd-Boland
Chief Executive Officer
Australian Dental Association
PO Box 520
ST LEONARDS NSW 1590

Dear Mr Boyd-Boland

I refer to your letter dated 20 June 2011 and the meeting on 13 July 2011 with you and Dr Fryer representing the Australian Dental Association Inc. (ADA) and senior representatives from the Department of Human Services Medicare Program (DHS). I thank you and Dr Fryer for your attendance at the meeting which I consider clarified a number of matters associated with the audits being conducted on the conduct of the Chronic Disease Dental Scheme (CDDS).

At this meeting and in your letter the ADA raised concerns about the manner in which DHS is managing situations where dental practitioners have retrospectively rectified non-compliance with CDDS requirements by providing treatment plans and quotes after the provision of services to the patient.

Dr Fryer was particularly concerned that the comments provided by him in the ADA News Bulletin of 11 May stating in summary that "dental practitioners should get their house in order, review their records and correct all administrative deficiencies and that such actions will hold them in good stead if they are subject of an investigation or audit" were now being shown to be inaccurate in view of the actions of DHS.

I can assure you that this advice to the members of the ADA was accurate and was greatly appreciated by me and DHS. This advice stands. As I am advised and was mentioned by DHS at our meeting, once an audit by DHS has been notified or commenced such retrospective action would be unlikely to be taken as compliance with the requirement of the CDDS, however, DHS does consider such circumstances on a case by case basis. I can confirm that there have been a number of instances where DHS has used its discretion in relation to dental practitioners' compliance with the CDDS requirements and has provided education and not sought recovery, due to the particular pattern of non-compliance identified.

Dr Fryer and you 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

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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 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 high billing category of audits to be conducted includes dental practitioners identified as high billers of the Scheme with a high benefit claimed per patient average when compared to their peers.

Where tip offs or complaints are received about dental practitioners compliance with the CDDS , DHS is obligated to assess the concerns raised in the complaints and will conduct its audits by examining records from the dates relevant to the complaints, which may be prior to April 2010. To date the majority of audits undertaken by DHS have related to tip offs or complaints but will be now complemented by the high billing category audits.

I would like to reiterate that the legislative requirements associated with the Chronic Disease Dental Scheme are aimed at assisting patients suffering from chronic disease. These requirements are essential and facilitate appropriate communication between the patient, the treating general practitioner and the dental practitioner to ensure adequate patient care is provided. In addition, the requirements are necessary to ensure that patients fully understand the treatment they are receiving and the cost of that treatment, regardless of any out of pocket expenses. As well Medicare is required to conduct assurance activities to ensure that the public funds expended on the CDDS are being used in accordance with legislative requirements.

I would ask that you pass on to the members of the ADA that while each audit involving a dentist is considered on an individual basis and the dentist's current and retrospective efforts in complying with the requirements of the CDDS are taken into account, there is no scope for DHS to not follow through on recovery action when warranted.

I have been advised that shortly a further meeting will be arranged between senior representatives of Medicare and the ADA to continue discussions on these and other issues relevant to the ADA.

I would like to assure you that I have asked DHS to continue to work in close partnership with you and I appreciate your efforts in ensuring that dental practitioners have all the information they require to successfully operate within the requirements of the CDDS.

Yours sincerely

Tanya Plibersek

29-7-11

NATIONAL ADVISORY COUNCIL ON DENTAL HEALTH

Members will note from the President's Comments [September 2011] that Dr F Shane Fryer, President of ADA Inc. has been appointed to the National Advisory Council on Dental Health (the Council). As requested by the Minister for Health and Ageing, the Council is being established as a time-limited group to provide strategic, independent advice on dental health issues to the Government.

The priority task is to provide advice on dental policy options and priorities for consideration in the 2012-13 Budget. In acquitting this task, the Council will consider:

- Dental health programs currently funded by the Australian, State and Territory governments, and the mix and coverage of services currently provided in the private sector;
- How to improve these programs and better support people with dental illness, in a cost-effective manner, including through better coordination and integration of existing dental health programs and services; and
- How to focus dental health programs for people with particular needs, including younger people, older people including those with chronic illness and co-morbid conditions, people from diverse cultural and linguistic backgrounds, Indigenous Australians, and people in rural and remote areas.

The ADA congratulates Dr Fryer on his appointment and wishes him well in his role on the National Advisory Council on Dental Health.

CHRONIC DISEASE DENTAL SCHEME CLOSURE AND MEDICARE AUDITS

The ADA continues to receive correspondence from members concerned about the development of the Chronic Disease Dental Scheme (CDDS) and their capacity to continue to treat patients under the scheme.

The ADA advises members to assume the CDDS operates as it has to date and to ensure they remain complaint with the administrative requirements enforced by Medicare.

Further development has seen a motion requiring the Federal Government to detail all audits of dentists by Medicare Australia (MA) pertaining to the CDDS will be required by 31 October 2011, Senator Concetta Fierravanti-Wells has confirmed this week.

Senator Fierravanti-Wells presented the Senate with information stressing the importance of the scheme including the 680,000 Australians that have undergone treatment comprising of 11,000,000 dental services, whilst questioning the Federal Government's motive and process in the future of the CDDS.

The Senator proposed that dentists have acted in good faith in providing necessary treatment under the scheme, and has called for the Federal Government to desist pursuing onerous financial restitution from those dentists that have made inadvertent administrative errors in providing appropriate clinical services to eligible patients in audits conducted by the appointed MA taskforce. Furthermore, the proposition requires documentation be presented to the Senate outlining the number of dentist's required to repay Medicare benefits and justification for the repayment.

The Federal Government has voiced the intention to close the CDDS in the near future, but the ADA would remind members that two previous attempts to secure closure of the CDDS in 2008 were both unsuccessful and rejected by the Senate to protect the interests of public health which cannot be achieved with closure of the scheme without a suitable replacement.

Source: Media release, Australian Dental Association Inc., 21 September 2011.

WHAT HAPPENED TO THE *DENTAL FILES* QUIZ?

We've received a number of queries from *Dental Files* listeners who are wondering what has happened to the quiz. That aspect of the *Dental Files* service has been discontinued. But don't despair, you can still claim credit for your time listening to Dental Files interviews and for watching the bonus material included on each disk.

The Dental Board of Australia (DBA) does not require any form of assessment towards your mandatory continuing professional development hours. Registered dentists are simply required to keep a log of the educational activities they participate in. Each time you listen to or view *Dental Files* programs write down the edition, date and time you spent. You can create your own log or take advantage of the CPD log available online at the ADA's website.

BABY TEETH ORAL HEALTH CAMPAIGN

The ADA is set to launch its popular biennial oral health campaign **'Baby Teeth'** with a national media and PR campaign being promoted during October and November. As part of the campaign, the ADA has produced four fact sheets and a postcard that will be distributed to early childhood centres nationally.

The fact sheets provide parents and mothers-to-be information on good oral health practices and cover:

- Oral hygiene
- Tooth development
- Healthy eating
- Pregnancy

ADA members are welcome to download and distribute the fact sheets by visiting: www.babyteeth.com.au

president's comments

F. Shane Fryer
Federal President

"...if you are or intending to deal with Medicare in any way proceed with caution as this article indicates the true reason behind the Government's actions against dentists."

DEAL WITH MEDICARE CAUTIOUSLY – DENTISTS IN SWAN'S SIGHTS TO BALANCE BUDGET

It was with interest that I read an article in *The Australian Financial Review* (Tuesday, 8 November 2011), titled 'Swan sinks teeth into dental rorts'. The statement is made that "The government is examining structural savings in the broad health portfolio that could include targeting dentists for over-claiming under the limited publicly funded dental scheme" and "Rorts in the publicly funded dental scheme are in the federal government's sights as it hunts for savings to ensure the budget returns to surplus as planned."

It appears that dentists are being used as a scapegoat by the Government to fill its revenue gaps and achieve a budget surplus. As we know this targeting by the Government largely relates to the making of minor administrative errors under the Chronic Disease Dental Scheme (CDDS) and demanding dentists repay the full cost of delivering dental care and treatment to patients with chronic diseases.

The manner in which Medicare has pursued dentists delivering legitimate care is quite extraordinary. The ADA does not support inappropriate conduct by dentists in any way. If there has been a serious or blatant breach of the scheme from a dental treatment perspective or a fraudulent activity, then pursuit of repayment of Medicare claims would be warranted.

On a number of occasions now Medicare has been requested to provide a detailed breakdown of the reasons for dentists being deemed non compliant. We have asked them to delineate between those practitioners that have merely fallen down on their paperwork and others where different issues may be involved. To date, this request is being ignored as it appears the simplicity of conducting a paper trail audit makes life for the Medicare auditor easy.

However, our efforts and the efforts of others now seem to be getting somewhere. At the time of writing this, I note that the Senate has passed a motion calling on the Government to formally provide this information and acknowledge that non-compliance errors in the scheme have been minor and technical in nature and to desist from demanding full repayment of all Medicare benefits from dental practitioners where non-compliance has been of an administrative nature. The Senators also asked that the Government instruct Medicare Australia to halt all recovery action until a full reassessment of audit results has been carried out so as to allow for consideration of a warning or smaller penalty applying. Let us hope that sense will now prevail.

Having said this, members should be aware that it is a requirement of Medicare to conduct audits to ensure that the public dollar is being spent correctly. The ADA's position in relation to the current situation is that Medicare's communication to dentists about the administrative requirements for the CDDS has been exceedingly poor and the audit activity is being conducted in an overzealous way.

Given this latest newspaper piece if you are or intending to deal with Medicare in any way proceed with caution as this article certainly indicates the true reason behind the Government's actions against dentists.

THE GREENS

Members will no doubt have read of the outcome of the Greens party conference where the party again called for the introduction of a universal dental plan to be provided by the federal government. This is contrary to the ADA's option of targeting funding for dental care to those that really need government assistance to access treatment.

Prior to the Greens Party Conference, a meeting was held with the Greens health spokesman, Senator Richard Di Natale in Melbourne (a general medical practitioner and public health specialist) to discuss the ADA's preferred option for government funding and to also liaise with him in relation to the considerable work the Senator had done in the Senate's hearing regarding the Medicare CDDS audits.

While we may have to agree to disagree on our opposing stances with respect to a public dental scheme, the Senator was certainly sympathetic to the logic behind the ADA's approach that instead of providing a very basic service to all Australians it would be more economic and effective to provide worthwhile long-term solutions to those experiencing difficulty accessing care. We were on the same page though when it came to the need for concerted oral health promotion/education activities being essential and the need for more investment in public dental health facilities. Workforce issues were addressed where the Senator was advised of the almost certain creation of an oversupply of dentists in the future, as well as the current maldistribution of the dentist workforce and thus the need for more incentives (such as those provided in medicine) to be provided to encourage practitioners to practise in the rural and remote regions of Australia.

I am pleased to report in relation to the CDDS audits that Senator Di Natale (as can be seen from his activities in the Senate hearings) was very sympathetic to the plight of those dentists being pursued by Medicare Australia for recovery of monies received due solely to non-compliance with administrative requirements. On behalf of all members I conveyed my appreciation to the Senator and thanked him for his actions.

SEASON'S GREETINGS

2011 has certainly been an eventful year from many perspectives but now as it is coming to a close I would like to take this opportunity to wish everyone all the compliments of the season and a happy New Year. May 2012 be all that you are hoping for!

THE INCREASED MEDICARE COMPLIANCE AUDITS INITIATIVE

The Increased Medicare Compliance Audits (IMCA) Initiative details were published in the May 2011 issue of the *News Bulletin.*

However, it is again worth noting that with the introduction of this initiative, additional powers and penalties have been introduced. The Health Insurance Amendment (Compliance) Act 2011 took effect on **9 April 2011**. It applies to Medicare services provided on or after this date.

THE LEGISLATION

- Allows the Chief Executive Medicare (CEM) in the Department of Human Services (DHS) to give a notice requiring a person to produce documents to substantiate a Medicare benefit paid in respect of a service;
- Provides for an additional financial penalty for certain practitioners who are not able to substantiate a Medicare benefit paid in respect of a service; and
- Provides an opportunity for a health professional to seek a review of a decision on amounts recoverable.

CONDITIONS PRIOR TO ISSUING A NOTICE

Before a notice to produce documents can be issued, the CEM must fulfil several conditions:

- Firstly, the CEM must have a reasonable concern that the Medicare benefit paid for a service may exceed the amount that should have been paid;
- Secondly, the CEM must take advice from a DHS medical adviser on the kinds of documents that contain information relevant to substantiating the Medicare benefit;
- Thirdly, the CEM must take reasonable steps to consult with a relevant professional body about the types of documents that contain information relevant to substantiating a Medicare benefit before commencing a compliance audit; and
- Finally, the CEM must first give the person a reasonable opportunity to respond to a written request to voluntarily provide documents.

PRACTICAL IMPLICATIONS OF THE REFORM

The practical implications of the reform are that:

- The Department of Human Services can now issue a notice to health professionals, or a person in charge of the professional's records, if there is a reasonable concern that a Medicare benefit has been paid that exceeds the amount that should have been paid. This notice will require a health professional to produce documents to substantiate services.
- An administrative penalty with a base rate of 20% for unsubstantiated amounts that total more than $2,500 has been introduced. This penalty is automatically decreased where a health professional voluntarily cooperates with an audit, but can be increased where a health professional does not cooperate.

Health professionals can seek a review of a decision from the Department of Human Services to recover funds where a Medicare service has not been substantiated.

> "The message is clear and the advice to members is that if there have been errors made then the earlier this information is conveyed to Medicare Australia the better..."

PENALTIES

If a practitioner tells Medicare Australia that an incorrect amount has been paid for a service:

- prior to being contacted by the CEM, the penalty is reduced by 100% (no penalty);
- before a notice to produce documents is issued, the penalty is reduced by 50%;
- after a notice to produce documents has been issued but before completion of the audit, the penalty is reduced by 25%.

On the other hand, if a practitioner:

- does not respond to a notice, the full amount of the services identified in the notice become repayable and the penalty is increased by 25%; or
- has been unable to substantiate an amount paid for other services in the previous 24 months, and the total they repaid was more than $30,000, the penalty for the current amount is increased by 50%.

The message is clear and the advice to members is that if there have been errors made then the earlier this information is conveyed to Medicare Australia the better; a penalty may be avoided or at least minimised.

The ADA hopes to have an interview with a senior Medicare Australia officer available shortly. This will be placed as a podcast on the website and will be included in the February edition of the ADA's *Dental Files.*

Robert Boyd-Boland
Chief Executive Officer

For more information it is recommended that members visit and read carefully the information at:

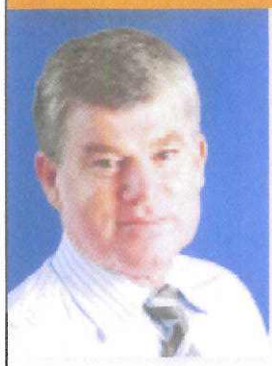
www.medicareaustralia.gov.au/provider/business/audits/imca-resources.jsp

This site provides a detailed Fact Sheet; Medicare compliance audit flow chart; FAQs and some useful forms.

The Health Insurance Amendment (Compliance) Act 2011 can be found at:

www.comlaw.gov.au/Details/C2011A00010

president's comments



F. Shane Fryer
Federal President

"The concepts of 'moral hazard' and 'adverse selection' reaffirm our position that a targeted means tested scheme is the best way forward."

PUBLIC DENTAL SCHEME

I noted an article in the *Australian Financial Review* last month by Professor Philip Clark, Chair in Health Economics, School of Population Health, The University of Melbourne. The debate regarding what is the best form of a public dental system is still ongoing while the government considers its options. Members will be aware that the ADA has developed *'DentalAccess'* as the solution to solve the access issues to dental treatment confronting some of the Australian community.

Professor Clark introduces some additional aspects to this ongoing debate, in particular, what is referred to as 'moral hazard' and 'adverse selection'.

'Moral hazard' is described as that action which occurs when consumption of healthcare increases once an individual becomes insured. When the disadvantaged can access insurance this allows them obtain necessary care; however, the hazard arises when others realise they can access insured care and then seek to access additional treatments under the insurance scheme. Such actions cause the insured scheme to cost significantly more than anticipated.

'Adverse selection' in health insurance occurs when more than one type of insurance scheme exists and individual choice allows people to select between schemes depending on their expected sage, that is, there is a risk-based sorting across insurance plans. The concern with the adverse selection spiral is that in theory it could lead to the collapse of an insurance scheme. Within healthcare in Australia the private insurance industry has been dealing with issues that arise due to the fact that it functions alongside Medicare, a publically funded scheme for many years. Professor Clarke indicates "the issues that have plagued running a private insurance system alongside Medicare will be extended to dental care" if a universal dental insurance scheme is introduced.

The ADA continues to provide solutions to the Government's problems with respect to the provision of public dental care. The concepts of 'moral hazard' and 'adverse selection' reaffirm our position that a targeted means tested scheme is the best way forward.

CHRONIC DISEASE DENTAL SCHEME

The compliance issues associated with the Chronic Disease Dental Scheme (CDDS) continue to remain a thorn in our side. On face value all members will now be aware of the compliance requirements associated with the Scheme. Thus correct documentation is now being provided as per Section 10 of the Scheme – although as discussions occur with Medicare Australia (MA) inconsistencies continue to occur in the advice provided by MA on some of the nuances of the CDDS.

Significant amounts of information have been provided to members in recent times together with the advice that the ADA, both at a Federal and Branch level, is continuing to press for a solution to the situation that many find themselves in from dealings under the CDDS in the early years. As I write these comments meetings have occurred and have been arranged for the future with various politicians to persist in presenting our position.

The ADA is maintaining a non-political position and arguments are based on the fact that our members have provided quality dental care to a population cohort that in most instances would not have been treated. **The CDDS was poorly designed and the law that governs it is bad law** and it is this combined with poor communication from MA that has created this unacceptable state of affairs. I would also like to inform members that the ADA has a number of 'prongs in the fire' in its approach to try and solve this CDDS matter.

NATIONAL ADVISORY COUNCIL ON DENTAL HEALTH

The Report of the National Advisory Council on Dental Health (NACDH) was released on 23 February 2012 and may be viewed in its entirety on the ADA website at www.ada.org.au. Although the ADA does not agree with all parts of it there are certainly aspects that are coincident with ADA policy.

Summarising the Report I can say that basically a number of options were provided to The Hon. Tanya Plibersek MP, Minister for Health, for consideration as the Government determines the form of a public dental scheme it wants to establish. Options for consideration with respect to service provision were separated into children and adult population cohorts.

The Chair of the Council, Mary Murnane PSM, has stated "...the Council commends the importance of a universal option for children. However, given the existing fiscal environment, the Council has included scaled down options for children, and adult options that are focused mainly on the most economically disadvantaged."

There is more than just the clinical treatment of individuals that requires consideration in a public dental scheme and again, Mary Murnane states "Foundational activities, such as investments in oral health promotion, infrastructure, and workforce, are integral to all options..."

Finally, the ADA has indicated to the Government that it wishes to be at the table when any final plans are developed for a public dental scheme. I am not ashamed to say that if the ADA had been listened to in 2007 when we were very briefly and belatedly consulted on the CDDS maybe the current CDDS fiasco would not have occurred.

CHRONIC DISEASE DENTAL SCHEME UPDATE

The Australian Dental Association Inc. (ADA) continues to receive calls from members and their practice staff regarding the proposed closure of the Chronic Disease Dental Scheme (CDDS).

Notwithstanding the comments from the Hon Tanya Plibersek, Minister for Health some little time ago that it is the Government's intention to close the Scheme, there is currently no legislation in before Parliament for this to happen.

The ADA understands that the reference to the Scheme's closure on 31 March 2012 referred only to the date for which future funding has been identified within budget estimates.

The process for closing this Scheme is the introduction of a legislative determination to repeal the existing legislation into Parliament. This legislation needs to pass through both the House of Representatives and the Senate. It must be presented into the House for 15 sitting days before it can be passed.

The ADA is monitoring all legislative amendments being introduced by the Federal Government and will keep members up-to-date if there is any change or if further information becomes available.

Robert Boyd-Boland
Chief Executive Officer

THIS MONTH ON THE DENTAL FILES CD

Modern Material

This month's Dental Files program begins with one of the best-known names in dentistry – Dr Gordon Christensen. Gordon is the Founder and Director of Practical Clinical Courses and Senior Consultant for Clinicians Report in Utah. Thousands of dentists worldwide look to Gordon's work in CR for his advice on dental products. Gordon's most recent speaking tour to Australia was sponsored by Power2B Dental Seminars. After his presentation in Melbourne he took time to speak with our interviewer, Dr Jeff Kestenberg.

Implant Selection

Dr Clark Stanford is Associate Dean for Research and Director of the Office for Clinical Research at the University of Iowa. He holds secondary appointments in the Department of Rehabilitation and Orthopedic Surgery and the Department of Biomedical Engineering. His background provides a unique perspective on balancing the mechanical demands and the biological requirements of dental implants.

After his presentation in Adelaide for the Australasian Osseointegration Society's 8th Biennial Conference, Clark spoke with our interviewer, Dr Patrick Meaney.

Orthodontics Update

Recently, the University of Sydney Orthodontic Alumni held a two-day course focusing on evidence-based orthodontic treatment. The presenter was Dr Ravindra Nanda. He is the Alumni Endowed Chair, Professor and Head of the Department of Craniofacial Sciences and Chair of Division of Orthodontics, University of Connecticut. He is also an author of five orthodontic books and more than 100 scientific and clinical articles in major journals. After two long days of teaching, Dr Nanda kindly took time to speak with our interviewer, Dr Morris Rapaport.

Establishing Rapport

Jim Eicher is a specialist consultant and author in the areas of organisational strategy, leadership, sales and communication. In a workshop for the Centre for Professional Development, Jim presented techniques to help practitioners systematically improve their communication skills and quickly establish rapport with their patients. After the program, he spoke with our interviewer, Dr Patrick Meaney.

In addition to the interviews on the CD, you will also find a video presented by Dr Stephen Blackler on how to conduct an endodontic examination.

Patrick Meaney

THE 'EIGHTH' EDITION OF THE PRACTICAL GUIDES NOW ONLINE

The 7th Edition of *The Practical Guides* was published in hard copy format in 2006 and has since been periodically updated.

In order to ensure currency of information with the provision of the Guides, the Dental Instruments and Materials Committee (DIME) will undertake regular review of the Guides as part of its meeting cycle. In view of this, it has been decided that in future there will be ongoing replacement of individual Guides as they are each updated. The Guides will then be available electronically from the Association's member web site. As each Guide is revised, the revision date will be shown on the Contents page and on the Guide, and the existence of the revision announced in the *News Bulletin*. Members will be able to download the Guides in PDF form.

The Practical Guides was first published in 1982, with Dr Derrick Beech, then Director of the Australian Dental Standards Laboratory (now subsumed into the Therapeutic Goods Administration) and Professor Henry Atkinson MBE as Editors. As we move into digital distribution, I would like to thank all the successive Editors and especially the contributors for their expertise and dedication in producing hard copy updates for the last 29 years.

The current edition of the Guides is now available for download on the ADA members' website.

Martin Tyas AM

AUSTRALIAN DENTAL ASSOCIATION INC.

Summary of ADA member survey - Medicare Chronic Disease Dental Scheme

The ADA member survey of their experiences with the CDDS

- From Wednesday 18 April – Wednesday 25 April 2012 the Australian Dental Association Inc. (ADA) issued a survey of its members to gather their views and experiences of the Medicare Chronic Disease Dental Scheme (CDDS).
- The ADA received approximately 2,000 responses out of our total membership of approximately 13,000 members. This is a statistically valid sample. The views expressed come from a proportion of members who serviced from between 1-20 patients under the CDDS to between 100 and 500 patients.
- Three main themes arose from members' responses to the survey that confirm the concerns expressed by the ADA:

1. Education

Members indicated they were not adequately counselled, educated or supported about the requirements of the CDDS.

Medicare Australia/Government

- Medicare Australia (MA) only raised compliance issues with about 1-3% of members outside an audit.
- When MA did raise an issue with members, 7 out of every 8 members said they received no appropriate education, support and counselling to amend the identified behaviour.
- The Medicare Provider Enquiry Line (MPEL):
    - 17% of members received useful and helpful advice.
    - The same proportion found the length of time waiting for a response too long.
    - 30% of members said they did not find the MPEL useful due to either incomplete or contradictory advice.
- 86% of members stated they did not have adequate education about the CDDS' requirements from MA.

- 80% of members were not aware that the Commonwealth Department of Health and Ageing website published material related to the CDDS.

CDDS vs. DVA Scheme

- Over 90% of members provided services to patients under the Department of Veteran's Affairs (DVA) scheme.
- Over 90% of members indicated that those requirements were straight forward and simple to comply with.

Potential penalties

- 85% of members were not aware that hygienists could not provide services under the CDDS until the ADA informed them.
- Less than 5% of members were aware of the CDDS' potential penalties from the start of the scheme until 2009.
- 20% of members stated they became aware of the potential penalties in 2010. 53% of members stated they became aware in 2011.
- At the time of the survey (late April 2012), under 10% of members indicated they were not aware that penalties could apply to the non-provision to treatment plans/summaries.

2. Practice

The CDDS states that dentists must adhere to administrative requirements such as sending treatment plans to General Practitioners (Section 10 Determination).

- Over 75% of members stated that no referring medical practitioners ever discussed their patients' treatment plan or other aspects of patient care under the CDDS.

- 86% of members stated that Section 10 Determination administrative requirements were not important for clinical outcomes from a dental perspective.
- Clinical item numbers 419 and 911 are the dental clinical emergencies codes under the CDDS that dentists are required to use.
    - Over 85% of members said that dental clinical emergencies were not able to be adequately treated by one of these item numbers.

3. Members' future participation in a dental scheme

- 25% of members indicated they do not plan to continue to treat patients under the CDDS.
- 90% of members said that their experience with the CDDS makes them less likely to provide dental services to patients under a future Medicare-funded scheme.
- 86% of members indicated they are less likely to participate in any future Government funded dental initiatives.