Below is a statement of our experience with the Chronic Dental Scheme:

In 2009 I joined the dental practice I am currently working in. At that time the practice was already seeing enhanced primary care (EPC) patients. That was the first time I've ever heard of the scheme and started seeing EPC patients. The operation of the practice was to bulk bill patients for the treatment. Despite the fee charged to EPC patients were approximately 30-50% lower than what we normally received from private fees, we decided not to charge patients any gap. We believed that it was a way of helping patients with complex needs as many patients may not have otherwise received the treatment. This means patients could receive the most ideal treatment in many cases without having to worry about the cost. It is only when the EPC has reached its expiry date of 2 years or when treatment fees were higher than the $4250 paid by Medicare, and then patients may have to pay private fees which they are informed of prior to treatment commencing.

Whenever we see patients for treatment, we diagnose the problem and inform the different treatment options available. All patients are informed of the cost they will have to pay. This applies to private and EPC patients to make sure informed consent is obtained. For EPC patients we inform them of the approximate cost of the total treatment, how much they may have left from the EPC fees, whether they have to pay private fees if the treatment exceeds the allocated $4250. This is all done verbally but patients can obtain a written statement if they express the desire to do so.

Our experience with Medicare and EPC patients:

From 2009 when I first started the scheme till early 2010, I have never had any information sent to me personally from Medicare about the need to send paperwork to the patient's GP and to the patient prior to starting treatment, and that there was a restriction on the types of treatment that could be claimed on the patient's very first visit. Medicare has never informed us of any problems related to the way we process and treat patients during that period. It was only when my dentist friend was audited in 2010 that she informed me personally of the requirement to send out treatment plans to patient's general practitioner and a quoted itemised treatment plan to patients was required before starting treatment. I had previous to this conversation with her, had never ever heard of that requirement and neither did any of my dental colleagues. Most dentists I had spoken to where baffled and confused about the Medicare requirements at that time and some had never heard of it. My friend and her practice while labelled as non-compliant because they did not provide the proper paperwork to the GP and patient prior. They then started to provide GPs and patients the required paperwork highlighting that it was just an innocent mistake but only to be told by the Medicare audit team that it didn't matter and they had to repay the money due to the error in paperwork, despite their plea that the dental work was carried out and the patient was satisfied. At that time, most of the media hadn't reported the problem with the scheme as it was done 'quietly.' No information was provided by Medicare to us in relation to the paperwork obligations during that period.

It was only when the ADA started reporting the incident and the unfairness in the ADA bulletin then the issue became wider known. So our practice decided to provide the treatment plans to the GP even though Medicare still had not informed us of the requirement. I had gone onto the Medicare website to find if there was any information on the requirements of the EPC- I looked and looked but

at that time there was no direct link to the Medicare schedule on what to do for EPC patients. I finally found it but it wasn't a direct link and the website was very difficult to navigate.

Most of the information informing us of the Medicare scheme was reports from our dental union Australian Dental Association (ADA). The ADA bulletin had articles warning dentists to be wary complying with EPC requirements. However there was an air of confusion on the information about what format the paperwork had to be in, what guidelines need to be followed and what treatment was allowed to be claimed on the first visit and exactly what treatments were covered or weren't. Then Medicare sent us a letter informing that they had countless times informed dentists of the requirements and dentists were responsible for being compliant. We were quite baffled as this was the first correspondence from Medicare and prior to that no information was given to us on how to comply or the consequences of not doing so.

More and more media reports on the Medicare scheme surfaced on the media in the last few years, mainly in dental magazines. The most informative being the recent checklist of things to do when treating EPC patients which only appeared in the ADA bulletin 2 months ago but again was not provided by Medicare.

I have worked with other schemes such as the Veteran's affairs and teen vouchers and we have never had any problems in knowing what treatment is covered, and how to claim. We were provided with information before starting the scheme which was clear and concise however we have found the EPC scheme to be confusing, uninformative and unhelpful when dealing with dentists.

Issues with EPC paperwork:

The idea of the EPC scheme is to help those patients who are in need for dental treatment as their medical condition may mean they have more complex dental issues. Dentists have provided the treatment to help many patients who otherwise may not have sought treatment. This aim has been achieved, but

- whether sending treatment plan to the GP and patient has no adverse impact on the patient

  - As mentioned patients are all informed of the treatment they are receiving and the cost to them (usually that is nil as most treatment is usually covered by Medicare or waived by us) In many cases, we have provided treatment well above the amount Medicare will pay, but we don't chase the patient or Medicare to pay the gap, or we have provided some small treatments or follow up checkups for free as it wasn't covered by Medicare and the patients had expected Medicare to pay but the process of chasing patients for small amounts of fees was too troubling.

When we have issues or treatment decisions affecting the patient, we would call the patient's general practitioner to discuss or confirm details. I have been told by GPs that they don't understand or care about the treatment plan unless it affects the patient in which case they will discuss those issues over the phone with us.

- little information was provided by Medicare.

- The amount of administration and paperwork involved: write treatment plan to GPs, formalise a plan to give to patients and to sign a copy, scan both forms to retain a copy in case Medicare does an audit, send to GP, and then ensure the GP has received it. Sometimes we need to change the course of treatment as needs change or the patient hasn't respond to treatment as well as we would like but any minor change we need to print the treatment plan again for every change. This work is done by the dentist which is time consuming and almost no benefit to the patient. The patient already knows what treatment is being provided.

<u>Issues with Medicare audit of dentists due to non-compliance of paperwork</u>

The EPC scheme was confusing in terms of the requirements before starting treatment, and Medicare did not provide clear information to assist dentists. Medicare has then turned around and labelled dentists as 'milking the system' because they have not been complaint mainly due to paperwork errors which many dentist were not previously aware of.

I believe there may be some dentist who may be fraudulent in their dealings with Medicare and should be investigated, but I believe this to be a small number and not as Medicare describes on the media as 'many dentists milking the system.' Helping patients and to be labelled as criminals because of paperwork errors which were non-deliberate while being misinformed is a slap in the face by Medicare.

Surely if the paperwork is so important, Medicare should have informed dentists CLEARLY and have a more efficient method to ensure compliance so that the dentist's time and energy can be spent providing treatment rather than worrying if the paperwork they do is enough to be complaint or not.

So how does the paperwork affect the treatment provided to patients? We should ask Medicare this, and if so important why we were notified two years later when so many patients have been seen and any paperwork mistakes later rectified by the dentist is still considered non-compliant with the need to refund all monies.

Medicare only cares whether the required paperwork was sent before or after the treatment provided date and that is what they question GPs in their surveys. It's to see whether they can ask the dentist for money back while ignoring the treatment provided to the patient, and the time and cost to the dentist.

The need to refund the money because of non-complaince in paperwork may mean:

----the dentist would have to pay back the money they earn, despite being taxed on the income that t hey have to now pay back. Don't forget dentists also are tax payers too and contribute to paying for the scheme.

----the dentist paid for the treatment to the patient out of their own pocket so may become bankrupt. Dental treatment cost money too, such as for materials and lab work.

----has been paid no salary for their time and the nurse's time in providing treatment

And this simply because of paperwork that wasn't done because there was very little knowledge of how to comply with Medicare, and lack of information. We have heard of cases where monies were demanded EVEN If the dentist tries to do the paperwork from first being aware. Most of the information was from the ADA on the need to comply, and not Medicare. If the dentist was non-compliant, why does Medicare not inform them immediately but wait for 2 years and still let the dentist keep providing treatment and claiming for costs, and hence digging a deeper hole for themselves and unknowingly keep providing treatment to the patient only for Medicare to ask for the amount back when the patient's treatment is finished and done and gone. I hope I'm wrong but it sounds almost like a dental scam to make dentist do free work and any minor error will allow a loop hole for Medicare to perform a revenue raising exercise to demand money from paperwork errors that have little and I suspect no effect on the treatment we provide to patients. How do staffs at Medicare feel if they have to return 2 years worth of their salary because they came late for work one day or left early for 1 minute, forgot one minor thing etc? There was little warning or education from Medicare, with their all or nothing approach and very little room for small errors and honest mistakes.

Issues with restrictions on the type of treatment to be provided on the first visit

The EPC scheme was confusing in terms of our obligations before starting treatment, then when the information was provided to us by our own dentist association (not Medicare), we were informed that the treatment that can be provided on the first visit is restricted, not covered by Medicare and may be breaching the rules only because it was provided on the first visit. However the irony is that these treatments can all be performed on a subsequent visit. We were all very confused on whether we can claim certain items or not.

Patients with a toothache needing a filling, an extraction cannot have treatment on the first visit unless all the paperwork is done and they will need to come on the second visit. These administrative processes imposed by Medicare ACTUALLY HINDER treatment to patients, especially EMERGENCY treatment. If a patient needs an extraction even for life threatening reasons, they can't because Medicare doesn't allow it unless the patient pays it privately or comes on another visit when THEN it could be claimed. Sometimes a patient has so much plaque on their teeth that we can't do a proper check up and treatment plan for the teeth unless the teeth are cleaned beforehand but this also can't be done on the first visit even if we have the time, so no final treatment plan can be finalised until after the second visit. All this simply because of Medicare rules that benefit no one- patient, dentist, Medicare. It simply wastes the patient and dentist's time.

We understand health services are expensive as the overheads are high but Medicare does not seem to realise this. The performance and behaviour of Medicare towards dentist is poor and conducts what seems to be like a witch hunt of dentists. I have little faith in Medicare, and though we still see EPC patients at the practice as we do try to help those in our community and finally with the help of our dental association become more familiar with the scheme, I would be wary of participating in

any new schemes Medicare has as I now realise that despite our best attempts, Medicare does not appear to care at all what we do for the community.

The scheme does help many patients but needs to be better structured in the best interest of helping patients, and helping health professionals to be more informed but ALSO to more effectively complete paperwork and ensure the system is not misused. Patients eligible for the scheme is not up to the dentist but up to the GP as the dentist mainly just provides the treatment to eligible patients. Medicare may benefit better in investing their time and their budget in making sure the scheme is better targeted to the right patients (eg to patients who also are financially disadvantaged as well, rather than just patients who have a chronic condition) and organising the scheme so it has a more structured approach in it's dealings with health professionals.