SENATE FINANCE AND PUBLIC ADMINISTRATION COMMITEES

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AUSTRALIA

HEALTH INSURANCE (DENTAL SERVICES) BILL 2012 [NO.2]

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5 April 2012

"Master always finds a staff
to beat a dog"
Old proverb

WITHOUT PREJUDICE

SAD CASE OF THE DENTISTS

(?DELIBERATE SET UP BY MEDICARE AND PSR?)

Recently press reported that "*Medicare identified 629 dentists who will be investigated for suspected overuse of chronic disease management items, in a bid to recoup almost $20 miillion in misused funds*" ("GPs' staff caught out in MBS fraud crackdown", Australian Doctor, 7 October 2011, page 3, /ref attachment 1/). Among Medicare reasons for demanding money back from dentists was that some dentists failed "*to provide copies or summaries of treatment plans to the referring GPs*" (same source).

This report follows a previous article by the Australian Doctor titled "Dentists now under Medicare scrutiny as crackdown continues" (Australian Doctor, 1 April 2011, page 3 /ref attachment 2/) which clearly shown the PSR's involvement. The former PSR Director, Dr was quoted as saying that "*there had to be a clear link between the disease and dental health for a patient to be eligible*" and he questioned eligibility of patients with osteoarthritis and chronic eczema. It appeared that Dr knew which chronic diseases made and which did not make patients eligible to receive Medicare subsidised dental treatments and on the basis of this knowledge was prosecuting GPs and dentists. Interestingly when I approached Medicare bureaucrats administering CDDS and asked them to provide me with the list of "qualifying" chronic diseases I received a written answer that they had no list which indicated that Dr was "an authority to himself" in interpreting Medicare.

Inspection of the MBS in regards to the Chronic Disease Dental Scheme ("CDDS") shows an extremely complicated and ambiguous set of rules, which appears to be set deliberately like this to rather prevent than to promote wide use of Medicare subsidised dental treatments obviously because the scheme architects were aware and expected great public demand for such services. Their fears surely come true with enormous blow up of the scheme cost, amounting to $328 million in just 2009 and 2010 years, which prompted Labor to try twice (unsuccessfully) to axe the scheme.

As early as in 2007 GPs tried to get some clarification as to their role, their obligations and expectations. Three sticking points were quickly identified and Medicare was asked for clarification:

1) Exactly which chronic diseases qualify a patient to receive the Medicare subsidised dental treatment?

2) How GP is supposed to develop and launch Item 723, i.e. Team Care Arrangement ("TCA") and follow the steps described in 2007 MBS Book under headings A.30.18 (c) (d) (e) and A.30.41 without first getting a dentist's treatment plan and quote?
3) Who pays the dentist for the assessment of the patient's dental health and for the development of dental treatment plan and its costing?

My inquiry at Medicare in 2007 (contact person was Ms , who named herself a policy adviser of the CDDS) revealed that Medicare was not intending to pay dentists anything for the work involved in creating treatment plans or treatment costing as stipulated in 2007 MBS book under heading A.30.21 (ref attachment 3). Dentists obviously did not want to examine patients and draw treatment plans and quote costs without payment. This put GPs into an unenviable (and certainly unsustainable) position to demand treatment plans and costings from the dentists for free, or to turn blind eye to the practice of their penniless patients circumventing the initial dentists' input. GPs without initial dentists' input (for which neither Medicare nor pensioners wanted to pay) found themselves in a very unenviable position where they were not able to follow the TCA development steps proscribed in the MBS Book, under A.30.18 and were not able to inform their patients about the costs and record their consent as proscribed under the heading A.30.41.

The other source of confusion was the issue which chronic diseases made patient eligible. The inquiries at Medicare were contradicting. One advice was that the eligible chronic illness was the one impacting on dental health. The other advice was the other way around that the dental health must impact on the general health of the patient. Multiple inquiries asking for some, even incomplete, list of chronic diseases that were eligible for CDDS did not result in anything that could help GP to identify which diseases were and which were not acceptable to Medicare and PSR. GPs were told "to use their best judgement" only to be prosecuted for it by the notorious former PSR Director, Dr . Osteoartritis is both "arthritis" and "musculoskeletal condition" which are listed in MBS Book under A.30.41 (a) as eligible chronic conditions (ref attachment 3) but Dr questioned its eligibility as reported by the media (ref attachment 2).

Correspondence (ref attachment 4) with Medicare also provides the evidence of a frustrating advice given to GPs by Medicare in regards to CDDS.
Medicare e-mail of 3 May 2011 10:25 AM is refraining to tell which of the listed chronic diseases are eligible and instead states that "*it is essentially a matter for GP to determine, using their clinical judgement*". Why then GPs who follows a very sound logic and considers osteoarthritis to meet MBS Book descriptor of "arthritis and musculo-skeletal condition" is deemed guilty of inappropriate practice? Another Medicare e-mail of 3 May 2011 6:37 PM states that "*in order to be eligible under CDDS, the patient's oral health must also be impacting on, or likely to impact on, their general health*" which is quite different than the PSR Director's view that ""*there had to be a clear link between the disease and dental*

health for a patient to be eligible". So what it is? Is it he link between the disease and dental health or the link between oral health and general health?? How GP should know if Medicare themselves do not know???

Lets now put in focus recent audits and demands for repayment of dental services by the dentists who did not provide Dental Treatment Plans and started dental treatment without them and consider that Medicare in their e-mail of 3 May 2011 (ref attachment) stated clearly that any services provided by dentists before GP Management Plan ("GPMP") and TCA are not payable by Medicare. In this setting the very core question is: If the government does not pay for the development of Dental Treatment Plans how Medicare/PSR auditors can demand them and penalize dentists for not providing them for free? **It is my belief that under the Australian Constitution *(ref. Constitution s 51 (xxiiiA)* such demand for a free service, requiring that the dentists provide Dental Treatment Plans to GPs for free, amounts to "conscription" which is explicitly forbidden by the Constitution.** The court ruling speaks for itself, see:
(ref. http://www3.austlii.edu.au/au/journals/MULR/1999/14.html#Heading46).

The above information fully supports a claim made in the recent submission to the Senate Committee Inquiry into PSR of the Australian Dental Association that **the government knew and tolerated the situation that the dental treatment plans were frequently not done before commencement of the dental treatments. The Medicare/PSR started their "audit frenzy" when the Labour government realised what an enormous hole in their budget and deepening fiscal deficit the CDDS caused...** My correspondence with the Medicare regarding CDDS fully confirms this claim.

One cannot help an impression that the current "audit frenzy" by the government bureaucracy is a clever attempt to remedy the CDDS fiscal blow-out by making the dentists repayments to fill the budget sucking hole... and the Dental Treatment Plans are just a proverbial staff in the Master's hand...

Compiled on behalf of
AUSTRALIAN DOCTORS UNION

by

Dr Richard Waluk (Secretary)
MD(Hons), PhD, ACCAM, JP

...aims from aggressive BP control

...e outcomes, the review of about ...00 people found.

...owever, stroke risk decreased sig... antly with tighter control of BP ...e target 130/80mmHg, while ... outcomes were significantly ...oved, researchers found.

...r either target, achieving blood ...sure control was more likely ...n treatment was based on telmis... ...or the combination of telmisar... and ramipril, compared with ...pril alone.

Professor Jennings ... results do not support altering guidelines.

"These results cast doubt on the widespread perception that to maximise [cardiovascular] protection, physicians should pursue aggressive BP control when patients have a high CV risk, a concept reflected by the current guidelines," the researchers wrote in *Circulation*.

However, co-author Professor Garry Jennings, director of the Baker IDI Heart and Diabetes Institute in Melbourne, said the results did not support any change to the current guidelines of controlling to the target of 130/80mmHg in high-risk cardiovascular patients. The findings showed the risk of stroke and renal events were significantly linked to blood pressure control, he said.

The findings came from the Ongoing Telmisartan Alone and in Combination with Ramipril Global Endpoint Trial (ONTARGET), a trial of patients with end-organ cardiovascular disease.

Circulation 2011; online.

...nmission called ...r clinic stymied

Uncertain future ... Redcliffe super clinic.

...sometimes more than once a week. I simply can't rely on ever-changing finance data in agreeing to a taxpayer-funded loan," he said.

The minister has now referred the foundation's financial dealings to the state's crime commission.

The foundation did not respond to ...*alian Doctor*'s calls.

Federal Health Minister Nicola Roxon said delays in the construction of the super clinic were a "regrettable impediment to a wonderful new service".

She said the Federal Government had independent financial advice indicating that the super clinic project was viable and sustainable.

A spokesman for the minister later revealed that the government could recoup the $10 million if the clinic does not go ahead.

Michael East

GPs' staff caught out in MBS fraud crackdown

GENERAL practice administrative staff are among the targets of the Federal Government's crackdown on Medicare fraud, with two employees given suspended jail sentences in the past year.

In one case, a receptionist at a NSW general practice had to repay more than $60,000 and received a 12-month suspended jail sentence after colluding with her friend to make false claims. While working at the practice, the receptionist deposited numerous false claims into both her account and her friend's account.

In another example, a practice manager in Victoria and his female partner were ordered to repay $110,000 after making numerous false claims at Medicare offices. The practice manager was sentenced to 12 months' imprisonment, to be released immediately and placed on a three-year good behaviour bond.

Federal Minister for Human Services Tanya Plibersek said there had been 14 cases of Medicare fraud not involving doctors in the past financial year. Those found guilty have been ordered to repay more than $235,000.

Medicare has also identified 626 dentists who will be investigated for suspected overuse of chronic disease management items, in a bid to recoup almost $20 million in misused funds.

There are concerns some dentists claimed benefits under the scheme without having carried out any treatment, and having failed to provide copies or summaries of treatment plans to the referring GPs.

As of last week, 419 cases had commenced, with 39 dentists already found to be non-compliant.

Michael East

Dentists now under Medicare scrutiny as crackdown continues

Mark O'Brien

MISINFORMATION from dentists is putting pressure on GPs to refer patients for dental work via the controversial Chronic Disease Dental Scheme, according to the head of the PSR.

PSR director Dr Tony Webber raised the issue as the Government announced it would focus on the scheme as part of its latest crackdown on inappropriclaiming of MBS items.

The scheme, which allows eligible patients to claim up to $42.50 in dental work, is in the sights of Human Services Minister Tanya Plibersek after Medicare audits since July last year found $13.2 million of "potentially incorrect" claims and revealed 59% of dentists audited had bent the rules. Further auditing will cover another 400 dentists and the GPs who made the referrals.

Dental services cost the MBS almost $186 million in the 2010 final quarter – a rise of $44 million on the same 2009 period.

Dr Webber said "reverse referrals" had increasingly undermined the scheme, which Labor has twice attempted to axe.

"There has been some fairly aggressive advertising by dentists... that gives the impression it is just a matter of having a form filled out, [and] GPs have been facing sometimes quite aggressive patients who have been given the wrong idea," he said.

Dr Webber warned that GPs were sometimes complicit, either by stretching the rules or by unintentionally referring patients to the scheme for inappropriate conditions.

GPs, he said, may not realise there had to be a clear link between the disease and dental health for a patient to be eligible. He cited cases of patients referred to the scheme for conditions such as osteoarthritis and chronic eczema.

Australian Dental Association president Dr Shane Fryer, however, said it was up to GPs to act as the gatekeepers of the scheme, adding it was not the dentists' place to "challenge a doctor's medical opinion".

Dr Fryer said the scheme was the first time dentists had worked with Medicare in an arrangement involving other healthcare providers, and that the vast majority of incorrect claims were a result of administrative errors rather than fraud.

Dr Webber said GPs who had made incorrect referrals could be asked to repay only the rebate received for the referral, not the total cost of work claimed by the dentist.

Less dietary salt equals better health, savings and sex

Helen Carter

MEN might take more notice of messages to reduce salt con- blood pressure.

"Hypertension damages arteries to the heart, brain and penis. of vascular- and BP-related diseases at one-tenth the cost of treating hypertension, Professor food categories, the Australian Government had set only two – for bread and breakfast

Australian Government

Department of Health and Ageing

MBS

Medicare Benefits Schedule

Medicare Benefits Schedule

A.30.14 This GP service is available to patients in the community. It is also available to private in-patients (including private in-patients who are residents of aged care facilities) being discharged from hospital, where their usual GP (or a GP from the same practice) who prepares the GPMP is providing in-patient care; in this case the GPMP is claimed as an in-hospital service. A GPMP is not available to public in-patients being discharged from hospital. It is not available to residents of aged care facilities, except where they are private-in patients being discharged from hospital.

A.30.15 Depending on variations in patients' needs, a new GPMP may be required around once every two years, with regular reviews (recommended six monthly) of the patient's progress against the plan. In general, a new GPMP should not be prepared unless required by the patient's condition, needs and circumstances, however, the minimum claiming interval for this item is twelve monthly, to allow for completion of a new GPMP where required. This means that a rebate will not be paid within twelve months of a previous claim for a GPMP or within three months of any other EPC chronic disease management item, other than in exceptional circumstances eg repeated discharge from hospital (see A.30.50 and A.30.51).

COORDINATING THE DEVELOPMENT OF TEAM CARE ARRANGEMENTS (TCA) – (Item 723)

A.30.16 This item is for patients with a chronic or terminal medical condition and who require ongoing care from a multidisciplinary team of their GP and at least two other health or care providers. A rebate can be claimed once the patient's usual GP (or a GP in the same practice) has coordinated the development of TCA by completing the steps at A.30.18 and meeting the relevant requirements listed under A.30.41 and A.30.42. The GP may be assisted by their practice nurse, Aboriginal Health Worker or other health professional in the GP's medical practice or health service (see A.30.44). The service must include a personal attendance by the GP with the patient as part of item 723.

A.30.17 This service can be provided to patients who have a current GPMP or to those patients whose care is, in the opinion of the providing GP, appropriately managed at the GP level without a GPMP.

A.30.18 The steps in coordinating TCA must include:

(a) discussing with the patient which treatment/service providers should be asked to collaborate with the GP in completing TCA;

(b) gaining the patient's agreement to share relevant information about their medical history, diagnoses, GPMP etc (with or without restrictions) with the proposed providers;

(c) contacting the proposed providers and obtaining their agreement to participate, realising that they may wish to see the patient before they provide input but that they may decide to proceed after considering relevant documentation, including any current GPMP;

(d) collaborating with the participating providers to discuss potential treatment/services they will provide to achieve management goals for the patient;

(e) documenting the goals, the collaborating providers, the treatment/services they have agreed to provide, any actions to be taken by the patient and a review date i.e. completing the TCA document; and

(f) providing the relevant parts of the TCA to the collaborating providers and to any other persons who, under the TCA, will give the patient the treatment/services mentioned in the TCA.

The GP may, with the permission of the patient, provide a copy of the TCA or of relevant parts of the TCA, to other providers involved in the patient's care.

A.30.19 The collaboration between the coordinating GP and participating providers at A.30.18 (d) must be based on two-way communication between them, preferably oral, or, if this is not practicable, in writing (including by exchange of fax or email, but noting that the means of communication used must enable privacy to be safeguarded in relation to patient information). It should relate to the specific needs and circumstances of the patient. The communication from providers must include advice on treatment and management of the patient.

A.30.20 To develop Team Care Arrangements for a patient, at least two health or care providers who will be providing ongoing treatment or services to the patient must collaborate with the GP in the development of the TCA. This includes people who will be organising or coordinating care services for the patient that will be provided by their organisation. Each of the health or care providers must provide a different kind of ongoing care to the patient. One of the minimum two service providers collaborating with the GP may be another medical practitioner (normally a specialist or consultant physician but not usually another GP). The patient's informal or family carer may be included in the collaborative process but does not count towards the minimum of three collaborating providers (see A.30.48).

A.30.21 Once a GPMP (item 721) and TCA (item 723) have been prepared for a patient and claimed on Medicare (or item 731 for aged care residents), the patient is eligible for access to certain allied health and dental services (items 10950 to 10977 inclusive). The patient can be referred by their GP for services identified in their TCA after the TCA has been completed and claimed. Medicare rebates are not payable for allied health providers' involvement in contributing to the development of the TCA or the review of the TCA.

A.30.22 A TCA should document all the health or care services required to address the patient's needs – this should include services to be provided by people or organisations that are not members of the TCA team.

other than in exceptional circumstances such as hospital discharge (see A.30.50 and A.30.51).

CONTRIBUTING TO A MULTIDISCIPLINARY CARE PLAN OR CONTRIBUTING TO A REVIEW OF A MULTIDISCIPLINARY CARE PLAN FOR A PATIENT WHO IS NOT A RESIDENT OF AN AGED CARE FACILITY – (Item 729)

A.30.34 This item is for patients who are having a multidisciplinary care plan (which may include Team Care Arrangements) prepared or reviewed for them by another health or care provider (i.e. other than their usual GP). Other health or care providers include (but are not limited to) allied health providers, home or community service providers and medical specialists, but not usually other GPs. A rebate can be claimed once the patient's usual GP (or another GP in the same practice) has contributed to the care plan or to the review of the care plan being prepared by the other provider, by completing the steps at A.30.35.

A.30.35 The steps involved in contributing to a multidisciplinary care plan or to a review of the care plan must include:

(a) gaining or confirming the patient's agreement for the GP to contribute to the care plan or to the review of the care plan and to share relevant information with the other providers;

(b) collaborating with the person preparing the care plan to set goals and specify treatment/services to be provided by the GP;

(c) adding to the patient's records a copy or notation of the GP's contribution to the plan (either the treatment/services to be provided by the GP or the GP's advice to the person preparing the plan).

A.30.36 See A22.19 and A.30.20 on collaboration and communication.

A.30.37 This GP service is available to patients in the community and to both private and public in-patients being discharged from hospital. It is not available to patients who are residents of aged care facilities (see item 731 below).

A.30.38 The recommended frequency of this service is once every six months. Other than in exceptional circumstances, a rebate will not be paid within twelve months of a GPMP or TCA claimed by the same practitioner for that patient or within three months of a previous claim for the same item or within three months of a claim for other CDM review or contribution items.

CONTRIBUTING TO ANOTHER PROVIDER'S MULTIDISCIPLINARY CARE PLAN OR CONTRIBUTING TO A REVIEW OF A MULTIDISCIPLINARY CARE PLAN FOR A PATIENT WHO IS A RESIDENT OF AN AGED CARE FACILITY - (Item 731).

A.30.39 This item, including the components of the service, is similar to Item 729 (see A.30.34 to A.30.38 inclusive) except that:

(a) this service is only available to residents of aged care facilities;

(b) this service can only be provided to a resident where the multidisciplinary plan is being prepared by the aged care facility or by a hospital from which the resident is being discharged;

(c) a contribution to a care plan for an aged care resident must be at the request of the aged care facility or the discharging hospital;

(d) the GP's contribution should be documented in the care plan maintained by the aged care facility or discharging hospital and a record included in the resident's medical record; and

(e) a rebate will not be paid within three months of a previous claim for the same item or within three months of a claim for other EPC CDM items.

A.30.40 Where a resident's GP has contributed to a care plan prepared by the aged care facility or discharging hospital for the resident, the resident is eligible to access rebates under the allied health and dental care items (item numbers 10950 to 10977 inclusive).

In addition, patients with type 2 diabetes may also access new MBS items 81100, 81105, 81110, 81115, 81120, 81125 (Allied Health Group Services for Patients with Type 2 Diabetes) subject to patient eligibility and other restrictions.

ADDITIONAL INFORMATION

A.30.41 Before proceeding with any EPC CDM service (other than a care plan contribution under items 729 and 731) the GP must ensure that:

(a) the steps involved in providing the service are explained to the patient and (if appropriate and with the patient's permission) to the patient's carer;

(b) in the case of TCA and TCA review services, any likely out-of-pocket costs to the patient for the involvement of other providers are explained to the patient; and

(c) the patient's agreement to proceed is recorded.

Note that Medicare rebates are only payable for certain allied health and dental services, provided to the patient on referral from the patient's GP, after both a GPMP and TCA are in place and claimed on Medicare or after item 731 (for aged care residents) is in place and claimed on Medicare. Medicare rebates are not payable for allied health providers' involvement in contributing to the development of TCAs, multidisciplinary care plans, TCA reviews or multidisciplinary care plan reviews.

In addition, patients with type 2 diabetes may also access new MBS items 81100, 81105, 81110, 81115, 81120, 81125 (Allied Health Group Services for Patients with Type 2 Diabetes) subject to patient eligibility and other restrictions.

A.30.42 Before completing any EPC CDM service (other than a contribution item) and claiming a benefit for that service, the GP must offer the patient a copy of the relevant document and add the document to the patient's record.

A.30.43 For the purpose of paragraphs A.30.1 to A.30.52:

(a) "a chronic medical condition" is one that has been or is likely to be present for at least six months, including but not limited to asthma, cancer, cardiovascular illness, diabetes mellitus, mental health conditions, arthritis and musculoskeletal conditions;

(b) "the patient's usual GP" means the GP, or a GP working in the medical practice, that has provided the majority of care to the patient over the previous 12 months and/or will be providing the majority of care to the patient over the next 12 months; and

(c) offering a copy of a documented GPMP, documented TCA or a reviewed or amended version of either of them to a patient should include, if the patient permits, offering a copy to their carer, where appropriate.

A.30.44 A practice nurse, Aboriginal Health Worker or other health professional may assist a GP in preparing or reviewing a GPMP or TCA (for example in patient assessment, identification of patient needs and making arrangements for services); however, the GP must review and confirm all assessments and elements of the GPMP, TCA, reviewed GPMP or reviewed TCA and must see the patient.

A.30.45 Patients being managed under a GPMP (Item 721) and/or TCA (Item 723) by their GP may receive ongoing support and monitoring services from practice nurses and Aboriginal Health Workers under item 10997, consistent with the scope of the plan, and for and on behalf of the GP managing the patient's chronic condition.

A.30.46 The GP Management Plan and Team Care Arrangements CDM items cover the consultations at which the relevant items are undertaken, noting that:

(a) If a consultation is for the purpose of undertaking the GPMP or TCA item only, only the relevant GPMP or TCA item can be claimed.

(b) If a GPMP or TCA item is undertaken or initiated during the course of a consultation for another purpose, the GPMP or TCA item and the relevant item for the other consultation may both be claimed.

In general, a separate consultation should not be undertaken in conjunction with a GPMP or TCA item unless it is clinically indicated that a problem must be treated immediately. In this case the patient's invoice or Medicare voucher (assignment of benefit form) for the separate consultation should be annotated (eg separate consultation clinically required/indicated).

A.30.47 A benefit is not claimable and an account should not be rendered until all components of the relevant item have been provided.

A.30.48 Whenever an EPC chronic disease management service is available to a hospital private in-patient and is provided to that patient in a hospital, the Medicare voucher (assignment of benefit) or patient invoice must be marked accordingly. In-hospital services attract a Medicare rebate at 75% of the schedule fee. See 7.1.2(vi) of the General Explanatory Notes.

A.30.49 If a patient agrees, their informal or family carer may be involved in the preparation/review of the GPMP and/or the development/review of TCA, having regard to the patient's circumstances, the degree of support provided by the carer for the patient and the capacity of the carer to provide ongoing support to the patient and to participate in the relevant processes. The patient and their informal or family carer do not count as one of the minimum three members of the multidisciplinary team.

A.30.50 Where a patient changes practices, so that a GP in the new practice becomes the patient's usual GP, the new GP may use item 725 or item 727 as appropriate to review the patient's existing GPMP or TCA, in accordance with the requirements of those items, at the request of the patient or their carer.

Exceptional circumstances

A.30.51 There are minimum time intervals for payment of rebates for EPC chronic disease management items (as detailed above), with provision for claims to be made earlier than these minimum intervals in exceptional circumstances. 'Exceptional circumstances' apply where there has been a significant change in the patient's clinical condition or care circumstances that require a new GPMP or TCA or a new review, rather than, for example, amending the existing GPMP or TCA.

A.30.52 Where a service is provided in exceptional circumstances, the patient's invoice or Medicare voucher (assignment of benefit form) should be annotated to briefly indicate the reason why the service involved was required earlier than the