Senate Finance & Public Administration Committees

To whom it may concern:

Over the past 4 years, I have treated approximately 180 patients under the auspices of the Medicare funded CDDS. The majority of those patients were existing long term patients of the practice. The remainder were new patients that were referred to our practice by a number (approximately 25) of medical GPs from the surrounding area.

At no time did the practice or myself actively seek or promote this scheme to these medical GPs - in fact there was no communication with them or vice versa them with us to discuss the merits of this scheme other than the standard GP referral letter and my treatment plan summary and occasionally a telephone call to a patient's GP where the patient's medical history required further input.

There has never been any differentiation in my practice between private patients and those treated under third party schemes such as the Medicare funded CDDS and the Veterans Affairs Scheme. Everyone has been treated on the basis outlined below.

In order not to prejudge a patient's wallet and give a patient all their treatment options openly without price being a consideration, I abide by 2 simple rules.

1. Diagnose as if all dentistry was free

2. Diagnose as if the treatment was for my own mouth or that of my mother, my wife or my own children.

Not everyone can afford optimal treatment and for a number of personal reasons, not everyone wants optimal treatment (eg. time constraints, dental phobia, disabilities etc.)

I have been in private dental practice since 1985 (26 years) and have always treated patients who had presented with a Veteran's Affairs Card without prejudice and without any issues with the Department of Veteran's Affairs. I embraced the CDDS in the same manner and with hindsight recognise that I was perhaps a little naive in thinking that it would be managed in a similar and professional manner, whereby both parties would be working collectively together to improve the patient's oral health.

The CDDS first came to my attention in early 2008 when one of my regular long standing patients presented a form from her medical GP confirming her eligibility for the scheme.

The majority of the patients were long standing patients of the dental practice and many had a pre-existing dental treatment plan in place whereby we were endeavouring to deliver this treatment sometimes over a 3 to 5 year time period to make it a financially feasible proposition. For many of those patients that were eligible for funds under the CDDS this money enabled them to achieve their dental treatment over a shorter time frame or delivered a more optimal treatment plan.

90% of patients were charged our normal practice fees and consequently incurred a personal out of pocket fee (which they had been advised of in advance and had accepted) whilst 10% of patients were bulk billed.

Some patients are quite proactive in their dental treatment whilst others are simply reactive - only dealing with dental issues when the need becomes so great and overwhelming. Again the funds provided by the CDDS allowed some patients in this latter group to afford to be more proactive.

Even as recent as 5th March 2012 I received further correspondence from the Victorian branch of the ADA reiterating steps in order to stay compliant with the CDDS. In their interpretation of Section 10 - you cannot undertake any definitive dental restorations or treatment on the first visit. One of my patients whom I treated under the CDDS lives on King Island in Bass Strait. Cost is a big issue for her and whilst a dentist does visit King Island from Tasmania he was renown for his high fees and hence she elected to continue to see me despite only coming to the mainland once a year. It would have been unconscionable to have simply examined her and formulated a treatment plan and advise her that due to the requirements of Section 10 that she needs to come back next week when I can be sure that her medical GP has received my written summary of the proposed treatment plan prior to me undertaking necessary dental treatment. Her medical history was significant and she was in remission from a significant cancer and she was not in a financial position to fly back to Victoria again in the short term. Such is the administrative burden of the CDDS in its current format that the patient comes second.

There was not one patient that did not appreciate the benefits that the CDDS afforded them. There was the odd patient that complained of the out of pocket cost - but they had been advised of this at the outset and had chosen to stay with the practice. A number of patients had not wanted any out of pocket expenses right from the outset and our receptionist not wanting to waste the patient's time nor ours directed them elsewhere.

This should not be seen as being monetarily / greed orientated. There have been a number of dental schemes to assist those that are disadvantaged over the years in which I have supported and participated and they have come and gone. By electing to continue to charge our normal dental fees (with the exception of a number of individual cases) participation in this scheme would not jeopardize the practice when the scheme ultimately concluded.

It is my belief / assumption that patients that did not have any out of pocket costs would not always fully appreciate what had been provided for them. In addition by having them make a contribution toward their dental treatment it involves them in the decision making process and serves as a check against rorting the system.

Any invoice that I served upon Medicare Australia related to dental services that were all delivered to those patients. I did not maliciously defraud Medicare but with hindsight I recognise that in the early stages of my participation in treating patients under the auspices of the CDDS there were 3 areas that I believe I was remiss in relation to Section 10 of the Determination. These 3 areas (which I will expand upon below) I believe are accurately described as minor administrative errors and I personally do not believe that any of my patients were adversely affected in those circumstances where I did not comply with all the rules of the CDDS as outlined in Section 10 of the Determination.

1. Not having always sent a summary of the treatment plan to the referring medical GP and ensuring that he/she had received it prior to the commencement of actual dental treatment.

Prior to June 2010 when I became fully aware of the requirements of the CDDS (more so by various communications provided by the Australian Dental Association communications than Medicare itself) the letters had not always been sent in a timely fashion.

Having now treated approximately 180 patients over the past 4 years, not once has any referring medical GP contacted me with regard to my proposed treatment plan. Occasionally I telephoned the GP to further discuss the patient's medical history in light of the necessary dental treatment that I had proposed and recommended - but never once did any of the medical GPs contact me.

2. Not having always provided a written fully costed treatment plan.

In the early stages of the scheme where I was often treating long standing patients of the practice and simply continuing with their original treatment plans that I had previously gained consent - sometimes only a verbal summary of the Medicare rebates was provided.

Similarly where I had agreed to bulk bill the patient and simply accept the Medicare rebate for the dental services provided I would simply advise them verbally. For example I would verbally advise the patient that the normal fee for a partial metal denture was $1500 but I would be happy to accept the Medicare rebate of approximately $1200 as full payment and that there would be no out of pocket cost. It honestly did not register with me that I would be accused of defrauding Medibank Australia simply because I did not physically provide written confirmation that there would be NIL cost to the patient. I have since re read Section 10 of the determination more than 20 times and I have no doubt about the actual requirements now.

3. Invoicing the patient at the conclusion of the actual treatment.

In the early stages of my participation in the CDDS I had continued our normal business practice of billing / invoicing the patient at the beginning of the treatment - for example when undertaking the preparation of a tooth for a crown - the full amount was invoiced on

this day - when under Section 10 it should have been invoiced on the actual day that the crown was fitted. Again once I was made fully aware of the requirements of Section 10 I simply reverted to invoicing on the day of inserting the prostheses. Again I reiterate that at no time was any treatment invoiced that was not actually undertaken and completed.

It just seems to me that dentists like myself - that once we had been educated sufficiently and made fully aware of the requirements and the consequences of not adhering to Section 10 in its entirety - are quite capable of 100% compliance. Initial non compliance was simply an innocent oversight on my behalf and apparently many others. Again I can only reiterate that there was and never has been any attempt to rort the CDDS or deliberately attempt to defraud Medicare Australia.

In early 2011, I received notification that I would be subjected to an audit of 20 randomly selected patients that I had treated under the CDDS during the 2 year period March 2009 to March 2011. As stated previously, I had ensured that I was fully compliant from approximately June 2010 when I had acted upon the recommendations of the ADA to ensure that my house was in order should I be subjected to any future audit. The information that Medicare sought was fully provided but as yet (12 months later) I have not received any correspondence as to the outcome of the initial audit. I had the assistance in preparation of the information required by a solicitor provided by our professional indemnity insurance via the Victorian branch of the ADA. Without prejudging my own audit - I suspect that I could be potentially deemed to have been non compliant with 10 patients out of the sample of 20 - via one of those 3 actions listed above. In that 2 year period I would estimate that I may have treated 120 CDDS patients. I do not know for certain how much was received from all of these patients but if I were to be conservative and assume that not all patients received the full entitlement of $4250 but work on approximately $ per patient this would work out to be $. Assuming that the 50% non compliance was applicable to all those 120 patients this could result in Medicare initiating a claim of $ against me.

This claim would be made on the basis of

1. sometimes not having written a letter to the medical GP in a timely manner

2. sometimes having provided a verbal costed treatment plan instead of in writing

3. sometimes having invoiced the patient at the start of treatment instead of at the end.

and despite having diagnosed and treated the patient's dental needs in a timely and professional manner and gained their personal consent to having the treatment undertaken.

Personally, I wish that Medicare Australia had reviewed my first 10 patients at the outset and then they could have identified quite early in the piece my wrong doings and areas of non compliance and given me corrective guidance. Upon further review /audit if it was

found that I had not taken action to rectify my non compliance then I could not complain should they seek punitive damages. What I find extremely disappointing is that I have been allowed to continue practicing for greater than 3 years without any direct oversight, interpreting things how I perceived they read and making changes to my practices along the way as deficiencies were identified and brought to my attention and yet threatened to have to return all monies received from Medicare Australia where what can only be deemed administrative errors have been identified.

I find the actions of Medicare Australia quite draconian when compared to another government department - namely the Taxation Office.

My accountant advised me that there are numerous case reports whereby people have been found upon auditing to be non-compliant yet as a result of being able to demonstrate that there was no deliberate attempt to defraud or there was no deliberate malice and the issues were mere technical oversights then the Deputy Commissioner of Taxation has used his/her discretion in giving due consideration to the circumstances and not penalized the person. With new taxation legislation, I understand the taxation office even have people come out and assist in compliance of the new legislation and automatically provide fact sheets to assist in compliance. I would urge Medicare Australia representatives to look at how the Taxation Office appears to act in a more humane and logical manner in dealing with minor non compliance.

To date, I have continued to fully support the CDDS despite being subjected to an audit that has not yet been fully completed. Administrative areas where I had been non compliant have been addressed to ensure that I am fully compliant with Section 10.

However, in talking to various professional colleagues, it is a fact to say that a lot of good will by the dental profession that over many years has supported and sustained various Government funded public dental health schemes has been severely diminished / eroded due to the alleged "hard nosed callous approach taken by Medicare against non compliant dentists in pursuit of monies on the basis of paperwork and administrative oversights".

Medicare Australia may well say that they have issued numerous papers via mail and email etc - however this was not the case in the initial stages - it was only later when they perceived and recognized a need. I believe Medicare Australia should accept their share of the responsibility of the shortcomings and failures of the administration of this otherwise worthy scheme. I believe that dentists are being played as a political football whereby a scheme introduced by the former government is being attempted to be closed due to significant unbudgeted for costs. This is a scurrilous and disturbing action that has caused an inordinate amount of stress to many otherwise professional practitioners including myself.

No one including myself and the dental profession at large condones rorting. As the evidence already attests - there have been some instances of deliberate / intentional defrauding of Medicare Australia and everyone supports Medicare in pursuing those persons responsible but the majority of instances of non compliance in many cases including my own were not deliberate or with malice but innocent administrative oversights and I implore those people that have the power to have and show some compassion in correcting this injustice.

Yours sincerely,

Dr Shayne Hateley

NB: I hereby allow this submission to be made available for public usage.