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Wednesday 11th April, 2012

The Senate Finance and Administration Committee
PO Box 6100 Parliament House
Canberra ACT 2600
Australia

To whom it may concern,

I am a Dental Prosthetist (a clinically qualified dental technician), not a dentist or doctor. Essentially I provide and fit dentures.

Although all publicly funded denture schemes pay less than half my normal unsubsidised fees for the same service, I choose to participate since I feel a moral obligation that every patient should have access to high quality dental care. Particularly if they have complex needs. This is why I initially chose to participate in the Medicare Chronic Diseases Dental Scheme (CDDS). CDDS patients both have complex needs are often from otherwise more disadvantaged groups.

The first thing I knew about the CDDS was when a patient presented with a form. After quickly registering I was given a 60 page booklet aimed at Dentists, Specialists and Prosthetists. Subsequent correspondence from Medicare has largely referenced dentists and other health professionals. Indeed most of the information has gone to the ADA (Australian Dental Association) of which Dental Prosthetists are not members. Correspondence from Medicare refers to me usually as a dentist and calls me Doctor. Until recently I don't think Medicare knew what a Dental Prosthetist is.

As knowledge of the scheme spread through the general community, more and more of my private patients were displaced and I had little choice but to go with providing subsidised services to those with multiple health issues. Practicing in the northern suburbs of Melbourne, I estimate 90% of my work has become CDDS funded, given the demographics of the area.

Accepting less than half our normal fee means we work much longer and harder hours, live with greater stress and at the end of the day, labour under a deluge of onerous paperwork. Now Medicare is demanding a substantial part of these fees assigned to me be returned.

In order to support its claim for the return of these monies, Medicare is apparently claiming that there has been some sort of false or misleading statement by me. Medicare alleges those false and misleading statements, which form the basis of Medicare's case for return of the monies, arise by virtue of my alleged non- compliance with the words of the Determination- a document I never read, because my attention was never specifically directed to it until very recently.

I have denied these allegations emphatically in my Application for a Review of the initial Task Force finding that I must return to Medicare certain monies assigned to me by my patients.

ANALYSIS OF THE CDDS TRANSACTIONS

In my view there are two contracts in the CDDS transactions performed by me:

In the first contract I provide a dental prosthetic service to a patient for a fee. The patient is required to pay me for that service. That obligation in the patient to pay me continues until the Invoice is paid.

The second contract is a contract in which, in certain prescribed circumstances, my patient (who is one type of 'eligible person') may, under contract and pursuant to section 20A of the Act, assign to me (another type of 'eligible person') the benefit that DHS-Medicare has agreed to pay my patient in respect of that patient's liability to pay me for my service.

My patient's contract in this second scenario is with Medicare. The Government, through Medicare has said it will pay my patient a benefit for certain services. My patient, on the strength of the government's promise, also contracts with me to perform those services I am able to perform. To partly pay for that service my patient assigns to me its benefit payment.

I have, by general agreement, properly performed the services to the patient in all the cases in which I am asked now to return money to Medicare. No fraud, no over servicing, no problem with the quality of the services performed. My contract has been properly performed as far as I am concerned. My patient has paid me and therefore the various contracts are executed, at an end.

How, in the above set of transactions, is DHS- Medicare alleging a false and misleading statement has been made by me here? Is any false or misleading statement alleged by the patient, whom Medicare is required to pay (and has in fact paid)? The answer is no, in both cases.

If Medicare insists on conducting mass audits of various dental services providers years after events in which it made a correct payment to the person whom it is obliged to pay, why is the Department now pursuing me and other dental service providers?

The correct person to pursue (if anyone) here is the patient. Either Medicare pursues the patient or if, the Courts or the Parliament, do indeed insist or rule that I must to repay to DHS- Medicare monies paid on behalf of a patient who assigns to me its right to accept such payment, my patient nevertheless remains liable under contract to pay for the services rendered to that patient by me. In which case I must then again invoice that person or its estate for the work performed but which remains unpaid by my patient. As unpleasant as it may be, that to me is the correct way to look at these transactions. I am, after all is said and done, a small business person upon whom more than one family depends and I am obliged to protect my income and my family, among that of others in my practice.

If the Government and DHS- Medicare and its political masters think that the recent 'audit' is a pretty nifty solution to its present deficit woes, this putative solution should be re- thought. Those that will suffer in the end are those with chronic illnesses who were able to access much needed dental services after 2007 on the basis of a political and governmental promise, policy and implemented program. Patients took advantage of those promises, programs and policies and had work for value performed by me and other dental professionals. We have worked in good faith and now we are being asked to return honestly earned money to pay for Medicare's administrative failures.

MEDICARE'S ADMINISTRATIVE FAILURES

I believe that DHS- Medicare has maladministered the Chronic Disease Dental Scheme from its inception and is now attempting to shift the blame for this maladministration from itself to dental practitioners and dental prosthetist and to recover a large amount of money as well.

On 25 November, 2011 the Senate passed the Motion giving further credence and substance to the widespread public concern about the manner in which this process is being pursued.

Dental practitioners, prosthetists and other allied health professionals (who had little or no previous experience of dealing with Medicare) are being harassed (or Audited) on a basis which is not declared. Practitioners have been told nothing about the methodology of the Audit. They have been told nothing about why some practitioners were chosen for Audit and others not (so far). They have not been advised how long the Audit will continue and what is the target number of practitioners to be Audited. What is known is that it is clear these audits are continuing and of those Audited 65% or more are being found to the non- compliant. Again the definition of 'non- compliance' being used by DHS-Medicare is not clear.

I refer to a Fact Sheet issued by Medicare dated November, 2010 and headed "Information of Dental Prosthetists Dental Services under Medicare for People with Chronic and Complex Conditions". Firstly, it is worthwhile noting that the *Health Insurance (Dental Services) Determination* 2007 is not mentioned **at all** in this fact sheet. On page 4, however, the Fact Sheet says: "To assist patients in understanding the cost of dental treatment, dental, prosthetists are required to provide a written quote **or cost estimate** to the patient

prior to commencing a course of treatment." (My emphasis added.) The other thing worth noting about this fact sheet was how late in the administration of this Scheme it was issued. The program had been operational about 3 years by the time practitioners received this fact sheet.

Around the middle of 2011 I was approached by Medicare and invited to participate in a random audit. Throughout the initial process I demonstrated full and honest cooperation, unsuspecting of the course that Medicare was embarking upon.

On 28 July, 2011, I received a letter which said, under the heading '**Acknowledgement of non- compliance'**, the Chronic Disease Dental Scheme Taskforce said: "You stated during a telephone conversation on 26/7/11 that you are non- compliant with the requirements of section 10 of the *Health Insurance (Dental Services) Determination* 2007". I simply did not say that. This is an attempt to put words into my mouth to incriminate me (and by the way it makes Medicare's job of whitewashing its maladministration significantly easier for it to do).

Despite this, the Taskforce compliance officer later told me that the audit had found no fraud and that I had submitted a treatment plan to referring practitioners, but then went on to allege that I had failed to provide patients an itemized treatment plan and quote. I was surprised, as I had routinely written the quote (including a statement of the projected out of pocket expenses) on my patients' initial history and then ALWAYS wrote it again on their appointment card. This was accompanied by my sitting down with each patient and overviewing exactly what work I would do, how much it would cost, how much Medicare would pay and how much each patient would have to pay me personally (the gap). My patients were very well informed. So much so that I thought that I had in fact been compliant.

The Medicare Audit officer then went on to aggressively pursue this matter for patients treated over a two year period and asked for full repayment of all fees due to this alleged administrative non- compliance. Even though I initially took part voluntarily in the Taskforce's enquiries, I began to be concerned when I received the above letter from the Taskforce dated 28 July, 2011 where it had said I had said something I did not say. I then sought legal advice.

Since then the Taskforce undertook a full 'audit' of my services provided under the Scheme. for a given period. This meant they questioned infirm patients with multi disciplinary health issues (that may have included dementia) and who often didn't speak English, about treatments that happened up to three years ago. The reliability of data achieved in this manner is unreliable (among other things).

Since the scheme's inception nearly all my private patients have been displaced by Medicare cases. In my view this is because I have the confidence of the Referring Doctors, Dentists and indeed, patients in his area (which by the way is a low SES area with high levels of persons who speak a language other than English and are in receipt of Benefits or Pensions). I surmise that the audit legislation was drafted to protect the public against

fraud and over servicing. Since I have done (and been accused of) neither, there seems be another agenda that threatens to ruin me personally and also the three families that this practice supports.

If compliance was really the issue, Medicare would have, at the outset of the Scheme and regularly throughout its roll out, spoken to the practitioners' professional bodies and to the practitioners themselves and provided us with templates as practical guides and advice if there were any particular issues. In which case this current problem would have been obviated.

Medicare's web site states "... our focus is to ensure providers have the information and support to do this correctly...we do this through a variety of means including engaging with stakeholders and conducting education activities, face-to-face and online, in a collaborative fashion." On no occasion have I experienced this collaboration or support. The only face to face contact I have had with Medicare was a talk given to the Australian Dental Prosthetists' Association (ADPA) by Dr Andrew Leaver on 20 April 2011. This was too little and too late. Dr. Leaver's visit only served to reinforce the confusion felt by everyone in attendance.

I have also read the *Medicare Australia National Compliance Plan 2008- 2009*. This glossy publication was taken up mainly with detailed overviews of compliance programs in the PBS and Medical Benefits areas. It touched on the extension of Medicare Benefits into other ancillary health areas and the overall fast growth in money amounts of rebates and the number of services Medicare paid out. No mention at all was made of the Chronic Disease Dental Program in this particular annual compliance overview.

The *Medicare Australia's National Compliance Program 2009- 2010* was a much more substantial document than its immediate predecessor. It again mentioned the very fast growth in Medicare rebated services, the entry of new classes of professional service providers who could seek provider numbers, and be paid benefits, **and the problems of properly supporting the entry of these providers** (my emphasis added). It also mentioned the Chronic Disease Dental Program. It said it had conducted compliance activities but gave no specific details of the outcomes of those activities. It said though: "We also anticipate we will have an eLearning module on the Chronic Disease Dental Program in place by the end of 2009- 2010." To the best of my knowledge that eLearning module was not in place by the end of 2009- 2010 and is not yet in place. If it is in place, I haven't been told of its existence and neither has my professional body, the Australian Dental Prosthetists Association. If it has not been prepared and it is not yet out in the practitioner community, Medicare is in my view grossly negligent and taking cynically oppressive actions to cover its default.

The audit that was recently completed in my practice alleges I have to repay $150,804.70 of benefits paid to me for services that professionally and properly rendered under the Chronic Disease Dental Program because of what the Senate Motion on this matter 24 November, 2011 called: "... non compliance..." of a "... minor and technical ... nature...".

Further, the Senate motion states that to date only 62 of 11,469 ‘dentists’ who had participated in the Scheme had been audited. Of these 62, 41 or 66% had been found to be non-compliant. The facts speak for themselves. With such a high rate of non- compliance, Medicare’s administration of the Chronic Disease Dental Program has failed. The Senate motion goes on to say that currently 419 to 556 audits are presently in train. Again, I understand that a very high non- compliance rate (over 65%) is being shown.

I note that the Medicare Fact Sheet to which I referred above was dated November, 2010. This was when compliance issues began to be an issue. The total money amount of the allegedly non- compliant services performed by me is $150,804.70. Of this amount I have done a rough estimate of the allegedly non- compliant services rendered by me from December, 2010 to March 2011. That is, after November, 2010. These allegedly non- compliant services totalled $16,970.15. Allegedly non- compliant services rendered by me in 2009 and 2010, therefore, totalled $133,834.55 or 88.75% of the total allegedly non-compliant services. This was the period when I (and other practitioners) were basically continuing to do what we had done since 2007, with no help, support or even feedback from DHS- Medicare.

In the recent audit, no allegedly non compliant services were found to have been made after March, 2011 (or indeed after Dr Leaver’s talk of 20 April, 2011). My point here is simply that when I knew there were issues, I changed my procedures to ensure compliance. If these rules had been made clear by Medicare from the outset, compliance would have been a given for me (and I am sure, most other practitioners).

More focus on checking, counselling, help and support from Medicare Compliance would have produced huge benefits in rates of compliance if this had been done from the inception of the Scheme.

Oncer again I quote the Medicare Australia’s National Compliance Program 2009- 2010 which said (*inter alia*): “We recognise that we can do more to support good record keeping practices. In 2009- 2010 we will undertake a project to develop and deliver better record keeping support. We will do this in consultation with key stakeholders ...”. I believe, this too never took place. This failure, of course, goes to the heart of the current return requests.

This current issue is about record- keeping pure and simple. If Medicare had done what it said it would do, the overwhelming majority of this alleged non- compliance would not have taken place and Medicare could be using its compliance time and money much more effectively to target fraud and over servicing. As the old sayings go: “A stitch in time saves nine” and “prevention is better than cure”.

Despite that, however, this Medicare ‘cash grab’ and ‘cover up’ continues to be emotionally crippling for the practitioners involved and at this stage there seems no common-sense resolution in sight. My profession has neither the financial strength nor influence of doctors or dentist nor has it had the long association of these other professions with the procedures for claiming Medicare benefits.

CONCLUSION

I am now over 50 years old and I began in this industry when I was 17. In that time I have participated in at least two other public schemes including the Victorian Denture Scheme and Veterans Affairs. I have never had issues with any in the past. With both these bodies I have felt that I can discuss treatment and administrative issues and feel that I am working as part of a team. Medicare has been a much different experience. Medicare have always been unapproachable and the relationship adversarial. Getting answers to questions by either phone or email has proved unreliable at best and impossible in reality.

I do not provide the range of services to clients that dentists and medical practitioners provide. GPs refer their patients to me for one specific reason, to obtain dentures, which allow them to feel better about themselves and to assist them to eat and live in a healthier manner. All my patients were treated professionally, with dignity and their work completed in good faith to the highest standards. The onerous sum of money that Medicare hope to recover (for very trivial reasons), will acutely impact the security of my family and the 2 other families that this business supports. I can no longer hope that I will one day be in a financial position to retire.

I have been audited by Medicare and required to return over $150,000. It doesn't seem to matter to Medicare that the treatments have been provided in good faith, professionally and in conformity with best practice. Medicare's main allegation is that I have not provided an adequate treatment plan or written quote to patients. I believe that this information has indeed been provided, but perhaps not in the form that Medicare has decided it requires. Despite that, my patients were all very well informed of the treatment they were to receive. In my initial consultation with my patients I showed them the amount Medicare would pay and the amount they would be "out of pocket" (hugely discounted). If I hadn't fully informed all my patients, they would never have paid me. In fact, they would then have had approximately six weeks to pull the plug, if they wished, before completion. None did so. I never thought that every quote or piece of written documentation given to patients needed to be scanned and kept for audit purposes.

In cases of fraud, those involved should be dealt with appropriately. I have been told that Medicare has no discretion to differentiate between minor or major breaches of the Health Insurance Act. While this may be the case, it is clear from Medicare's published responses to Senate enquiries etc that it does have (and has apparently exercised) the discretion to choose between education or recovery. There appears to be huge inconsistencies in the way the Act and the Determination have been interpreted and ultimately how the compliance officer decides whether to ask for recovery or not.

As far as education goes, the only face to face contact I have had with Medicare was a talk given to my association by Dr on 20/04/11, too little and too late. Dr. visit only served to reinforce the confusion felt by everyone in attendance. If Medicare would have audited practitioners at the inception of the scheme, and engaged

with stakeholders, this entire episode could have been avoided. This is poorly drafted legislation that should be changed.

For me personally the poor administration of the scheme by Medicare has caused myself, my family (and others in the profession) - unbearable stress. It threatens my career and the security of my family, and for no good reason. I can assure you that I regularly now hear of doctors who refuse to give plans to eligible patients and I know of dentists that will no longer deal with Medicare patients when referred. This means that patients with multidisciplinary health issues, who might not otherwise be able to afford prosthetic treatment are already falling between the cracks, compromising their standard of living and their ultimate health outcomes. Surely common sense has to eventually prevail.

Regards,

Iain Indian
Dental Prosthetist