Australian Dental Association NSW Branch

SUBMISSION TO THE FINANCE AND PUBLIC ADMINISTRATION LEGISLATION COMMITTEE

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

April 2012

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About the Australian Dental Association (NSW Branch)

The Australian Dental Association (NSW Branch) (ADA NSW) represents dentists practising in the public and private sector in New South Wales and the Australian Capital Territory. The Branch has 4,000 members, including dental students, and represents over 80% of registered dentists (or close to 90% of practicing dentists) in NSW and the ACT.

Our vision is to add value to the community as the oral health authority in NSW and the ACT. Our members play an important role in the community as trusted health care professionals. The Branch promotes access to dental care that is safe, high quality, affordable and ethical. Working with our members, government and other stakeholders the Branch strives to promote leading models of care.

A highly valued member service provided by ADA NSW is its Dental Defence Advisory Service. This service helps form a connection between the world of dentistry, the legal profession and regulatory agencies for members of ADA NSW. Its primary role is to provide direct empathic support for those members of ADA NSW who are dealing with legalistic issues that arise from the practice of dentistry.

To date, Peer Advisors from the Advisory Service have provided advice and support to over 250 dentists from NSW and ACT who are the subject of a Medicare audit relating to the Chronic Disease Dental Scheme. This puts the Association in a unique position to provide advice to the Finance and Public Administration Legislation Committee with respect to its inquiry into the Health Insurance (Dental Services) Bill 2012 [No.2].

Executive summary

The Chronic Disease Dental Scheme allows eligible patients to claim up to $4,250 in Medicare Benefits for dental services in any two consecutive calendar years. The scheme was introduced in the last months of the Howard Government and in 2008 the new Rudd Labor Government tried and failed twice to close the scheme. The initial estimate of patient numbers to be treated under the scheme and its cost to the Commonwealth were significantly underestimated and the scheme has now cost more than $2.3 billion.

While preliminary auditing of dental practitioners commenced in late 2008 the number of audits increased significantly about the second half of 2010. These audits have primarily focused on 'incorrect claiming' associated with legislative requirements found in section 10 of the *Health Insurance (Dental Services) Determination 2007*. It is the contention of ADA NSW that these requirements (and the consequences for non-compliance) were either poorly communicated to dentists or not communicated at all.

This conflicts with claims by the Department of Health of Ageing and the Department of Human Services that there has been a very extensive program of education about the CDDS for dentists which commenced in October 2007. The level of non-compliance by dentists revealed to officers of the ADA NSW Advisory Service suggests there has been a systemic problem with the way in which information about the CDDS was communicated to dentists.

In discussing why the education process for dentists was so flawed, this submission will focus on three issues ADA NSW says have a direct bearing on this question. First, there was little or no consultation with the dental profession regarding the construct of the scheme and its ongoing operation. This is a significant factor contributing to the high levels on non-compliance experienced by dentists who have participated in the CDDS. Consequently, many of its requirements seem impractical and fly in the face of the standard treatment protocols. They are not consistent with excellence in patient care and often fail to encompass the duty of care dentists owe to their patients.

Second, ADA NSW strongly suspects both the DHS and DoHA assumed the CDDS would close relatively early in its existence. If true, this would explain the initial reluctance to consult with and educate dentists about the CDDS, at least in the first two to three years of the scheme. After all, why waste time and resources educating a relatively small profession if the scheme was to be closed?

Third, there are many examples which demonstrate both the DHS and DoHA were unclear about the parameters of this scheme, about dentistry in general and about the way in which the dental profession operates in practice. These examples continue to this day. How then could these agencies have possibly educated dentists about the requirements of the scheme (and the obligations on dentists) in a clear, unambiguous and timely fashion if they themselves were confused and unsure about these requirements?

About the Chronic Disease Dental Scheme

Background to the scheme

Dental care items were first introduced in the Medicare Benefits Schedule (MBS) for patients with chronic conditions and complex care needs in 2004 under former Enhanced Primary Care (EPC) arrangements. Eligible patients were only able to access three dental services per year and the Medicare rebate for each service was set at just $77.95. Not surprisingly, the uptake of EPC dental items was extremely limited.

In May 2007 significant changes to the EPC program were announced in the Budget which would take effect on 1 November that year. Eligible patients could now claim up to $4,250 in Medicare Benefits for dental services in any two consecutive calendar years.

The change to EPC dental items was made on the basis that people with chronic conditions and complex care needs often have poor oral health which can adversely affect their medical condition or general health. These changes would greatly assist people with a chronic disease to quickly access dental services in the private sector where the vast majority of dental practitioners are employed.

The new Medicare items covered a comprehensive range of dental services provided by dentists, dental specialists and dental prosthetists including high end items such as crown and bridge work. The Medicare items were based on existing dental schedules used by the Department of Veterans' Affairs (DVA), with some modifications.

In May 2007 the Coalition Government announced the EPC dental program would cost $377.6 million over the first four years. 200,000 patients were expected to access the dental care items in this period.

At the time the Australian Dental Association acknowledged the scheme would assist people with chronic and complex illnesses to access dental treatment but was critical of the fact the new scheme was not means tested. Means testing eligibility, similar to the way public dental services restrict eligibility, would enable scarce funding to better target Australians with the greatest dental needs but the least ability to pay for care.

Changes to the EPC dental program did not enjoy bipartisan support and the Labor Party went to the 2007 election with a policy to abolish the program and replace it with a Commonwealth Dental Health Program (funding State and Territory public dental services at a cost of $290m over three years). The new Rudd Labor Government tried and failed twice to close the EPC dental program in 2008 and so the scheme continues to operate to this day.

Note: references to the EPC have been removed from the Medicare Benefits Schedule (MBS) and replaced with the term Chronic Disease Management (CDM). The dental component of the program is now known as the Chronic Disease Dental Scheme (the CDDS). All references in this document to this program will refer to it as the CDDS.

Key Statistics of the CDDS (from November 2007 to 29 February 2012)[1]

No of dental practitioners claimed:	11,970
No of services provided:	17,516,308
Total spend:	$2,333,696,342
Number of complaints:	1025
Relating to Number of dental practitioners:	745
Audits underway:	535
Audits completed:	94
Number found compliant:	29
Number found non-compliant:	65
Amount identified for recovery:	$21,618,721
Repayments received:	$259,427

Source: Department of Human Services, Undated, Submission to the Senate Standing Committee on Finance and Public Administration, ATTACHMENT A, at page 2.

Comment on scheme utilisation

At the end of August last year over 784,000 patients had been treated under the CDDS, almost five times as many expected to access treatment in the first four years. By the end of February 2012 almost 12,000 dental practitioners had provided more than 17 million dental services under the scheme.

More noteworthy perhaps is the cost of the CDDS to date. Expected to cost $377.6 million in its first four years the actual cost to the Commonwealth in that time was more than $2 billion.

How an initial estimate of 200,000 patients over the first four years was arrived at is uncertain however, that figure obviously underestimated the high demand for dental services under this program and, as a consequence, the cost of the program has escalated significantly.

Auditing and compliance

Background to Medicare auditing

In November 2008 an internal audit program was established by Medicare Australia to focus on compliance by dentists participating in the CDDS. This decision was apparently made as part of Medicare's annual National Compliance Program. However, auditing of dentists only commenced in any significant number about July 2010 coinciding with an increase in funding to Medicare Australia for compliance activities generally, not just in relation to dentistry[2].

By the end of 2011 there were 933 audits under consideration or active. Of these, 629 were under way or completed and 89 were closed. Of the 933 audits under consideration or active, 436 relate to dentists practicing in New South Wales and the Australian Capital Territory (about 47 per cent).

Health Insurance (Dental Services) Determination 2007

To date, auditing has primarily focused on incorrect claiming associated with legislative requirements found in the Health Insurance (Dental Services) Determination 2007 (the Determination), particularly Section 10 requirements.

Section 10 of the Determination is reproduced below:

> **10 Quotation for dental services and reporting**
>
> (1) This section applies if:
>
> (a) an eligible dentist, an eligible dental specialist or an eligible dental prosthetist performs an initial examination and assessment of an eligible patient, including consideration of any diagnostic tests; and
>
> (b) provides a course of treatment to the patient.
>
> (2) An item in Schedule 1 applies to a dental service included in the course of treatment only if, before beginning the course of treatment, the eligible dentist, eligible dental specialist or eligible dental prosthetist:
>
> (a) gave to the eligible patient, in writing:
>
> (i) a plan of the course of treatment; and
>
> (ii) a quotation for each dental service and each other service (if any) in the plan; and
>
> (b) gave a copy or written summary of the plan to the general practitioner who referred the patient for dental services.

The program underpinning the CDDS involves the coordinated care of people with a chronic disease who are experiencing health issues in part, at least, as a result of their dental illness. So coordination between the dentist and the referring general practitioner is not incidental to the operation of the scheme, it is integral to it.

Furthermore, according to the Department of Human Services (**the DHS**), there is a very clear legislative obligation found in section 10 of the Determination which dentists must comply with to claim Medicare benefits. These requirements go to the core of the CDDS and are essential to fulfilling the scheme's purpose: to improve the health outcomes of sufferers of chronic disease.

According to the DHS, compliance with Section 10 (provision of documentation prior to commencing a course of treatment) is important for the following reasons:

- patients can give informed financial consent in relation to how their entitlements are to be used;
- patients understand the treatment that is proposed;
- patients have the options to seek clarification or a second opinion; and
- the referring GP can provide effective coordinated care of the patient's chronic health condition.

Consequently, a small but growing number of dentists have now been asked to repay hundreds of thousands of dollars each primarily for breaching these section 10 requirements. An even smaller number of dentists (12 in total) have been found non-compliant for claiming Medicare benefits prior to these services being provided to the patient. ADA NSW understands however that this would include services never provided (or never intended to be provided) but may also include services not yet completed.

For example, a dentist will be non-compliant even if the service was actually provided to the patient, although at a point in time after the service was initially billed. This situation arises frequently as it is standard practice for dentists to pre-bill patients for some services before they are completed or before they are provided to the patient. This includes, but is not limited to, services which require payments to third parties: dental laboratories for instance who manufacture and produce items such as dentures. While this may be standard practice in the profession it is prohibited by Medicare.

Audits completed to date by Medicare Australia indicate that about seventy per cent of all dentists audited were found to be non-compliant with administrative aspects of this scheme.

Role of ADA NSW Advisory Service in Medicare Audits

As audit letters were received from Medicare Australia many affected dentists contacted the Advisory Service at ADA NSW. Peer Advisors from the Advisory Service have now conducted interviews with over 250 dentists from NSW and ACT. Almost all of these interviews were conducted face-to-face with the dentist collating and presenting to the meeting, at the very least, a random sample of documents relating to the treatment of patients under the CDDS and nominated by Medicare Australia for audit review.

In each case documents were examined for compliance and billing issues by Peer Advisors who quickly noticed a familiar pattern emerge. Although most dentists were initially confident they were compliant with the requirements of the scheme, most were told they were non-compliant due to one or any combination of the following:

1. copies of treatment plans to referring general practitioners either not sent or not sent prior to commencing the “course of treatment”;
2. Copies of treatment plans and quotes not given to the patient, or not given prior to commencing the “course of treatment”;
3. services performed at the initial appointment, including relief of pain, not permitted (i.e. not included in the list of allowable procedures);
4. bulk billing items included some level of co-payment;
5. pre-billing for items which required payments to third parties;
6. some other reason.

Overwhelmingly, the first response of dentists was surprise and/or shock followed by anger. This anger arose from two common issues.

First, dentists uniformly said they did not understand the requirements of the scheme and in particular the strict legislative requirements. Many also advised that they could not recall receiving any information from Medicare Australia about the scheme until they went looking for it when their first patient presented with a

CDDS referral.

Second, many members allege they contacted the Medicare Provider Hotline and acted on advice provided to them which later turned out to be incorrect. This complaint was raised by so many members of ADA NSW we are certain incorrect advice was provided by Medicare Australia staff on many occasions.

Even dentists who had read the MBS clearly had no appreciation of the legislative requirements to be found in Section 10 of the Determination. They either did not understand their obligations or attribute the same importance or value to the timing of communication with referring general practitioners, patient quotes and treatment plans.

The questions remains therefore, how could so many dental practitioners make the same mistakes in relation to this program? This was put to an officer the DHS in October 2011 when he was asked the following: given the fact that non-compliance is so high, are you concerned that there has been some systemic problem with the way in which this information has been communicated to dentists? His response is telling:

> *It is too early to say. That is the honest truth. Clearly, in relation to the audits that have been completed there is a problem about the charging or billing behaviour. If in the next 500 audits we uncover equivalent levels of non-compliance then your hypothesis would probably have been proved. But it is too early to say. All any of us at the table can say is that it is very clear on the face of the available documents how many times this material has been communicated and in how many different ways to dentists who are putting in place changes to make themselves able to claim under this scheme*[3].

Given the level of non-compliance revealed to the ADA NSW Advisory Service we would suggest that there has been a systemic problem with the way in which information about the CDDS has been communicated to dentists and we dispute any assertion that information was communicated to dentists many times and in many different ways.

Was adequate information sent to dentists?

In October 2011 the Department of Human Services stated that:

> *Dentists were written to on six occasions, starting with a letter from the then health minister, Minister Abbott, on 5 October 2007, through until 29 April 2011. They received letters at regular intervals through that time providing information about the scheme and, in particular, a booklet with a checklist. It has been reissued on a number of occasions but has basically stayed the same since 1 November 2007.*
>
> *. . . The booklet. It is called Medicare Benefits Schedule: dental services. It is a 65 page document which goes through in quite a lot of detail the specific requirements of the scheme. There are associated webpages, fact sheets and that kind of stuff. It is worth dwelling on one page of it, which is a checklist for dental practitioners to use. It goes through a number of things that they need to do in order to lodge a successful claim. . .*
>
> *. . . The checklist then goes on to say, 'You have to provide an itemised quote to your patient and, by the way, before treatment commences, you have to provide a treatment plan or summary to the*

> *referring GP.' In different places in the documentation that is described as a must or a requirement or it is underlined. It is. That kind of language is used.*
>
> *To go back to the start, there has been a very extensive program of education that started, in fact, under the previous government in October 2007. There has been a lot of engagement with the Australian Dental Association. There have been articles in the Australian Dental Association's newsletter. There has been material on the website. There has been direct communication from government to dentists. There has been communication from the Dental Association to dentists. There have been a range of activities put in place over that entire period of time*.[4]

Similar claims by officers from the DoHA and the DHS have been made time and again and are repeated, for example, in Attachment A of the Submission by the DHS which states:

> *The department supports the requirement for education to support practitioners to claim services correctly. Since the introduction of the Scheme, both DoHA and the department have provided information to the dental community to ensure dental practitioners were aware of the requirements of the Scheme and to support appropriate claiming.*
>
> *On introduction of the Scheme, DoHA wrote to dentists, dental specialists and dental prosthesis's describing the Scheme and its requirements. DoHA also issued a fact sheet on the Chronic Disease Dental Scheme as well as the Medicare Benefits Schedule Dental Services book that detailed the requirements and the related eligibility criteria of the Scheme.*
>
> *The Medicare Benefits Schedule Dental Services book clearly outlined the obligations on dental practitioners to return newly established care plans to the referring general practitioners and provide a written quotation of costs to the patient. Also included in this reference material was a referral to a Medicare Help Line and a checklist designed to assist dental practitioners to comply with the requirements of the Scheme.*[5]

The inescapable conclusion to be drawn from these and other similar statements is simple: the education program undertaken in relation to the CDDS was extensive and far-reaching and dentists have no excuse for not understanding all of the requirements.

ADA NSW rejects this emphatically.

Review of information sent to dentists

During Supplementary Budget Estimates in October 2011, the DHS was asked a question relating to when the Medicare Benefits Schedule (Dental Services) and any other explanatory correspondence was sent to dentists. The Department took the question on notice and, in a written response, subsequently identified six key documents it says were sent to dentists which explain the requirements of the CDDS[6].

The assertion that dentists were written to on "six occasions" has surfaced during questioning of officers from the Department on a number of occasions. The Department has been keen to paint a picture of an ongoing series of correspondence that, in its view, amounted to an extensive program of education dating back to October 2008.

ADA NSW has reviewed each of the six documents (occasions 1-6) and the claim by the DHS and DoHA that dentists received adequate information and education is clearly false. In relation to each of the six

documents we make the following comments:

1. October 2007

   This short letter announces the commencement of the CDDS and identifies eligible patients. It does not specify any obligations of dentists other than "a requirement that patients are informed about the cost of any recommended dental services before they commence a course of treatment."

   At the time approximately 14,000 dentists and prosthetists were registered to practice in Australia. This letter was only sent to about 10,000 of them and only on the basis of a mailing list provided by the Australian Dental Association and the Australian Dental Prosthetists Association.

2. 17th October 2007

   The Medicare Benefits Schedule (Dental Services) and fact sheet was sent to approximately 9,000 dentists. At the time there were probably closer to 13,000 registered dentists in Australia and, once again, non-members of the ADA were not included.

   ADA NSW accepts that the MBS contains detailed information about the scheme (65 pages). However, the simple act of mailing this to dental practitioners, or placing the MBS and fact sheets on the Department's web site, does not in our view constitute an extensive program of education for dental practitioners.

3. 3rd March 2008

   This notice to dentists and dental specialists only informs them that the Government intends to discontinue the CDDS. Yet it has been identified by the Department as a document specifying the requirements of the scheme. It does no such thing, demonstrating perhaps that Departmental officials either did not comprehend the contents of the letter or, more worryingly, the scheme itself.

4. July 2008

   This notice was sent to dentists to announce the start of the Medicare Teen Dental Plan. It refers briefly to the CDDS and only to make the following points.

   (i) Although closure of the scheme has been blocked in the Senate it is still the Government's intention to do so. Practitioners were warned not to expect a period of transition following the closing date, during which patients will be able complete treatment;
   (ii) the Government, through Medicare Australia, will continue to closely monitor CDDS usage to ensure it remains appropriate and consistent with the schemes legal eligibility requirements.

5. June 2010

   A very short letter from Medicare Australia to dental practitioners advising of an audit project to determine the level of compliance with the requirements of the CDDS.

We believe this is the first time Medicare Australia has written to dental practitioners and specifically identified Section 10 of the *Health Insurance (Dental Services) Determination 2007* and stipulated that non-compliance with Section 10 may result in practitioners being asked to repay all Medicare benefits paid in relation to services provided to patients where they are incorrectly claimed.

Note that this letter was sent to dental practitioners a full 30 months after the CDDS commenced and two years after the previous piece of correspondence was sent to them by Medicare Australia.

6. 29 April 2011

A more detailed letter (two and a half pages) from Medicare to dental practitioners advising of increased audits of the CDDS. This is the first time we recall Medicare Australia writing to dentists and specifying the explicit purpose underpinning Section 10 requirements.

These requirements relate unambiguously to patient's rights and ensure the referring general practitioner is placed in an informed position to manage the overall health of the patient. The letter states failure to provide a general practitioner with a copy of the treatment plan undermines the integrity of the scheme, does a disservice to sufferers of chronic disease and potentially puts patient's health at risk.

We note that this letter was sent to dental practitioners a full 42 months after the CDDS commenced.

As noted, the Department nominates these documents to demonstrate that the requirements of the CDDS were explained to dentists in written correspondence on at least six occasions. By our reckoning however, occasions one, three and four contain little or no information about the requirements expected of dentists or about the scheme generally.

The first occasion contains no information about the requirements of the CDDS; it simply announced the scheme had begun.

Occasions three and four also contain no information about the requirements of dentists under the scheme. Rather, references to the CDDS in this correspondence relate only to the fact that the scheme is to be closed or that it is the intention of the Government to close the scheme.

Only in June 2010 did Medicare Australia write to dental practitioners stipulating that non-compliance with Section 10 may result in practitioners being asked to repay all Medicare benefits. Ten months later, in April 2011, dental practitioners were written to again, this time explaining the purpose of Section 10 requirements and why these were so important to the scheme.

By this stage however, the auditing of dentists was well and truly underway. The first dentists to receive their audit notices from Medicare Australia in February 2010 were audited for the period 1 November 2007 through to 31 October 2009. Yet Medicare did not identify the importance of Section 10 compliance until June 2010 at the earliest.

Prior to June 2010 the only occasion when detailed information about the scheme was sent by Medicare Australia, or any other Government agency, directly to dental practitioners was when the MBS and fact sheet was sent to them in October 2007, around the time the scheme commenced. Mailing the MBS to dental practitioners or placing subsequent versions and fact sheets on the DHS web site, does not

however constitute an extensive program of education for dental practitioners.

ADA NSW is at a loss to understand how or why the DHS considers these documents to be the best examples it can find to demonstrate information it says was sent directly to dentists clearly outlining the requirements of the CDDS.

In summarising the education process . . .

- Letters number 1, 3 and 4 contained no educational value at all.
- Letter number 2 (the MBS) sent to 69 per cent of registered dentists containing 65 pages of information. Does not specifically refer to Section 10 requirements.
- Letter number 5, sent 30 months after the CDDS commenced, makes first reference to the importance of Section 10 requirements and warns dentists may be asked to repay Medicare benefits claimed incorrectly.
- Letter number 6, sent a full 42 months after the CDDS commenced, is the first time Medicare writes to dentists to specify the explicit purpose of Section 10 requirements.

ADA NSW believes Senators have been seriously misled, whether intentionally or otherwise, in respect of the level of education and support given to dental practitioners relating to the CDDS. The claim by the DHS and the DoHA that the education process was comprehensive and far-reaching is not true.

The MBS (Dental Services)

In November 2007 the MBS (Dental Services) 2007 edition was provided to most (but not all) dental practices by way of a general mail-out. This document came to be known colloquially as 'the green book' and is the document most commonly referred to by dental practices across the nation.

Amongst other things, the document outlines how to submit claims under Medicare, a list of item numbers and their descriptors, an outline of billing practices NOT permitted and a checklist for dentists.

The MBS (Dental Services) 2007 does not specifically mention the *Health Insurance (Dental Services) Determination 2007* and, in particular, Section 10. However the Checklist for Dental Practitioners on page 16 of the document notes:

Where the patient has been examined/assessed (including any diagnostic tests) and requires further work:

- Dental treatment plan including an itemised quotation of proposed charges provided to the patient
- Copy or summary of treatment plan sent to referring GP (may be e-mailed)

What the MBS (Dental Services) 2007 edition does not say

It does not say that an initial consultation must be restricted to a small number of diagnostic services (items 85011 – 85013 and 85022 – 85071).

It does not say that paperwork MUST be provided before any treatment is contemplated including many routine services traditionally provided during an examination appointment.

It does not give any indication that the provision of paperwork and the timing of when this paperwork is provided underpin the entire Scheme.

Nor does it indicate that the provision of this paperwork is a strict legal requirement and that significant penalties may apply if it is not provided (other than a single sentence at the end of Explanatory Note No. 2 which says: "*where a Medicare benefit has been inappropriately paid, Medicare Australia may request recovery of that benefit from the practitioner concerned*".)

There is no information concerning the provision of emergency treatment in this publication, despite the fact that a significant proportion of patients present with some form of dental complaint or condition which, if following standard dental protocols, generally requires immediate intervention.

Subsequent to this general mail out to practitioners in November 2007, all further information, and updates to the MBS (Dental Services) compendium were not sent directly to dentists but were posted on the Department of Health and Aging website for dentists to find themselves.

Medicare Provider Hotline

Practitioners were encouraged however to call the Medicare Provider Hotline on 132 150 for any additional enquiries or information. ADA NSW Advisory Service has conducted interviews with hundreds of dental practitioners involved in Medicare audits. During these interviews a common issue which arose time and time again was that information provided by the Medicare Provider Hotline was often inconsistent, misleading, confusing or incorrect.

By way of example, a Peer Advisor working in the ADA NSW Advisory Service called the hotline in 2011 seeking advice in relation to dental hygienists providing treatment under the scheme. The Association holds a file note indicating that the officer was assured that:

> "*it is fine for a hygienist to provide treatment and for a claim to be submitted under the supervising practitioner's provider number. The supervising dentist does not even have to be in the same room as long as they are on the premises at the time."*

On the contrary, we subsequently learned in 2011 that dental hygienists are prohibited from providing treatment under this scheme.

This submission has already outlined our point of view concerning the negligible educative process implemented for the CDDS. The Medicare Provider Hotline further contributed to the general confusion and misunderstanding with respect to fundamental requirements of the CDDS, a situation Medicare Australia has, up to this point, failed to accept or acknowledge.

Why was the educative process for dentists so bad?

Clearly, only the DoHA and/or the DHS can answer this question definitively. However, ADA NSW can point to a number of issues which help to explain why both Departments failed to provide dentists with clear, unambiguous and well-timed information about this scheme.

First, there was little or no consultation with the dental profession, either before the scheme started or in the intervening period since, to determine how dentistry is practiced and whether the requirements of the scheme are appropriate in all the circumstances.

Second, we think both the DoHA and Medicare Australia had an expectation that the CDDS would close almost from the moment it commenced. If true, this would go a long way in explaining why there was so little consultation with stakeholders regarding the construct of the scheme and why so little education about compliance requirements was undertaken once the CDDS commenced.

Finally, it would appear both the DoHA and the DHS were unclear about the parameters of this scheme, about dentistry in general and about the way in which the dental profession operates in practice. Disturbingly, this uncertainty continues to this day despite the fact the scheme has now been operating for more than four years and has cost the Commonwealth over $2.3 billion. If these government agencies were unclear about many aspects of this new dental program, how could they possibly have educated dentists about the requirements of the scheme and their obligations in a clear, unambiguous and timely fashion?

Lack of consultation with the dental profession

Remarkably, prior to the CDDS commencing there was little or no consultation with the dental profession regarding the construct of the scheme and its ongoing operation. This is a significant factor contributing to the high levels on non-compliance experienced by dentists who have participated in the CDDS.

Many of the requirements of the scheme are, to dentists, impractical and fly in the face of the standard treatment protocols and best practice dentistry. Overwhelmingly, the consensus of the profession is that these requirements are not consistent with excellence in patient care, often fail to encompass the duty of care owed to patients and frequently place unnecessary cost and inconvenience on dentists, patients and tax payers.

The CDDS was dentists first real interaction with Medicare, its systems and processes

Prior to the CDDS dentists had only limited interaction with Medicare and its processes through the DVA Scheme operated under the auspices of the Department of Veterans Affairs. The DVA was a very different system to Medicare's conventional operating systems. Under the CDDS dentists were introduced for the very first time to concepts such as:

- different methods of claiming Medicare payments (bulk billing; full payment by patient; copayment by patient)
- prohibition on pre-billing (a common practice in dentistry)

The paperwork requirements in Section 10 and the subsequent discovery by dentist's and the professional body representing them, that these were pivotal to the scheme were also new concepts.

Treatment at initial consultation

A case in point relates to section 10 requirements that must be complied with at the initial consultation when a dentist makes their assessment and diagnosis of the patient. Failure to comply with these requirements has, in the course of audits to date, rendered all subsequent services non-compliant and the dentist liable to repay all Medicare benefits paid in relation to these.

The requirements found in section 10 have been interpreted by the DHS in a way which severely limits the services which can be provided to patients:

(i) prior to giving the patient a written treatment plan and quotation for each of the dental services identified in the plan; and
(ii) prior to giving the general practitioner who referred the patient for dental services a copy or written summary of the treatment plan.

In many cases dentists would find it impossible to comply with these requirements if they also insisted on putting the interests of the patient first.

For example, at a recent seminar conducted by the Royal Australasian College of Dental Surgeons attending dentists were provided with guidelines for conducting an initial assessment and diagnosis of a patient. A systematic approach was recommended involving:

1. Collection of data: medical history, social history, intra-oral evaluation, extra-oral evaluation, x-rays, periodontal charting, tooth charting
2. Assessing data including: chief complaint (reason for attendance); history of the present complaint, other complaints.
3. Addressing the chief/presenting complaint
4. Disease control: restoring to health – oral hygiene evaluation and advice, dietary advice, removal of supra-gingival plaque and calculus to address superficial inflammation
5. Treatment staging: caries control
6. Periapical infections – root canal therapy
7. Bruxism evaluation and control
8. Restoration to form and function – fillings, then prosthetic devices such as crowns and dentures.

Treatment planning sessions will frequently involve aspects from at least the first four areas mentioned above, if not the first six, to stabilise the patient's condition and render them comfortable. Removal of plaque and calculus (a clean and scale) in order to properly assess the teeth, performing a periodontal charting and evaluation and providing dietary and oral hygiene advice are all routine aspects of an initial examination appointment.

<u>None of these are allowed under the CDDS without first having provided S10 paperwork identified above</u>.

The paradox here of course is that these services will often be necessary to construct an appropriate treatment plan for the patient. However, to comply with section 10, such services cannot be provided

before giving the patient and the referring general practitioner a copy of the treatment plan!

Emergency and acute care treatment

The protocol for treating patients under the CDDS as it is currently understood (provision of section 10 paperwork) also poses serious clinical dilemmas for both patients and treating dentists.

Given that the CDDS targets patients with a chronic illness who have a dental condition which is impacting on their general health, it would be common for CDDS patients to present in pain, with infection or with dental trauma (i.e. broken tooth, lost filling, broken, lost or ill-fitting prosthesis). This is especially the case where patients have been unable to access appropriate and timely dental care in the past. Very often patients experiencing these symptoms will have difficulty eating, drinking, sleeping, communicating and working. Anyone who has ever suffered through the pain of a toothache will understand that these patients want immediate intervention and assistance.

However, to be compliant with section 10, emergency or acute care such as the extraction of an infected or rotting tooth cannot be provided before giving the patient a treatment plan and sending a copy to the referring general practitioner.

This is impractical for a whole host of reasons. For example, dentists wear a surgical gown, protective gloves, mask, eyewear and covered shoes, very similar to a hospital surgical ward. In most cases the dentist has a dental assistant on hand to assist with instrument transfer, mixing and transferring medicaments etc. Patient consultations take place in a surgical setting with the patient sitting in a specifically designed dental operating chair, not sitting at an office desk.

To suggest a dentist should stop treating a patient in order to comply with paperwork requirements in this situation is both illogical and impractical. Strict compliance with this requirement would, more often than not, necessitate treatment to stop and the patient would most likely need to present for another appointment on a subsequent day.

Patients with special needs

Other factors also play an important role in determining the timing of treatment provision for patients who are, for example, elderly or disabled, or who require assistance to attend a dental surgery. Attending for care can be difficult due to a whole of reasons including mobility issues, lack of access to transport and the need to have a carer attend as well. More often than not these patients require immediate but comprehensive treatment to meet specific needs and minimise or eliminate the need to return for a subsequent appointment or appointments.

Similarly, patients who are medically compromised often have a small window of opportunity where they are well enough to undergo dental procedures, or may require urgent dental assistance to render them dentally fit so that they may undergo other medical procedures. In such cases, immediacy of treatment is often paramount.

Given that the CDDS was designed specifically to treat patients with chronic diseases and complex care needs, these situations will arise quite commonly.

Finally, although not technically considered special needs patients, people in rural and remote areas who travel long distances to receive dental care do not want to be told they need to come back for another appointment so that paperwork requirements can be attended to. These patients invest a lot of time, money and energy attending these consultations. At the very least they expect their presenting condition to be attended to at the first consultation appointment so as to maximise patient outcome.

Case Study – experience of a dental practice in a small regional centre in Central West NSW

ADA NSW knows of a dentist who has opened a new dental practice in a small regional centre in Central West NSW. The current wait time for new patients to see a dentist at this practice is six months. Local medical practitioners welcomed the new dental practice in town and within a short period of time this practice found CDDS referrals to be 'almost overwhelming'.

Problems with the scheme were noticed almost straight away including:

- conflicting advice given by the Medicare Provider Hotline and/or local Medicare Australia office
- confusion when bulk billing patients
- the limited extent of services able to be provided to patients before Section 10 paperwork requirements are met

Late last year the practice realised it also had an issue with item number 85141 – Oral Hygiene Instruction. In many rural communities it can difficult to access regular dental care. Not surprisingly, the oral health of people in rural and regional areas tends to be worse than in areas which have greater access to dental services.

Although many of the patients attending this practice have a great need to improve their oral hygiene, most wait at least a month, and sometimes longer, before they can commence treatment because of lengthy waiting lists to see a dentist. As a result it is often in the patient's best interests to commence an appropriate home care regime (i.e. brushing and flossing correctly). Yet Section 10 requirements prohibit the provision of item 85141 – Oral Hygiene Instruction – to a patient before giving them (and the referring general practitioner) a copy of the treatment plan.

This practice now understands it has breached this requirement in relation to a large number of patients, many of whom have completed a comprehensive course of treatment.

Afraid to find itself in anymore "compliance" situations (a situation made worse by recent media cover of Medicare audits and stories of dentist's rorting Medicare) this practice has, for the most part, stopped accepting CDDS patients. Early this year an elderly patient was reduced to tears because the practice would not take her on under the CDDS and she felt she could not travel the 100+ kilometres to the next dentist she was comfortable attending.

ADA NSW knows of another dental practice in the same town who say that early on in the scheme they were advised by staff at the local Medicare office that they did not have to give the patient a treatment plan or provide the referring GP with a copy (or a summary). The practice manager has informed ADA NSW that she calls the local Medicare office in town and not the Medicare Provider Hotline because it is

generally quicker and easier to get someone on the phone in town.

Imminent threat of CDDS closure was constant

When the CDDS was announced by the former Coalition Government in May 2007 it did not enjoy bipartisan support. The Labor opposition said it would abolish the CDDS and replace it with a Commonwealth Dental Health Program which would fund State and Territory public dental services.

Three weeks after the scheme commenced on 1 November 2007 the Labor Party won the 2007 federal election. Not long after this it announced that it intended to close the CDDS. Despite this, the Coalition and the Greens have twice opposed efforts to close the scheme when legislative efforts to do so were brought before the Senate in March and September 2008.

ADA NSW suspects the DoHA and Medicare Australia had an expectation the CDDS would be closed in early 2008. We believe this helps to explain why so little consultation with stakeholders took place to help dental practitioners understand how Medicare operated and the compliance requirements of the scheme.

This belief is supported by the two following case studies.

Case Study – Call to the Medicare Provider Hotline January 2008

In late January 2008 a staff member of ADA NSW contacted the Medicare Provider Hotline on 132 150 to make enquiries about patient eligibility under the CDDS. During the course of a short conversation, the officer spoken to stated that Medicare was aware that general practitioners were referring patients to dentists who were not eligible under the scheme because:

- they did not have a chronic medical condition and complex care needs; and
- their oral health problems were not having an impact on, or likely to have an impact on, their general health.

The Medicare officer stated non-compliance on the part of general practitioners was both intentional and unintentional but that ineligible patients were receiving Medicare rebates for dental treatment such as a clean and scale.

The Medicare officer informed the ADA NSW staff member that this was being overlooked by Medicare because the scheme was about to be closed.

While this did seem somewhat surprising at the time, unfortunately the ADA NSW staff member did not have the foresight to request the officer's name or P number. A short summary of the conversation was recorded in an email however sent to both the CEO and President of ADA NSW the same day.

This incident demonstrates that as early as January 2008 at least one Medicare officer was contemplating the imminent closure of the CDDS as a sufficient reason not to follow up claims about non-compliance in relation to this scheme.

Later that same year, in September 2008, the imminent closure of the CDDS was also used as a reason not to provide dentists with information about compliance matters to do with this scheme and, to a lesser degree, the Teen Dental Program.

Case Study – contacting Health & Ageing in September 2008

On 18 September 2008 ADA NSW contacted Medicare Australia requesting it provide an article to be published in the *NSW Dentist*, a monthly publication distributed to all members.

Medicare Australia was asked to outline the purpose and parameters of the CDDS and the Medicare Teen Dental Plan, as well as the obligations on dentists who chose to participate in either scheme.

This was because a high degree of uncertainty about both schemes was present in the dental profession, especially in relation to the CDDS even though it had been in operation for almost twelve months. Furthermore, this was the first real experience for most dentists dealing with Medicare and its processes.

Medicare Australia was informed the article would be a timely reminder to dentists' vis-à-vis ethical behaviour and their obligation to act in compliance with both schemes so as to minimise any perceived abuses.

The following examples were given of what could be considered inappropriate behaviour:

- Inappropriate referral practices (i.e. patients asking their general practitioner to refer them to a dentist so that dental work can be claimed under Medicare or where dentists inform patients they can claim on Medicare if they get a referral from their GP);
- Aggressive advertising of Medicare dental benefits that patients may be eligible for (i.e. how do you balance ethical behaviour on the one hand with entrepreneurship and business practice on the other?); and
- Clinically inappropriate treatment and/or poor quality treatment.

The request made no reference to compliance with section 10 requirements of the Determination, explicit or otherwise. This was because in September 2008 the significance of section 10 and the consequences of non-compliance were still not understood or appreciated by ADA NSW.

Medicare Australia promptly advised ADA NSW that our request should be directed to the Department of Health and Ageing. So, on the 19 September 2008, the Media Unit of the Department of Health and Ageing was contacted with the same request.

Ten days later a follow up email was sent to the Department, copying the initial request sent on 19 September seeking a response.

An officer of the Department responded via email on 30 September 2008 with the following:

> *I remember this one now and held off because much of the Commonwealth's dental arrangements were under a cloud in the Senate – which I think is still the case. We may*

> *have to pass for your current edition, although I am checking on what we can say – will get back to you later this morning.*
>
> The same officer contacted ADA NSW by telephone later that day and in a brief conversation noted that closure of the scheme remained Government policy and that the Department was not in a position to accept our invitation.

The stance contrasts sharply with evidence given by many other officers from the DHS that the Department and the DoHA provided ample information to the dental profession to ensure practitioners are aware of the requirements of the Scheme and to support appropriate claiming.

For example, in October 2011 an officer from the DHS told the Senate Community Affairs Legislation Committee in October 2011 that:

> *There has been a very extensive program of education that started, in fact, under the previous government in October 2007. There has been a lot of engagement with the Australian Dental Association . . .*
>
> *. . . we are satisfied that a lot of education has been done stretching back now over four years about the requirements of the scheme.*[7]

ADA NSW says categorically that this was not the case.

It would not be too hard to draw the conclusion that the DHS and DoHA assumed the scheme would be closed relatively early in its existence. ADA NSW wonders whether the reluctance to consult with and educate dentists about the CDDS, at least in the first two years, was based on a notion that this would simply be a waste of time and resources if the scheme was to be shut down.

DoHA and DHS were themselves confused about the CDDS

This submission has already noted in some detail the high number of instances of dental practitioners who maintain they were provided with incorrect advice by staff from the Medicare Provider Hotline. This demonstrates, we believe, a lack of training and/or understanding on the part of Hotline staff of the CDDS and its requirements.

There are numerous other instances which we say demonstrate, or lend support to the notion that, both the DoHA and the DHS were unclear about the parameters of this scheme, about dentistry in general and about the way in which the dental profession operates in practice.

Case Study – treatment on the same day as the initial assessment

In response to a list of questions sent to the DHS by ADA NSW on 29 August 2011 the Department wrote to ADA NSW on 16 September 2011, stating, amongst other things, the following:

> *If a treatment plan or summary is not sent to the GP prior to the commencement of the course of treatment, the requirements of section 10 of the determination are not met, even if the treatment plan or summary was sent on the same day. This requirement has been confirmed with dental practitioners during compliance audits.*[8]

Later, on 31 January 2012, a meeting took place at the offices of ADA NSW with senior officers from the DHS. This meeting was organised by DHS in response to a letter sent to the Department on 12 December 2011 requesting urgent clarification on a number of compliance issues to do with the CDDS. The Department suggested a face to face meeting was the best approach to deliver the requested explanations.

During this meeting the issue of emergency care and the provision of treatment prior to completing section 10 paperwork requirements arose. A suggestion was put to DHS officers present that the list of eligible services at the first appointment should be expanded to include removal of plaque and calculus (i.e. a scale and clean) as well as a broader range of emergency treatments (i.e. an extraction).

One of the DHS officers present responded by asking why a treatment plan could not be prepared while the patient was in the chair, sent to the referring general practitioner and then the dentist could commence treating the patient. He was told that Medicare Australia had previously stipulated that treatment on the same day as the initial assessment was not possible.

Two DHS officer stated unequivocally that this had never been advised by Medicare Australia. They were then shown a copy of the letter sent to ADA NSW by DHS on 16 September 2011 in which it clearly stated that commencing the course of treatment on the same day did not satisfy section 10 of the Determination. The DHS officers appeared flummoxed by this revelation but insisted Medicare "would not seek recovery if a treatment plan is approved and treatment commences that same day".

There are other similar instances where officers from the same government agencies responsible for administering the CDDS have either been unclear about requirements of the scheme, or simply incorrect. Furthermore, at this point in time ADA NSW is still seeking guidance and/or clarification from the Department in relation to every day events and circumstances dentists are experiencing under the CDDS.

Conclusion

For more than two years now an internal audit program established by Medicare Australia has focused on auditing compliance by dentists who have participated in the Chronic Disease Dental Scheme. At the close of last year there were close to 1,000 audits active or under consideration. As a direct result of this action a small but growing number of dentists have now been asked to repay hundreds of thousands of dollars each in Medicare rebates, primarily for failing to provide patients with a written treatment plan and quotation before commencing treatment (including emergency dental treatment) and for not providing the referring doctor with a copy of the patient's treatment plan.

Audits completed to date indicate that over seventy per cent of all dentists audited were non-compliant with administrative aspects of this scheme. ADA NSW believes close to ninety per cent of all dentists who have participated would be deemed non-compliant under the existing audit regime.

The administrative requirements of this scheme were poorly communicated to dentists and in some cases not communicated at all. Despite many claims to the contrary, the education program for dentists was largely non-existent. In addition, there was little or no consultation with the dental profession regarding the construct of the scheme or its ongoing operation. This has been a significant factor contributing to the high levels on non-compliance by dentists.

ADA NSW strongly suspects both the DHS and DoHA assumed the CDDS would close relatively early in its existence which helps explain the initial failure to consult with and then educate dentists about CDDS requirements. It is also clear both organisations are themselves unclear about many of the parameters of this scheme and about dentistry in general and about the way in which the dental profession operates in practice. Even today, four years after this scheme commenced ADA NSW is aware of instances where officers from the DHS and DoHA cannot (or will not) provide dentists with information they are entitled to know, or provide them with correct information.

Dentists have been unfairly and very publicly accused of "rorting" this scheme for financial benefit when most non-compliance stems from a failure to complete required paperwork prior to attending to a patients dental needs.

ADA NSW strongly endorses the *Health Insurance (Dental Services) Bill 2012* introduced in both Chambers of the Parliament. The Bill seeks to ensure that dentists who have provided appropriate dental treatment to almost one million chronically ill patients since November 2007 are not unfairly penalised for failing to comply with strict administrative requirements –requirements that have little or no bearing on patient treatment and patient outcomes, despite repeated claims to the contrary.

ADA NSW endorses this Bill because it seeks to redress an injustice. Dentists should not be penalised if they have provided appropriate dental treatment in a timely fashion to patients with a chronic illness simply because they failed to comply with paperwork requirements they misunderstood or were not even aware of.

We are supportive of any action by the Parliament that will assist in this matter being resolved fairly and equitably. We remain engaged with all members of the Parliament and call on them to work constructively to achieve a fair outcome for dentists and for patients with a chronic medical illness.

End notes

[1] Department of Human Services, Submission to the Senate Standing Committee on Finance and Public Administration, Legislation Committee, for the Inquiry into the Health Insurance (Dental Services) Bill 2012 [No. 2], ATTACHMENT, available at https://senate.aph.gov.au/submissions/comittees/viewdocument.aspx?id=b039fa0c-6f27-4c8c-99e9-a0416d9decc3.

[2] Mr Jeff Popple, Deputy Secretary Future Services, Rehabilitation and Compliance, Department of Human Services from Official Committee Hansard Senate Community Affairs Legislation Committee, Estimates, 16 February 2012, Canberra, page 141.

[3] Mr Ben Rimmer, Associate Secretary Service Delivery, Department of Human Services from Official Committee Hansard, Senate Community Affairs Legislation Committee, Estimates, 20 October 2011, Canberra, page 182.

[4] Mr Ben Rimmer, Associate Secretary Service Delivery, Department of Human Services from Official Committee Hansard, Senate Community Affairs Legislation Committee, Estimates, 20 October 2011, Canberra, page 176.

[5] Department of Human Services, Submission to the Senate Standing Committee on Finance and Public Administration, Legislation Committee, for the Inquiry into the Health Insurance (Dental Services) Bill 2012 [No. 2], ATTACHMENT, at page 3, available at https://senate.aph.gov.au/submissions/comittees/viewdocument.aspx?id=b039fa0c-6f27-4c8c-99e9-a0416d9decc3.

[6] Department of Human Services, Answer to Question on Notice, Senate Community Affairs Legislation Committee, Supplementary Budget Estimates - 20 October 2011, Question reference number: HSW 38, page 2.

[7] Mr Ben Rimmer, Associate Secretary Service Delivery, Department of Human Services from Official Committee Hansard, Senate Community Affairs Legislation Committee, Estimates, 20 October 2011, Canberra, pages 176-177.

[8] Letter from Kathryn Campbell, CSC Secretary, Department of Human Services to Dr Matthew Fisher, CEO, Australian Dental Association (NSW Branch), 16 September 2011.