2nd April 2012

Finance and Public Administration Legislation Committee
PO Box 6100
Parliament House
CANBERRA ACT 2600

Finance and Public Administration Legislation Committee,

RE: SUBMISSION REGARDING HEALTH INSURANCE (DENTAL SERVICES) BILL 2912(No.2)

I am writing this submission regarding the above matter. I am a dental practitioner of 40 years.

During my practice life I have participated in a number of government schemes as part of my professional responsibility to assist people who are disadvantaged.

This participation includes provision of dental services free of charge to street people on set days during the year, the DVA scheme for entitled persons and the Medicare EPC scheme.

My experience with DVA during my career has been uncomplicated and I have always found that the management of this scheme to be flexible to allow for emergency situations.

During that time I have never had any complaint against me by a DVA patient nor have I ever had any request for treatment approval denied.

Information for DVA treatment rules have been simply explained and DVA staff have always been helpful and we have had direct access to staff who are able facilitate problem solving. Any audit activity has been appropriately focused on ensuring the work was provided and done appropriately.

The Medicare EPC scheme commenced in a cloud of confusion.

We received no information about the scheme at our clinic and we had to contact Medicare officers for assistance.

The advice received was contradictory and difficult to obtain.

Ironically the advice we received led us to be noncompliant as we were sending letters back to Dental general practitioners, who had referred the patients to us, rather than their medical general practitioner.

It took us several months before my practice received any booklet from Medicare, even after multiple requests.

We had been advised to use the internet for information but I use a day surgery facility where we had no internet access.

The booklet from Medicare was cumbersome and not user friendly and with only one staff member, impossible to read under the workload.

At present, I am being audited by Medicare.

I have a referral practice in which I have provided treatment to patients under the scheme and generally bulk-billed for these services.

I understand from colleagues, that I am the only bulk billing practitioner providing Oral Surgery services in Adelaide.

The cohort of patients that I manage are either emergency patients who are in pain, who have had their own dentist fail to complete a surgical task, or a patient who is to have a large number of extractions at once.

These patients are highly disadvantaged and have immediate dentures for the first time. They frequently have mental health issues, are ex homeless people, with drug/alcohol/violence abuse history.

The EPC scheme has provided these persons with a means of having basic dental needs met that are unobtainable in any state dental services.

State dental services do not provide for sedation, to have dental clearances or multiple extraction, where the patients can be unaware of the procedure.

I find it astonishing that the EPC does not allow for treatment of these patients who are in pain as an emergency and expects paperwork to be done that delays treatment and does not improve outcomes.

This assistance has led me to be noncompliant, as I have helped the patients out and then notified their GP. I have advised the patient that we will complete the procedure as simply as possible, but I do not know prior to attempting the work

what will happen. I have given them a range of fees and told them I will bulk bill them.

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The administrative requirements of the EPC scheme take longer than the procedure.

For emergency treatments I have squeezed patients in between other clients, and therefore I cannot provide the treatment and meet the administrative requirements in the time that I have available.
Often patients have either incorrect paperwork provided or have left it at home, have arrived without a carer, and so they are unable to have treatment.
This means that these patients are now left in pain.

I find the result of this situation very distressing.

After having spent so many years being scrupulous about providing treatment that I felt was in the interests of my patients and at minimum cost, I now find myself having to give a quote that allows for the most complex option.
A patient, who can often be in their 30's, is faced with a quote for the removal of all their teeth that exceeds the Medicare limit of $4250. When they realize that they do not then have funds for a denture, they are distraught.

In the past I adjusted my fees so that they could get their dentures, as well as the extractions, by either not charging a fee for the service or reducing the level of the fees charged by using less expensive item numbers.

I have ceased this practice given the attitude that Medicare has taken on EPC claims administration.

I am now faced with advising patients that they cannot be treated unless they have all the administrative requirements for Medicare EPC with them.

Unfortunately, many do not and these patients are told they have to pay in full or return to their GP to get valid documents. We now have to have this policy as we only see patients once, and do not send accounts.

Patients are also having to decline treatment because they have no funds.
Our staff now no longer provide any administrative assistance as we face the prospect of having helped emergency patients out by following up their documents after their treatment, and then being asked to repay the money.

With our practice having to strictly comply with Medicare expectations patients are being adversely affected. The reasons for this are as follows:

* we have insufficient time in our emergency slots to complete the requirements and provide treatment, so they are no longer treated immediately but given appointments in the future

* patients are not aware of what we need in terms of paperwork and often advise us post treatment that they have an EPC form

* Medicare does not view tooth extraction as an emergency procedure and so this cannot be performed without administrative procedures being followed, even though the patient is in pain. This requirement can delay treatment by a week or more.

* the threat of repayment of fees to Medicare for administrative non-compliance (even though most of our patients are seen once only), has led us to stop bulk billing which results in the treatment not being provided.

* there has been a cessation of pro bono work in our clinic and we will only provide work for items at fees strictly in accordance with Medicare fees (i.e. there are no longer fees waived or reduced)

The hard line attitude of Medicare in relation to administrative compliance has led to the following changes in our practice.

* cessation of acceptance of EPC patients in my general practice at South Terrace. Only referred oral surgery patients can be treated at my Exodontia practice

* cessation of bulk billing. There are now no bulk billing oral surgeons in Adelaide

* non treatment of patients in pain until administrative conditions are met by them

* cessation of time costly assistance to help patients organize these matters. They are referred to Medicare offices for advice

* cessation of discounting of Medicare fees and services

I would like to suggest the committee should look closely at making some changes to the EPC scheme..

* re-define emergency treatment to allow immediate treatment in pain

* allow flexible quoting to suggest that a number of options are possible at different costs, when treatment outcomes are difficult to determine

* in the case of people having full clearances and immediate dentures, having a sufficient limit to allow the removal of the teeth and provision of the denture by their referring dentist.

* allow a sufficient amount to cover the cost of anaesthetic fees as there are no bulk bill anaesthetists in private practice, to allow these procedures such as full clearances to be done painlessly

* review cooperation with State dental facilities to allow EPC patients to have general anaesthetic procedure without cost, for surgical procedures

* adopt an emergency hot line where dental practices can get immediate approval for management that is quick and cost effective, if required, similar to DVA model

* allow co-payment if electronic claims are made as with Hicaps to prevent patients having to pay in full themselves and then claim from Medicare.

I think that there have been many benefits derived from this scheme for the patients and that none of these benefits have been adversely affected by noncompliance with administrative matters.

I have not yet ever received any feedback from medical GP's regarding a treatment Plan, even when the plan involves medically compromised patients.

I have been the subject of an Audit and we have received no assistance or advice from Medicare or the compliance officers in correcting our systems.

All of our patients have received the treatment as claimed and most have been extremely grateful.

Details of the Medicare EPC scheme and its operation have been extremely poorly explained to our clinic. When contacted, Medicare offices are difficult to deal with as the advice given is frequently contradictory.

We find the correction of Medicare administrative errors particularly difficult to resolve.

On many occasions we have had to repeatedly re-lodge claims as the processing by Medicare officers is incorrect.

My experience with this Medicare scheme has left me feeling extremely disenchanted with Medicare and I am uncertain whether I should continue with any further schemes.

The situation has arisen where administrative process has become more important than providing relief of pain and care of the patients.

I am not sure that I want to be associated with this type of philosophy.

Yours faithfully,

Gregory Jaunay