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

Submission
by

Australian Dental Association (Queensland Branch)

12 April 2012

Executive Summary

Inequities and unfairness have arisen from Medicare's compliance audits of the Chronic Disease Dental Scheme (CDDS) resulting in the *Health Insurance (Dental Services) Bill 2012 [No.2*] which is aimed at redressing those matters.

Dentists who are deemed by Medicare to be non-compliant in following administrative processes are being demanded by Medicare to repay rebates, in full, despite the services having been provided to patients in good faith and in the absence of fraud or inappropriate treatment.

A demand to repay the entire amount claimed from Medicare because of a failure to comply with certain administrative requirements (when appropriate patient care has been provided) is a disproportionate, unreasonable, unjust and inequitable demand.

ADAQ's main concerns leading to inequity and unfairness with Medicare's compliance audits are:

1. Lack of consultation prior to introduction and ongoing lack of education since introduction of the CDDS
2. Inconsistent information from Medicare and its staff about requirements of CDDS
3. Administrative non compliance penalties are disproportionate in the extreme

ADAQ therefore supports any action to ensure equity and fairness for dentists who, when audited, are proven to have discrepancies on claims due to administrative errors under Section 10 of the Determination.

The Australian Dental Association (Queensland Branch) supports the *Health Insurance (Dental Services) Bill 2012 [No.2*].

Introduction

The Australian Dental Association Queensland Branch (ADAQ) makes the following representation in relation to the *Health Insurance (Dental Service) Bill 2012 [No.2].* (Bill)

The intention of the *Health Insurance (Dental Services) Bill 2012 [No.2*] is to address the inequities and unfairness that have arisen from the compliance operations under the Chronic Disease Dental Scheme (CDDS).

Dentists who are deemed by Medicare to be non-compliant in following administrative processes are being demanded by Medicare to repay rebates in full, despite the services having been provided to patients in good faith and in the absence of fraud or inappropriate treatment.

A large number of dentists have participated in the CDDS and provided quality and appropriate dental care services to a large number of patients.

The principal issues of ADAQ's concern which have lead to inequity and unfairness in relation to Medicare's compliance audits are:

1. Lack of consultation prior to introduction and ongoing lack of education since introduction of the CDDS
2. Inconsistent information from Medicare and its staff about requirements of the CDDS
3. Administrative non compliance penalties are disproportionate in the extreme

Lack of consultation prior to introduction and ongoing lack of education since introduction of the CDDS

The CDDS was introduced without broad consultation with the dental profession at both national and state levels and particularly with the Australian Dental Association. The Association with around 90% of the profession as members, is ideally placed to ensure widespread and effective communication of the nature, purpose and compliance requirements of such a scheme.

At the time of the commencement of the CDDS, dentists in Australia had little or no experience of dealing with claims involving Government rebates and particularly Medicare. The main avenue of government services provision was

through treatment of war veterans under the Department of Veterans' Affairs (DVA).

Dentists were unprepared for the CDDS and unfamiliar with Medicare's administrative processes, and the requirements of the CDDS were therefore new to dentists.

There was also no apparent implementation plan or communication plan by Medicare to educate dentists and others in their administrative processes. As a comparison, in 2010, when Nurse Practitioners were to become recognised providers under the Medicare Benefit Schedule, there was extensive discussion between nurses, nurse organisations, medical practitioners and other key stakeholders in relation to items eligible for rebates, the education that would be required by the profession to ensure that nurse practitioners understood how Medicare operated and the compliance requirements of providers.

The education program for Nurse Practitioners was conducted prior to implementation of this initiative. By comparison, no similar program was established for dentists when the CDDS was introduced in 2007.

Had the profession been consulted and engaged by Medicare to assist, many of the non compliance issues that have resulted in this Bill could have been avoided.

As addressed above, the CDDS was introduced with little or no consultation with the dental profession. Certainly, there has been no substantive Medicare educational program from its commencement to date.

As a result of the initial failure to educate the profession, many dentists only became aware of the CDDS when patients presented to them seeking treatment on referral from the medical GP.

The provision of a Medicare Benefits Fee Schedule which some dentists claim they was never received, combined with a checklist and a general reference to website information are not an effective education program for a scheme involving a professional group being exposed to Medicare compliance requirements for the first time.

Additionally, when it became apparent that non compliance with Medicare paperwork was the subject of audits that resulted in demands for full repayment of all monies, ADAQ approached Medicare in mid 2011 with an invitation for Medicare staff to conduct an education session for dentists who wished to or who were at that time participating in the CDDS.

Medicare declined our request without explanation.

Announcements that closure of the CDDS is imminent and to the point of specifying a date have also not contributed in any way to a belief that dentists need to educate themselves for the ongoing operation of the scheme.

Inconsistent information from Medicare and its staff about requirements of CDDS

It is accepted that the Department of Human Services developed and distributed advice regarding the CDDS. However, ADAQ has been advised by many dentists that that they did not receive any such correspondence from Medicare.

Certainly, the penalties that can apply should dentists and others who do not comply with administrative requirements were never disclosed and are not clearly set out in the Medicare Benefits Schedule Dental Services book or Fact Sheets on the Department of Health and Ageing website, or in any other communication sent to dentists.

Most dentists are quite familiar with the DVA scheme and from the outset of the CDDS, the political intent, as detailed in a letter to dentists by the then Health Minister, the Hon. Tony Abbott, around October 2007, would seem to be that the CDDS was would operate in a similar manner to the DVA scheme.

It is important to note that under the DVA scheme there is no requirement to provide a medical GP with information regarding the dental services provided to veterans before, during or after the provision of any services, but only on request. Nor is there any requirement to provide the patient with a written quote.

The message that the Scheme would operate along similar lines to the DVA scheme was further reinforced in the Medicare Benefits Schedule (MBS) Dental Services Book – effective from 1 November 2007, which on page 8 states:

> *"One of the key differences from the DVA dental arrangements is that under Medicare dental practitioners are free to set their own fees for services …….*
>
> *Unlike the DVA arrangements, prior approval by a dental adviser is not required for any of the Medicare dental items."*

Despite the above, there are substantial differences between the administrative requirements of DVA scheme and the CDDS. These were not communicated

effectively, if at all, to dentists. As such dentists rightly had the impression is that the CDDS would operate in much the same fashion as the DVA Scheme.

Inconsistencies are also apparent in the 'Checklist for Dental Practitioners'. This document refers to the two prerequisites being:

a) Dental Treatment Plan (including an itemised quotation of proposed charges) provided to the patient;
b) Copy or summary of treatment plan sent to referring GP (may be emailed).

This Checklist makes no reference to the need for any written fee estimate to be provided, nor does it stipulate the time at which those requirements have to be met.

The messages in these documents are inconsistent leaving ambiguity which has contributed significantly to non compliance by dentists.

The above matters aside, Medicare staff in response to telephone calls have provided inconsistent advice.

In one case in Queensland, which was later the subject of substantial demand for repayment of fees, the dental practice was advised that the purpose of a treatment plan and quotation to patients was to ensure that any patients who were going to pay additional fees on top of those met by Medicare were aware of these costs at the commencement of treatment. The dental practice was informed that, as they intended only to bulk bill patients, they were not required to provide patients with treatment plans or quotations prior to commencement of treatment. The practice manager was also advised that it was not a requirement that the surgery send out a treatment plan to the GP prior to commencement of the treatment but at the time treatment commenced.

This Medicare advice is in direct conflict with the compliance issues that resulted in an audit, a demand for repayment from Medicare and repayment of a large amount by the dentist involved.

Such inconsistency and lack of education are matters at the heart of Medicare compliance audits and the subsequent demands for full refund of fees paid to dentists.

Penalties for administrative non compliance are extreme and unreasonable

Medicare's Compliance Model (below) provides for situations where non compliance is accidental in that Medicare will counsel and provide feedback, with escalation according to the level of non-compliance.

Diagram 1—The compliance model

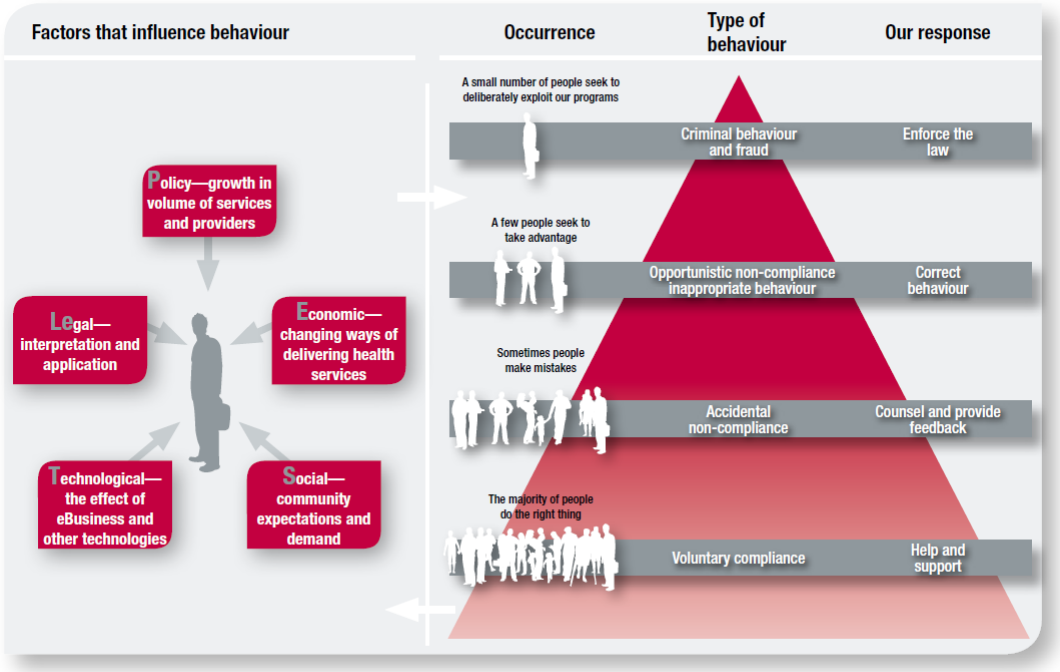

Diagram 1 illustrates the factors that influence behaviour (PESTLe framework) and the compliance triangle.

It is our view that the above compliance program model has not been followed by Medicare and a proportional and reasonable approach to compliance has not been applied in practice by Medicare.

It is also our contention, following legal advice of Senior Counsel, that in situations where the relevant services were actually performed and the issue is a technical non-compliance with the strict requirements of the Health Insurance (Dental Services) Determination 2007, rather than a substantial departure from its objects; and the dentist has not acted fraudulently or dishonestly, and has not knowingly or deliberately made a claim to which he is not entitled, strict compliance with administrative requirements should not be regarded as essential to the dentist's entitlement to receive payment.

Furthermore, Medicare audits, as a proper and thorough investigation of a situation where criminal charges for fraud may be instigated, in at least one instance brought to our attention leave much to be desired.

The circumstances are that an allegation of fraud stands from a Medicare conclusion that services were not provided. Medicare therefore has demanded a full refund of all monies. Medicare's conclusion that the services were not provided are seemingly based on a telephone call from a Medicare investigator to a patient who had a chronic disease, but there has been no check with the dentist provider, no check of his dental records and no independent clinical examination of the patient.

These are serious flaws in an 'audit' process that are unjust and extreme.

Such action by Medicare is both a denial of natural justice to the registered dentist involved and illustrative of the extreme and disproportionate actions of Medicare.

Conclusion

ADAQ does not condone fraud or other illegalities and will support appropriate action in such cases.

However, a demand to repay the entire amount claimed from Medicare because of a failure to comply with certain administrative requirements (when appropriate patient care has been provided) is a disproportionate, unreasonable, unjust and inequitable demand.

ADAQ supports any moves to ensure equity and fairness for dentists who, when audited, are proven to have discrepancies on claims due to administrative errors under Section 10 of the Determination.

President