Australian Dental Association Inc.

Senate Community Affairs Committee

Review of the Professional Services Review (PSR) Scheme

Authorised by

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1. ABOUT THE AUSTRALIAN DENTAL ASSOCIATION

The Australian Dental Association Inc. (ADA) is the peak national professional body representing about 12,000 registered dentists engaged in clinical practice. ADA members work in both the public and private sectors. The ADA represents the vast majority of dental care providers.

The primary objectives of the ADA are:

- to encourage the improvement of the oral and general health of the public and to advance and promote the ethics, art and science of dentistry; and

- to support members of the Association in enhancing their ability to provide safe, high quality professional oral healthcare.

There are Branches in all States and Territories other than in the ACT, with individual dentists belonging to both their home Branch and the national body. Further information on the activities of the ADA and its Branches can be found at www.ada.org.au.

2. EXECUTIVE SUMMARY

Based upon the experiences of dentists in relation to the Medicare Chronic Disease Dental Scheme (CDDS), the ADA considers it essential that in respect of all Medicare Australia (MA) programs that the Professional Services Review (PSR) adopt a proactive role in the provision of advice to MA on the administrative requirements and ramifications of such schemes.

While the ADA continues to be a critic of the CDDS due to it not being targeted to that one-third of Australians that cannot currently access adequate dental care, it did see the scheme provide some necessary dental treatment to those eligible. The conduct of MA, in the enforcement of some administrative requirements that now requires dentists to repay to MA monies received by them for services rendered to patients is, in the ADA's view, reprehensible. The administrative requirements contained in Section 10 of the Health Insurance (Dental Services) Determination 2007 (the Determination), were not adequately brought to the attention of participants in the scheme by MA; yet it is the failure to comply with the Determination that is requiring practitioners to repay all benefits paid by MA for legitimate dental services to patients. Resultant bankruptcy and/or closure of many dental practices will be the inevitable result. A result that does not serve the general community and will undermine the goodwill of the dental profession in participating in any future government funded schemes.

The ADA's recommendations in respect of the CDDS and Medicare schemes generally are:

1. That, if the PSR receives a complaint of inappropriate practice from MA that is solely attributable to noncompliance with the Determination, that the Director determine there is no case to answer for the practitioner.

2. In respect of claims associated solely with failure to comply with the Determination, pathways be made available to practitioners to demonstrate their bona fides to MA or the PSR and, if established, the Director then determine there is no case to answer.

3. The Director of PSR direct MA to ensure that with the introduction of any MA scheme, the administrative requirements associated with the scheme be kept to a minimum and be confined to those essential to the proper administration of the scheme. Further, when a scheme is introduced, proper governance procedures be put in place to test the participants' familiarity with the scheme, and if deficiencies exist, that they be addressed.

3. INTRODUCTION and BACKGROUND

The ADA and its members have not had a great deal of involvement with the PSR to date as its members have not, until relatively recently, had occasion to provide services which attract Medicare benefits to patients.

This changed with the introduction of the MA CDDS in 2005. A chronology of the introduction of the CDDS is therefore provided here to assist the Committee in its consideration of this submission.

Benefits under the CDDS were initially confined to three services with an eligibility of approximately $275 per annum. Initially the CDDS was not utilised to any great extent by either patients or the dental profession.

Later, benefits under the CDDS increased. This allowed eligible patients to receive dental services of up to $4250 in the initial two year period and $2250 pa thereafter. With this increase in eligible funding came an increase in the public's awareness of the CDDS. In turn, utilisation of the CDDS dramatically increased. As will be made clear later in this submission, along with the increased utilisation of the CDDS, there was very belated interest by MA in examination of dentists' compliance with the CDDS requirements.

While dentists had been familiar with schemes such as that available under the Department of Veterans' Affairs (DVA), the CDDS was the first occasion that the dental profession at large had been required to work under a Medicare scheme. Dentists' familiarity with Medicare up to this time would have been gleaned from their utilisation of it through their personal medical services received.

In conjunction with the commencement of the CDDS, information was provided to dentists as to the eligibility requirements for patients under the CDDS and with an outline of the administrative requirements of the Scheme. The ADA says the information provided was scant and confusing. It failed to advise practitioners of the key compliance requirements of the CDSS.

In a "Fact Sheet for Dentists and Dental Specialists" published in 2007, MA highlighted the following:

Summary:

• Medicare dental items (items 85011-87777) cover services provided by dentists, dental specialists and dental prosthetists in their surgeries (i.e. services to admitted hospital patients are not covered).

• Eligible patients can receive up to $4,250 in Medicare benefits (including Extended Medicare Safety Net benefits where applicable) for dental services over two consecutive calendar years.

• Eligible patients are those with a chronic medical condition and complex care needs being managed by a GP under specific Medicare care plans.

• The patient's oral health must also be impacting on, or likely to impact on, their general health.

• The patient must be referred by their GP to a dentist (or in some cases to a dental prosthetist) in order to access Medicare benefits for dental services.

• A comprehensive range of dental services are covered, including dentures.

• The Medicare items are based on the existing dental schedules used by the Department of Veterans' Affairs (DVA), with some modifications.

• Unlike the DVA arrangements, dental practitioners may choose to either bulk bill the patient or set their own fees for services.

Patient eligibility:

It is strongly advised that, before providing any services to the patient, the dental practitioner (or receptionist) phones Medicare Australia on 132 150 to check that the relevant GP care planning items have been claimed and paid for the patient – even where the patient has a referral form signed by their GP. The dental practitioner (or receptionist) should also check how much of the $4,250 in Medicare benefits available has already been claimed for the period.

If the care planning items have not been claimed and paid by Medicare Australia or the patient has used their $4,250 allocation, no Medicare benefits for dental services can be paid to the patient.

Claiming from Medicare:

Under Medicare, patients should not be billed for a service until it has been provided (i.e. dentists cannot charge patients for services that are identified in the patient's dental plan, but have not yet been provided).

Further information:

The Medicare Benefits Schedule Dental Services book (effective 1 November 2010) is available at www.health.gov.au/dental.

Dental practitioners can call the Medicare Provider Enquiry Line on 132 150 for further information on provider registration, claiming, and checking patient entitlements.

Elsewhere in the document but in areas not highlighted, it stated:

Reporting by the dental practitioner to the GP

Dental practitioners must provide a copy or summary of the patient's treatment plan to the referring GP before beginning the course of treatment (i.e. following an examination and assessment of the patient including any diagnostic tests).

Informing patients about the cost of dental services

Dental practitioners are free to bulk bill or set their own fees for services. In some instances, patients may incur out-of-pocket costs not covered by Medicare.

To assist patients in understanding the cost of dental treatment, dental practitioners are required to provide a written quote or cost estimate to the patient prior to commencing a course of treatment.

In July 2008, Medicare introduced a Medicare Teen Dental Plan. This enabled eligible teens the ability to access components of dental care from dentists. The requirements of this Scheme were straightforward. Patients presented with a voucher and were eligible to receive treatment. Administrative requirements were simple. A claim form is completed and benefits paid. None of the administrative minutia associated with the CDDS was required. Members were comfortable with this simplified MA procedure.

In late 2009/early 2010, what transpired with the CDDS was that nearly three years after its inception (coinciding with the recognition that expenditure was increasing under the CDDS), MA commenced audits of practitioners as to their utilisation of the CDDS and their compliance with the requirements of the CDDS.

These audits revealed that practitioners were non-compliant with the requirements to:

i) Provide a written treatment plan and quotation of costs to the patient prior to commencing treatment to ensure full financial consent, and

ii) Provide a written treatment summary to the referring medical GP.

As a consequence of these failures, MA commenced recovery from dentists of monies paid to patients/dentists for treatment rendered under the CDDS. This was notwithstanding clear evidence of provision of valid and proper services to patients and in some cases evidence of payments made by the dentist to dental technicians and other third parties for services which were included in the claims.

It is relevant to note that nowhere in the initial Fact Sheet or other material was it in any way made plain to practitioners that there were requirements (such as those set out) which were obligatory or that failure to comply with these requirements was crucial for a valid MA claim to be made for the services rendered.

The timing of these audits – some four years after the implementation of the CDDS – leads the ADA to suggest either that MA was aware of noncompliance and was happy to let dentists behave that way in the knowledge that recovery of expenditure was available or that the audits were motivated by the budget blowouts created and the Government's wishes to close the CDDS. It is inexplicable as to why audits were not conducted earlier to determine participants' compliance with the CDDS.

It is also relevant to draw to the attention of the Senate that the information contained in the Fact Sheet (referred to above) is inconsistent with the information published in the Medicare Benefits Schedule Dental Services booklet sent to some dentists by MA. For example, the information set out in the "*Checklist for Dental Practitioners*" at page 16 of that Booklet makes no reference to the need for a written estimate of fees to be provided to the patient. There is also substantial evidence that advice received from practitioners from MA was inconsistent. MA officers often expressed differing responses to enquiries. Confusion and inconsistency was rife.

MA's advice to those audited – provided for the first time – was that the failure to comply with steps (i) and (ii) above was in breach of the Determination. MA has advised that this Section's requirements are "the core of the scheme".

If the requirements were "the core of the scheme" the ADA says that it was clearly the duty of MA to emphasise these requirements in its education program on this new Scheme. Requirements, so fundamental to the Scheme, should have been first and foremost brought to the attention of the participants. Failure to do this is, in the ADA's view, a dereliction of the responsibilities of MA.

In March 2010, recognising the failure of MA to educate practitioners as to the requirements of the CDDS, the ADA published notices advising practitioners as to the Determination and its impact on claims. MA similarly saw there had been a failure to communicate this information and did likewise. The ADA had an officer from MA present on one of its electronic continuing education programs to inform members of the requirements of the CDDS. It had been hoped that this action would cause MA to not press forward with its audits and recovery as it would allow practitioners to familiarise themselves with the CDDS requirements.

Sadly, this did not prove to be the case. The ADA is aware of many members being the subject of claims for recovery by MA in respect of services provided to this time. In some instances this will result in bankruptcy of the dentist and/or closure of the practice.

Late last year the ADA sought Ministerial intervention. This was delayed initially due to the busyness of the then Minister for Human Services, the Honourable Chris Bowen MP and then the Government going into caretaker mode. Maternity leave by the new Minister, The Honourable Tanya Plibersek MP, further delayed the ability to meet with the relevant Minister. When a meeting was organised, the ADA felt that an understanding had been reached that would see MA exercise some discretion in its recovery of claims. The ADA and MA again communicated to

dentists as to their requirements under the CDDS and encouraged action to remedy any deficiencies that existed. See copies of the ADA's President's Comments to Members and an MA letter to dentists (Annexures 1 and 2).

Recent advice from members suggests statutory demands for repayment have not halted and claims for repayment of benefits are continuing to be made. The majority of claims for repayment are founded upon the practitioner's failure to comply with the Determination. This is occurring when it is evident to MA that in the vast majority of cases, services have been validly rendered to eligible patients. The ADA feels it is grossly inappropriate and unfair that dentists are being pursued for recovery of benefits paid in such circumstances. If the requirements of the Determination were the "core" of the Scheme then any failure to comply by practitioners has been attributable to MA's own inadequacies in educating practitioners.

At all times the ADA has made it clear that in the cases where evidence of fraud is established, the ADA is fully supportive of any disciplinary action being taken. It would encourage the PSR to strongly prosecute such cases. What the ADA has emphasised is that in the case of noncompliance with the Determination, should it be established that all other requirements have been met, a failure to comply with the Determination should be excused.

It will be with this background in mind that the ADA will respond in this submission.

4. RESPONSE TO TERMS OF REFERENCE

The ADA wishes to thank the Senate Community Affairs Committee for the opportunity to comment on the Terms of Reference which deal with reviewing and investigating the provision of MA or Pharmaceutical Benefits Scheme (PBS) services by health professionals.

In responding the ADA will focus its response to the following three Terms of Reference:

i. procedures for investigating alleged breaches under the Act;

ii. pathways available to practitioners or health professionals under review to respond to any alleged breach;

iii. any other related matter.

a) PROCEDURES FOR INVESTIGATING ALLEGED BREACHES UNDER THE ACT

It is noted that the PSR was created "to protect the integrity of Medicare and the Pharmaceutical Benefits Scheme (PBS)". The PSR through the performance of its statutory role has the objective to protect patients and the community from the risks associated with inappropriate practice and protects the Commonwealth from having to meet the cost of medical / health services provided as a result of inappropriate practice.

In dealing with any case brought to the PSR in relation to the CDDS, the ADA would ask that consideration be given to the matters set out in the "Introduction and Background" to this submission.

It is the ADA's belief that what has occurred here is that the Department of Human Services, in late 2009, has recognised that inadequate budgeting had been provided for the CDDS and in an effort to address this sought whatever avenues were available to it to recoup benefits paid. The ADA would like to point out that it has never favoured the CDDS as a valuable scheme for dental health delivery. This opposition has been based on the fact that eligibility was not means tested. The ADA advised Government at the implementation phase that there was considerable unmet need in the community and that the CDDS would prove popular and so considerable expenditure would be incurred.

The Government itself seemed to accept the ADA's arguments as it tried on two occasions to close the CDDS but was unsuccessful due to continuing support for the CDDS in the Senate. Rather than cause the CDDS to be closed or its use to be reduced, these efforts only drew public attention to the scheme and encouraged the public to seek treatment under it before closure was achieved. This escalated demand and only served to increase the delivery of services for which practitioners, who have been noncompliant with the Determination, are now being asked to refund benefits received by patients.

The result of this was the publication of comments from the then Minister, The Honourable Chris Bowen MP that dentists were "rorting" the CDDS. The ADA's response was the issue of a Media release (Annexure 3).

Inappropriate practice is defined as conduct in connection with rendering or initiating services that a Committee of the practitioner's peers could reasonably conclude was unacceptable to the general body of their profession. The ADA would contend that in light of the exceedingly poor educative processes instituted by MA to familiarise practitioners with the Determination any associated claim of inappropriate practice based solely on noncompliance with the Determination be summarily dismissed.

Recommendation:

> That, if the PSR receives a complaint of inappropriate practice from MA that is solely attributable to noncompliance with the Determination, the Director determine there is no case to answer for the practitioner.

b) PATHWAYS AVAILABLE TO PRACTITIONERS OR HEALTH PROFESSIONALS UNDER REVIEW TO RESPOND TO ANY ALLEGED BREACH

MA has adopted a very harsh line with dental practitioners in seeking recovery where noncompliance with the Determination has occurred.

It is acknowledged by the ADA that in many cases dentists have not complied with the Determination. It says the reason for this was ignorance on the part of those practitioners as regards its requirements. This in turn was due to MA's failures as outlined above. The ADA is yet to see any case where a practitioner has deliberately decided to ignore the requirements of the Determination.

What is of concern to the ADA is that the approach adopted by MA will cause dentists and other practitioners to avoid or be reluctant to participate in any Government-run healthcare scheme. ADA members have a well-established role in supporting DVA-eligible patients, as well as teenagers under the Teen Dental Plan. Actions by MA are severely prejudicing the goodwill of practitioners to participate in such schemes or proposed replacement schemes for fear of unfair claims being made against them.

In their view, if a patient is appropriately referred to them for treatment, they obtain the patient's consent and provide the required care; they should be entitled to be paid the appropriate fee for their services. The message MA is giving to the entire Australian dental profession is that Government schemes cannot be trusted to pay for work legitimately provided to patients in need. Rather than being appreciative that patients received the care they were referred to receive, they are being treated as if they have committed fraud and in some cases pursued to pay back sums that will ruin them financially.

Recommendation:

In respect of claims associated solely with failure to comply with the Determination, pathways be made available to practitioners to demonstrate their bona fides to MA or the PSR, and if established, then the Director determine there is no case to answer.

c) ANY OTHER RELATED MATTER

What has occurred to dental practitioners with the introduction of the CDDS must not be repeated.

The ADA believes that the PSR in its role as the body responsible to protect patients and the community from the risks associated with inappropriate practice should direct MA to ensure that when it introduces new health schemes, it properly educates both patients and practitioners of the details of the scheme so that such schemes are administered fairly and with a minimum of administrative requirements. If administrative steps are to be introduced then these must be clearly communicated to participants.

Further, there is the need to evaluate the effectiveness of any new scheme in a timely manner. If evidence is gathered that suggests participants are non-compliant then rather than punish those participants, MA should look internally to see what it is that needs to be done to address the issues identified.

Recommendation:

The Director of PSR direct MA to ensure that with the introduction of any MA scheme the administrative requirements associated with the scheme be kept to a minimum and be confined to those essential to the proper administration of the scheme. Further when a scheme is introduced proper governance procedures be put in place to test the participants' familiarity with the scheme and if deficiencies exist then they be addressed.

The ADA thanks the Senate for the opportunity to comment on the Terms of Reference. Should it require clarification of any issue please advise.

Dr F Shane Fryer
President
Australian Dental Association Inc.
12 August 2011.

Annexure 1.

president's comments

F. Shane Fryer
Federal President

"...all practitioners who have been involved with the CDDS should get their house in order, review their records and correct all administrative discrepancies."

MEDICARE AND THE CHRONIC DISEASE DENTAL SCHEME 'GET YOUR HOUSE IN ORDER'

You will have seen numerous previous reports of ADA's dealings with Medicare Australia (MA) over the last 15–20 months where the ADA has advised you as to how important it is for you to comply with the administrative requirements and rules with the Chronic Dental Disease Scheme (CDDS).

MA has undertaken an exhaustive investigation of some dentists' claims under the CDDS. These investigations commenced with MA either receiving a tip off about a dentist's treatment or billing, or from a direct complaint by a patient to MA about a dentist's conduct in respect of treatment under the Scheme. Investigations are at various stages from initial informal enquiries to those that have escalated to full blown audits. These investigations initially revealed widespread non-compliance with the administrative requirements of the CDDS and instances of pre billing of services by dentists. Non-compliance from the administrative perspective dealt primarily with a failure to meet Section 10 requirements, which obligates the dentist:

• prior to the commencement of the course of treatment, to provide a written treatment plan to the patient, along with a written itemised quotation for services within the plan, and

• prior to the commencement of the course of treatment, to provide a copy or summary of the treatment plan to the referring General Practitioner (GP).

These obligations exist whether the patient is being bulk billed or not. Provision of advice to the patient is designed to provide informed consent and financial consent for treatment. Provision of the treatment plan to the medical GP is designed to assist them to develop and monitor the overall treatment plan for the chronically ill patient.

If Section 10 of the Scheme was not complied with, the claim against MA for the services rendered is invalid and MA has a right to recover the monies it has paid in respect of those services.

The law is absolutely clear on this.

The ADA has been in frequent dialogue with the Ministers for Human Services, (currently the Hon. Tanya Plibersek), the Department and the Compliance Officers with MA. What the ADA has attempted to do in its approaches to Government is to seek the assistance of the Minister and MA in having the breaches in the CDDS administrative compliance requirements with respect to Section 10 sympathetically dealt with by MA in its recovery actions. The ADA has recognised that in many cases non-compliance was innocent due to lack of familiarity and education with the CDDS. (I want to make it clear that this is not about protecting those few who may have acted unprofessionally in claiming under the Scheme but is aimed at the larger group who may not have completed the administrative requirements in the correct sequence and are therefore in breach of the legislation.)

Initially, it was believed that MA was strictly seeking recovery for all dental benefits paid pursuant to invalid claims, however, after meeting with Medicare and outlining our concerns it is now evident that MA is adopting a more reasonable approach.

Recent dialogue with MA has seen a further slight adjustment in its stance on Section 10 breaches.

Following our most recent meeting with MA officials on Tuesday, 12 April I would like to advise members of the following matters:

• If you receive a request by MA to undertake an examination of your treatment records for patients treated under the CDDS, you should seek advice from your Branch and discuss with the Branch whether you have been compliant with the Scheme both now and in the past.

• As part of standard operating arrangements, MA officials indicate they will engage with you throughout the audit process, this may be by phone, letter and/or face-to-face. These opportunities are used to seek information, keep you informed of progress and allow you to move through the audit as efficiently as possible.

• If in this investigative process you assess or are advised that you have been non-compliant then you should determine in what areas this has occurred and after further consultation with your Branch consider seeking MA's advice as to how to best address the issues identified.

• Cooperation with MA may be in your best interests.

• If you are told to revise your method of dealing with claims under the CDDS then you must immediately take the necessary steps. Failure to comply (which is ill advised) will lead to an audit and the likely receipt of a formal demand for repayment of monies paid by MA. Compliance with MA's directions will only stand you in good stead. It may not result in a claim being avoided but you are more likely to be dealt with sympathetically by MA.

• In the investigation process you should heed MA's advice. If a demand for repayment is made, it would be sensible to promptly enter into discussions with MA to explain the reason for your non-compliance. For example, you may have been innocently unaware of the Section 10 obligations. If you can establish this and this is the only shortcoming in your compliance or claiming then you may be able to demonstrate that remedial action by you to address the administrative oversights will result in overcoming the impact of at least some of your non-compliance.

• If you ignore MA's approaches a statutory demand for repayment to the Commonwealth may be made.

• In either case if a demand for repayment occurs you are able to seek an internal review of the decision within 28 days and this review is conducted by a delegate of the CEO of MA. Following failure of this your only recourse would be to appeal to or seek some relief from the Commonwealth Minister for Finance.

• It should be noted that once a demand for repayment is made by MA the options available to you are limited.

• If you have not been approached by MA but are now aware that you have been non-compliant, I suggest you review your patient files and see what can be done to rectify any deficiencies with respect to your administrative requirements as soon as possible. Any steps you take in this regard will assist the medical GP to place your treatment in the overall management of the chronically ill patient and will assist the patient to understand their treatment plan and the financial costs associated with it.

You will be receiving a letter from MA shortly. It has been written by MA after our representations to the Minister and the Department. It provides some advice for you to deal with compliance issues under the CDDS. Please read the letter carefully as it sets out what it is you have to do to comply with the CDDS requirements. It is not forgiving you for any liability you may have but is offering a potentially more favourable outcome to you. I implore you to read it and act upon it.

Please heed advice you receive through your Branch or from MA. The consequences of non-compliance have left some members on the verge of bankruptcy.

So, in summary, all practitioners who have been involved with the CDDS should get their house in order, review their records and correct all administrative discrepancies. If you are the subject of an investigation or audit by MA now or in the future your ability to demonstrate a change in your administrative behaviour with respect to the CDDS will hold you in good stead and allow MA the option of exercising some discretion in your favour when they are reviewing your CDDS compliance level.

It is also worth noting that MA is aware of the content of this Presidential Message on the CDDS.

Your attention is also drawn to the article published on page 8 of the *News Bulletin* that deals with changes to the administrative powers of MA when dealing with claims. These changes make it even more imperative that you are fully aware of the rules and are compliant with the requirements.

Annexure 2.

Australian Government
Medicare Australia
If not delivered return to PO Box 1001 TUGGERANONG DC ACT 2901

29 April 2011

Phone: **02 6124 6300**
(Call charges may apply)

<Title> <Name> <Surname>
<Address 1>
<Address 2>
<SUBURB> <STATE> <Postcode>

Our reference: <reference>

Dear <Title> <Surname>

Increased Audit of Chronic Disease Dental Scheme

In June 2010, Medicare Australia wrote to all dental practitioners who were participating in the Chronic Disease Dental Scheme about a compliance project being undertaken in relation to the scheme. In that letter, Medicare Australia outlined concerns about dental practitioners claiming under the scheme and provided information about the legal requirements. These matters were drawn to your attention to give you the opportunity to ensure your claiming practices are compliant.

Since that time, Medicare Australia has undertaken a program of audits of dental practitioners who have made claims under the scheme. In the conduct of these audits Medicare Australia has found that 41% of practitioners complied, or made genuine attempts to comply, with the requirements of the scheme. I acknowledge the effort and professionalism of dental practitioners who have sought to comply with the scheme. I also appreciate the efforts of the Australian Dental Association which I note has been making information available to members about the scheme since October 2007.

While many dental practitioners are claiming correctly, these audit findings have also shown a high level of non-compliance with the legal requirements, particularly the requirements of section 10 of the *Health Insurance (Dental Services) Determination 2007* (the Determination). In addition, Medicare Australia has received hundreds of complaints from patients about dental practitioners claiming under the scheme. The results of these audits have given rise to significant concern about the use of the scheme across the dental profession.

The purpose of this scheme is to improve the health outcomes of sufferers of chronic disease. The section 10 requirements go to the core of the scheme and are essential to fulfilling this purpose. The requirements of section 10 of the Determination are as follows:

- Dental practitioners must provide patients with a written quotation for each dental service and each other service (if any) in the plan prior to commencing the course of treatment. This is to ensure patients give full financial consent to the services.

- Dental practitioners must provide patients with a written plan of the course of treatment prior to commencing the treatment. Dental practitioners must also provide referring general practitioners with a copy or written summary of the treatment plan prior to commencing the course of treatment. This is to facilitate appropriate communication

between health professionals to ensure adequate and appropriate care. It also ensures that the patient is aware of the full course of treatment.

These two requirements are explicitly about patients' rights and placing the referring general practitioner in an informed position to manage the overall health of the patient. This is not red tape. Failure to notify the referring general practitioner represents a serious level of non-compliance that undermines the integrity of the scheme, does a disservice to sufferers of chronic disease and potentially puts patients' health outcomes at risk.

In addition, there are specific requirements for any claim or billing under the Medicare program. For example, health professionals may only claim Medicare benefits after the service has been rendered and the service must meet the relevant Medicare Benefits Schedule item descriptor.

A range of information has been provided to dental practitioners and is available to explain the requirements of the scheme. In particular, the Medicare Benefits Schedule Dental Services Book was sent to dental practitioners who were members of the Australian Dental Association at the commencement of the scheme. If you have not already done so, you should make yourself aware of the content of the explanatory notes as well as the item descriptors. The Medicare Benefits Schedule Dental Services Book continues to be available on the website of the Department of Health and Ageing, along with a fact sheet for dental practitioners.

It is the basic responsibility of all health professionals who bill or claim benefits under the Medicare program to acquaint themselves with the requirements and to ensure their claims are fully compliant.

Medicare Australia has taken a fair and reasonable approach to conducting audits under the scheme. Audits have generally been confined to a two year period rather than the three years of claiming under the scheme. Medicare Australia has considered all information provided by dental practitioners that could potentially demonstrate compliance with the requirement to provide a treatment plan to patients and referring general practitioners. Medicare Australia has and will continue to accept standard industry practice of what constitutes a dental treatment plan. Medicare Australia has also focused primarily on those cases where the section 10 requirements were not met in relation to any of the claims made.

It is Medicare Australia's obligation to ensure the integrity of the programs it administers and that taxpayer funds are spent correctly. As a result of the findings, I am writing now to inform you that Medicare Australia is increasing audits of dental practitioners claiming under the scheme. A Chronic Disease Dental Scheme Taskforce that was established in June 2010 will be expanded to undertake this extra work.

Medicare Australia will continue to be flexible in our audit approach, but will seek recovery of benefits where there is a clear pattern of serious non-compliance with the core requirements of the scheme. Medicare Australia considers that clear and unambiguous information about the scheme's requirements is available to dental practitioners and expects that all claiming under the scheme strictly adhere to these requirements.

It is also clear that many dental practitioners have been less than cooperative in responding to Medicare Australia's audit activity. I urge you to cooperate with Medicare Australia's audit activities. You should be aware that, if insufficient information is provided by a dental practitioner in the course of an audit, given the seriousness of failure to comply with the requirements, patients and referring general practitioners will be contacted to determine each dental practitioner's level of compliance. Medicare Australia is seeking significant recoveries

from a number of dental practitioners who have been found to be non-compliant on the basis of information provided by patients and referring general practitioners.

I also draw your attention to the recently passed *Health Insurance Amendment (Compliance) Bill 2010*. The new law enables Medicare Australia to compel health professionals to produce documents to substantiate claims, enables the recovery of claims that are not substantiated, and introduces financial penalties for health professionals who do not comply with the law. These provisions will only apply to services rendered after the Bill becomes law, however Medicare Australia will continue to pursue recovery of incorrectly claimed benefits that were paid in relation to past services where serious non-compliance is found.

As indicated above, information about the requirements of the scheme is set out in the Medicare Dental Services Book. This is available on the website of the Department of Health and Ageing at **www.health.gov.au >Programs & Campaigns >Programs & Initiatives >Dental Health**

I urge all dental practitioners to review their claiming under the scheme to check that all the legal requirements are met. This will ensure the scheme operates optimally to improve the health outcomes of chronic disease sufferers. Where dental practitioners can show that efforts have been made to rectify non-compliance, Medicare Australia will take this into account when considering what action to take when non-compliance is detected.

If your claiming is compliant with the legal requirements of the scheme, you need not be worried about Medicare Australia's compliance activities. However, if you have any concerns about the requirements of the scheme or about your claiming under the scheme, I urge you to contact Medicare Australia to discuss your concerns as soon as possible. You can write to Medicare Australia by email at **Compliance.CDDS.Taskforce@medicareaustralia.gov.au**

Yours sincerely

Lynelle Briggs
Chief Executive Officer
Medicare Australia

Annexure 3.

AUSTRALIAN DENTAL ASSOCIATION INC.

MEDIA RELEASE

Dr Neil Hewson, Federal President

10 June 2010

DENTISTS MADE THE SCAPEGOAT FOR GAMES IN PARLIAMENT?

The Australian Dental Association (ADA) Federal President Dr Neil Hewson commenting on today's press reports of dentists exploiting the Medicare Chronic Disease Dental Scheme for those with chronic illnesses said "Let's get a few facts straight and stop blaming dentists for the failures of a poor scheme".

The facts are:

- When the scheme was introduced the ADA advised government that the scheme was seriously flawed. It has consistently maintained this position and offered simpler and better alternatives. It advised government that a means tested scheme delivering services to the financially disadvantaged based on dental need was and is the most effective model for government involvement in dental service delivery.

- The ADA advised government that with the introduction of this scheme significant unmet need for dental services would create demand for services and the budgetary allocation made would be inadequate.

- The pathway the scheme created for those with chronic illness to access dental care was through their medical GP. A medical GP has to certify a patient's eligibility for dental services under the Scheme.

- Patients referred to dentists by a medical GP for dental services are therefore automatically eligible for services. Determination of eligibility rests solely with the medical GP.

- Non compliance by dentists with the regulations under the scheme are as Senator Bowen has said primarily "accidental" and relate to administrative oversights only by dentists in a scheme with which they were unfamiliar. This scheme was the first association general dentists had with Medicare and its regulatory environment.

- Medicare, the Department of Health and Ageing and ADA are now better educating dentists as to the regulatory requirements under the scheme.

- The current government has consistently and unsuccessfully tried to close the scheme and introduce a means tested scheme. The ADA has frequently called on Parliament to stop playing politics and support disadvantaged Australians gain timely dental treatment.

- Numerous announcements of imminent closure of the scheme by government caused significant concern in patients prompting them to seek urgent eligibility for services under the scheme. This heightened the utilisation of the scheme in timeframes that placed significant pressure on dentists to complete services.

- Fraud by dentists is not condoned and the ADA has offered to assist Medicare in such cases.

- To place dentists as the demons in this scenario is unjust. The government maintains its opposition to the scheme and wants to close it. It now seeks to blame its own budgetary ineptitude by blaming the dental profession for providing services under its own scheme.

- Despite the poor structure of this scheme many genuinely needy and deserving Australians have received valuable treatment under the scheme.

- Make no mistake, the ADA supports closure of the Chronic Disease Dental Scheme and a targeted replacement that will deliver quality, worthwhile and effective dental outcomes to the disadvantaged. It is time for Parliament to do just that.

Dr Hewson says “Despite attempts to make dentists the scapegoats for a scheme the government wants to close down, the ADA maintains its willingness to work with government and the opposition in devising an effective and more targeted substitute”.

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