Chapter 2

Issues

Introduction

2.1 The Health Insurance (Dental Services) Bill [No 2] (the Bill) seeks 'to redress past and future inequities that have arisen from the operation of subsection 10(2) of the Health Insurance (Dental Services) Determination 2007' (the Determination).[1] The inequity is described in the Bill in clause 5: that a dental practitioner who has legitimately provided a dental service and claimed a Medicare benefit as payment, is required to repay the benefit where they did not provide a patient before commencing treatment with a written plan of their course of treatment and a written quotation, or failed to give copies of these documents to the referring doctor.[2]

2.2 As outlined in chapter 1, the repayments have arisen as a result of compliance audits by Medicare Australia. Those providers who have been found to be non-compliant are required to repay the total benefit received. The Department of Human Services indicated that the amount, as at 29 February 2012, identified for recovery is $21,618,721 with $259,427 received.[3]

2.3 The Australian Dental Association (ADA) commented that the auditing and recovery of payments through non-compliance with subsection 10(2) was 'unjust'. Dr Shane Fryer, President, ADA, stated:

> We are here though to address what the ADA sees as unjust treatment of dentists that have provided appropriate services to deserving patients yet are being chased by Medicare Australia to refund moneys due to noncompliance with regulatory requirements. That is under section 10—that is, it is administrative noncompliance.[4]

2.4 Dr Fryer went on to state that there were a range of causes for the non-compliance with the causes put forward by the ADA and other submitters including:

- lack of appropriate consultation occurred during the establishment of the scheme;
- problems with the operation of the scheme in relation dental practice and procedure;

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1 Senator David Bushby, *Senate Hansard,* 21 March 2012, p. 60.

2 Explanatory Memorandum, pp 1–2.

3 Department of Human Services, *Submission 201*, p. 2.

4 Dr Shane Fryer, Australian Dental Association, *Committee Hansard,* 1 May 2012, p. 1.

- insufficient education on compliance arrangements for the scheme, both at the commencement of the scheme and when non-compliance issues were identified; and
- provision of inconsistent advice to participants of the scheme.

2.5 Other issues raised by submitters included how the audits have been undertaken and the effects of audits on practitioners, patients and families; and the full recovery of benefits paid to the practitioner by Medicare, which the ADA described as 'grossly out of proportion to the offence'.[5]

2.6 The Department of Human Services (DHS) also noted the level of concern that has arisen for dental practitioners. However, Mr Ben Rimmer, Associate Secretary, DHS, stated:

> There is no doubt from the submissions that are in front of this committee that the compliance arrangements regarding the scheme have caused concerns for dental practitioners...It is also quite clear that some practitioners have not complied with the requirements of the scheme as set out in the law.[6]

Establishment of the scheme

2.7 Submitters pointed to three main concerns with the establishment of the scheme which, it was argued, contributed to non-compliance issues. First, it was argued that there had been a lack of consultation with the profession before the CDDS was implemented. Secondly, no comprehensive education program was put in place. Thirdly, the compliance arrangements for the scheme were seen as being more rigorous than other schemes administered by Medicare.

Consultation

2.8 The ADA and other submitters commented that there had been very little consultation with the profession when the CDDS was implemented. The ADA Queensland Branch stated that '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'.[7] Dr Mark Sinclair, President, ADA (NSW) Branch, concurred and stated:

> 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 high levels of noncompliance by

5 Australian Dental Association, *Submission 231*, p. 2.

6 Mr Ben Rimmer, Department of Human Services, *Committee Hansard*, 1 May 2012, p. 26.

7 Australian Dental Association Queensland Branch, *Submission 208*, p. 4.

> dentists. As a result, many of the requirements of the scheme are illogical or impractical and often fly in the face of standard dental treatment protocols.[8]

2.9 Dr Sinclair went on to conclude:

> I think that it is an extraordinary oversight for a professional body that is going to be responsible for the implementation of this scheme for there to be virtually no discussion.[9]

2.10 The Australian Dental Prosthetists Association (ADPA) also indicated that if consultation with the profession had taken place prior to the CDDS legislation being introduced, it would have been likely that some of the problems would not have arisen.[10]

2.11 In addition, it was noted that until the CDDS was implemented, dentists had very limited experience dealing with claims involving government rebates or Medicare and its rules. Most dentists had experience with Department of Veterans' Affairs (DVA) programs, but the 'complexity and importance of meeting the administrative requirements under the CDDS – as a health provider – were therefore new'.[11]

2.12 The Department of Health and Ageing (DoHA) did not agree with the above assertions regarding the level of consultation. Ms Kerry Flanagan, DoHA, stated:

> A number of discussions were held with the Australia Dental Association. In fact, as far back as 2006 we met with the ADA at national and state branch levels to receive feedback on the existing EPC dental items. There had not been a great take-up, so the government of the day was interested in talking to dentists about that and to better understand some of the barriers to that uptake. Following the budget in 2007 we held extensive discussions with the ADA and the ADPA on the implementation arrangements for the measure, including the content for the new dental items. There was also a joint meeting involving the ADA, ADPA and the GP groups—because, of course, we needed to understand how this process was going to work from GPs through to dental practitioners. Certainly our take of those consultations was that they were positive and cooperative. That is certainly the record that I have of those discussions.[12]

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8 Dr Mark Sinclair, Australian Dental Association (NSW), *Committee Hansard,* 1 May 2012, p. 10.

9 Dr Mark Sinclair, Australian Dental Association (NSW), *Committee Hansard,* 1 May 2012, p. 15.

10 Ms Sara Harrup, Australian Dental Prosthetists Association (NSW), *Committee Hansard,* 1 May 2012, p. 24.

11 Australian Dental Association, *Submission 231*, p. 3.

12 Ms Kerry Flanagan, Department of Health and Ageing, *Committee Hansard,* 1 May 2012, p. 32.

Compliance arrangements

2.13 A key issue for dentists has been the difference in the level of rigour required by the CDDS compliance arrangements. The ADA submitted that:

> We have been informed that the compliance regimes with this scheme are the most onerous of any scheme that Medicare is administering and controlling. Again, as I intimated in my introductory remarks, if the ADA had been approached and consulted and our advice heeded we would have argued—and still do—that these sort of compliance regimes are not necessary for the efficient delivery of dental services to the Australian community. That is not withstanding that it is appropriate and acceptable that Medicare conduct audits, because they must make sure there is responsible expenditure of public moneys.[13]

2.14 However not all dentists agreed with the ADA's position with one dentist submitting that the Medicare requirements are consistent with expectations of the Dental Board of Australia:

> One rule in particular – namely the provision of an itemised treatment plan and written quotation before treatment begins – is a fundamental safeguard that must be upheld rigorously to ensure the provision of (1) good medicine, (2) patient acceptance, (3) provider compliance, and (4) transparency for audit and complaint resolution purposes. This is no different from the underlying expectation the Dental Board of Australia places on dental practitioners to provide services to privately paying patients in this country.[14]

2.15 Some submitters have drawn comparisons with the way the Veterans' Affairs scheme operates and have generally viewed that scheme more favourably.[15]

2.16 DHS acknowledged that the requirements in the CDDS determination are more specific and greater in number than in many other Medicare arrangements, and in particular, have greater time specificity. Mr Rimmer stated:

> So they require the provision of documents before the treatment has started. 'It is kind of a binary switch: was the document handed over before the treatment or not? There is not much grey in that matter.' So the detail of this determination sets up compliance arrangements that are different in that respect from other parts of MBS compliance arrangements.[16]

2.17 DoHA explained the reasoning behind some of the compliance arrangements. Ms Flanagan stated:

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13 Dr Shane Fryer, Australian Dental Association, *Committee Hansard,* 1 May 2012, p. 6.

14 Dr Kia Pajouhesh, *Submission 429,* p. 3.

15 Dr Bella Kolber, *Submission 1,* p. 1.

16 Mr Ben Rimmer, Department of Human Services, *Committee Hansard,* 1 May 2012, p. 29.

> I might just talk about the policy intent of the particular clause that appears to be causing so much concern. This was done on the basis that it underpins two very important principles. The first principle is that this is treating chronic disease patients, so for the first time the former government made available dental treatment for chronic disease patients. So it was seen as very important and necessary for the GP who was managing the overall totality of a chronic disease patient to know what dental treatment was being provided in that context. The second part of this is the fact that it was important for informed financial consent to be given by the patient before treatment was started. That is a principle that we believe should follow right through the health system in terms of letting people know in case there might be a cost that they incur as a patient. So that was the policy intent. We believe that the policy intent of both those things stands.[17]

Education of the dental sector

2.18 The committee heard some quite divergent views on whether sufficient education had been provided to dental practitioners regarding the CDDS and in particular its compliance arrangements. Concerns were raised about:

- whether the avenues used by Medicare to inform practitioners were adequate;
- whether the information provided was adequate;
- whether the potentially imminent closure of the scheme impacted on the level of education provided.

Provision of information to practitioners

2.19 When the scheme commenced in 2007, DoHA undertook a mailout of the Medicare Benefits Schedule Dental Services Book to dentists, dental specialists and dental prosthetists. A Fact Sheet was also distributed at that time. Following this initial mailout, DoHA contacted dentists, dental prosthetists and their professional bodies on a number of other occasions to provide information about the CDDS. Details of these communications were provided in response to the Senate order for the production of CDDS documents.[18] The index of documents is at appendix 3 of this report.

2.20 Concern was expressed about the adequacy of the approach undertaken to provide dentists with information about the scheme. The ADA advised the committee that its membership mailing list was used by DoHA, but that there are a significant number of dentists who are not members of the ADA:

> The first notice was in October 2007, I think, from the then health minister, telling the profession about the new scheme that was to be introduced. But none of the correspondence, as far as we can ascertain, has been provided to

17 Ms Kerry Flanagan, Department of Health and Ageing, *Committee Hansard*, 1 May 2012, p. 30.

18 *Journals of the Senate*, No. 53, 19 September 2011, p. 1504.

> all practitioners; even the numbers that have been going out. I think 10,000 booklets were sent out, and there would probably have been 13,000 registered dental practitioners in the country at that time.[19]

2.21 The ADA undertook a survey to identify how many of its members had received information about the scheme. Mr Boyd-Boland, Chief Executive Office, ADA, provided the following results:

> Slightly less than 18 per cent—17.8 per cent—of members said they received it in November 2007; 21.6 per cent said sometime in 2008; 16.2 per cent said 2009; 14.6 per cent said 2010; 10 per cent said 2011; and 31.5 per cent said they have never received it.[20]

2.22 The committee sought evidence on whether there were alternatives to the ADA mailings for contacting dentists. The ADA (NSW) stated:

> As you would understand, national regulation consolidated a database, but even prior to that there was the ability for the dental boards who hold the register of practitioners to exchange information, even in the absence of the national scheme.[21]

2.23 DoHA explained to the committee why the ADA lists were used:

> When the scheme was introduced in November 2007, we did not have the national registration and accreditation scheme so we worked with the ADA. We recognised that there was an issue because not all dentists were members of the ADA, but it was the best source, I suppose, that we had to try and get to individual dentists.[22]

2.24 In addition, the ADA drew to the committee's attention the consultation and education undertaken by DoHA, Medicare and stakeholders in relation to nurse practitioners access to Medicare. The ADA noted that nurse practitioners were fully informed of the new arrangements including compliance requirements.[23]

2.25 The ADPA also pointed to the lack of education for its members, noting that they had received less education opportunities than dentists:

> For dental prosthetists, because of the lack of engagement with the ADPA from Medicare, the only education that they have really received is documents that were sent to them on their initial provider number request

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19 Dr Shane Fryer, Australian Dental Association, *Committee Hansard,* 1 May 2012, p. 5.

20 Mr Robert Boyd-Boland, Australian Dental Association, *Committee Hansard,* 1 May 2012, p. 5.

21 Dr Matthew Fisher, Australian Dental Association (NSW), *Committee Hansard,* 1 May 2012, p. 16.

22 Ms Kerry Flanagan, Department of Health and Ageing, *Committee Hansard,* 1 May 2012, p. 33; see also Department of Health and Ageing, Answer to question on notice, No. 1.

23 Australian Dental Association, *Submission 201*, p. 3.

> and two letters that were sent to them—one in June 2010 and one in April 2011.[24]

2.26 Ms Harrup went on to state:

> If we have a look at the statistics at the back end of the Medicare website we will see that they demonstrate that in the provision of dental services to patients dental prosthetists provided approximately 46 per cent of those services since inception of the scheme. At a meeting that we had with the Department of Human Services on 2 September this year they advised us that 990 dental prosthetists had registered with the scheme and 879 had made at least one claim at that time.
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> For dental prosthetists, because of the lack of engagement with the ADPA from Medicare, the only education that they have really received is documents that were sent to them on their initial provider number request and two letters that were sent to them—one in June 2010 and one in April 2011.[25]

Adequacy of information

2.27 The committee received evidence that the written information provided by Medicare was inadequate, that practitioners who sought assistance from Medicare were often provided with confusing and/or conflicting advice and little or no education was provided to those providing services under the scheme.

2.28 The ADA commented that while the section 10 of the Determination clearly imposes steps that need to occur before a dental service can be considered a valid Medicare service, these were not clearly set out in either the book or fact sheet provided to dentists.[26] Dr Jane Pinchback, ADA (NSW), noted that the references to section 10 were confined to one paragraph in the 65 page book.[27] Many other submitters mentioned that the section 10 requirements were inadequately detailed in the book.[28]

2.29 Of particular concern, was that even when compliance issues had been identified as being significant, Medicare did not implement an adequate education program. The ADA stated that:

> The ADA's position has been that there was exceedingly bad communication of the details and requirements of the scheme to dental

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24 Ms Sara Harrup, Australian Dental Prosthetists Association, *Committee Hansard*, 1 May 2012, pp 18, 19.

25 Ms Sara Harrup, Australian Dental Prosthetists Association, *Committee Hansard*, 1 May 2012, pp 18, 19.

26 Australian Dental Association, *Submission 201*, p. 4.

27 Dr Jane Pinchback, ADA (NSW), *Committee Hansard*, 1 May 2012, p. 13.

28 See for example Dr Paul Werner, *Submission 156*, p. 1; Mrs Jeanette Culic, *Submission 117*, p. 2.

> practitioners when it was introduced. The identification of a level of noncompliance with the administrative requirements was something that Medicare Australia seemed to have been aware of from mid-2009, if not earlier, and it was not until 2010 that the issue was brought to the attention of the ADA.[29]

2.30 The ADA (NSW) also commented that the first detailed letter from Medicare advising of increased audits of the CDDS was sent in April 2011. This letter specified the explicit purpose underpinning section 10 requirements.[30] Mr Rupasinghe for the ADA (NSW) went on to comment

> ...it was only 2½ pages. It was sent 42 months after the scheme commenced and it was what we would call a very short letter. It was the most comprehensive that had been sent but it was still a very short letter sent to dentists.[31]

2.31 As a result, the ADA described the education process as 'scant, inconsistent and confusing'. The ADA argued that its survey bore this out:

> ...our average member: in 2008–09, 95 per cent were unaware of the administrative compliance and the penalties. In 2010, 80 per cent were unaware—but that was at the end of 2009, when the ADA were notified that Medicare Australia had determined that there was administrative noncompliance; in 2011 it had dropped to 40 per cent being unaware—so the dentists and our members were starting to get the message. I would like to say that every ADA member is now aware—it is not quite that high, but it is certainly down to single figures who are not yet aware.[32]

2.32 In addition, evidence was received that the information provided by Medicare staff was often confusing, incorrect and inconsistent.[33] For example, submitters stated:

> When we received our first referral we had to call our local Medicare office for advice. They were not sure exactly what to do procedurally and we received differing advice from different officers on different days. This differed markedly with our experience in dealing with Dept. Veteran Affairs. They had a claim form which we had to fill out that satisfied their needs. It is easy and consistent.[34]

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29 Dr Shane Fryer, Australian Dental Association, *Committee Hansard,* 1 May 2012, pp 1–2; see also Mr Bernard, Rupasinghe, Australian Dental Association (NSW), *Committee Hansard,* 1 May 2012, p. 13.

30 Australian Dental Association (NSW), *Submission 343*, p. 9.

31 Mr Bernard Rupasinghe, Australian Dental Association NSW, *Committee Hansard*, 1 May 2012, p. 13.

32 Dr Shane Fryer, Australian Dental Association, *Committee Hansard,* 1 May 2012, p. 5.

33 Australian Dental Association (NSW), *Submission 343,* p. 11.

34 Dr Kim Stock, *Submission 26*, p. 1.

> Medicare assistance has been a bit perplexing and contradictory over time. There seems to be an enormous number of people one gets to talk to and they can give you misleading or incorrect information. The people are always friendly but don't seem to know much about dentistry.[35]

2.33 Some allegations were made that the proposed imminent closure of the scheme influenced how well communication to dentists was undertaken.[36] For example:

> The department seemed content to do as little as possible to educate members, perhaps thinking that, as the scheme was to close, education expenditure could be saved. Indeed, if you look at the material allegedly distributed to dentists before this time, as identified by the department in the material it presented to the Senate, you will see that almost as many letters were sent advising of closure of the scheme as were sent with details of compliance requirements with the scheme.[37]

> The ADA New South Wales strongly suspects both the Department of Human Services and the Department of Health and Ageing assumed the Chronic Disease Dental Scheme would close relatively early in its existence, which helps explain the initial failure to consult with and then educate dentists about the CDDS requirements.[38]

2.34 The ADA and other witnesses concluded that the inadequacy of the information and education provided by Medicare contributed to the high rates of non-compliance. Dr Fryer, ADA, commented:

> ...the completed audits show that 70 per cent of dental practitioners have been deemed to have failed to comply with the administrative compliance requirements of the scheme.
>
> In any arena, if a teacher had 70 per cent of their students fail an exam, a significant amount of the blame for that occurrence could be attributed to the educator rather than to the student. So although Medicare or the department are saying that they have supplied a significant list of documents and information to us, the emphasis within those documents has not had the same significance which Medicare applied to it when they were auditing the profession.[39]

2.35 In response to the evidence received concerning the provision of information and education to providers, DHS noted information had been provided from the inception of scheme. Mr Rimmer, DHS, commented:

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35 Dr Damir Culic, *Submission 160,* p. 4.

36 Australian Dental Association, *Submission 231,* p. 6.

37 Dr Shane Fryer, Australian Dental Association, *Committee Hansard,* 1 May 2012, p. 2.

38 Dr Mark Sinclair, Australian Dental Association (NSW), *Committee Hansard,* 1 May 2012, p. 10.

39 Dr Shane Fryer, Australian Dental Association, *Committee Hansard,* 1 May 2012, p. 2.

> The department has used its best endeavours through a whole variety of different media to communicate about the scheme and its requirements, going well back to its establishment under the previous government. That is probably the best that can be said on that one.[40]

2.36 Mr Rimmer also added that he did not accept that insufficient information was provided, and noted that there had been a 'very extensive effort from both departments and from the Minister for Health to communicate about this matter and to ensure that the dental profession understand their obligations under the scheme'.[41] Mr Rimmer went on to comment:

> I think respectfully we might disagree with the views put forward on some of these matters by the ADA and various branches of the ADA. The evidence that we have put before the Senate about what matters were covered in different letters was, I think, very transparent in the Senate...[42]

2.37 DHS pointed the committee to some examples of documents where the requirements were clear and noted that dentists had met some requirements of the checklist, but not others:

> I would just highlight the checklist for dental practitioners. I know that has been the subject of some comment in some of the submissions, which was really very clear about some things that dentists had to do before claiming. Some of those things, which are quite specific, dentists did do; for example, call in relation to a particular patient and check that item 713 had been claimed in relation to that patient in a particular time period. In other words, check their eligibility for the scheme. To check that the amounts that they had not already reached their cap of $4,250. Some of the things in the checklist were being done and were being done very effectively. Some other things in the checklist that are frankly very clear in the checklist were clearly not being done in at least some cases.[43]

2.38 When asked whether DHS and Medicare assessed if dental professionals had understood the literature provided to them, Mr Rimmer, DHS, stated:

> There have been a range of conversations with dental stakeholder groups such as the ADA and others, going back for some years now. In addition, we obviously hear from individual practitioners through our Medicare providers phone line. We aim to be as responsive as possible to what we hear in those conversations and what we find out in those phone calls.[44]

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40 Mr Ben Rimmer, Department of Human Services, *Committee Hansard,* 1 May 2012, p. 29.

41 Mr Ben Rimmer, Department of Human Services, *Committee Hansard,* 1 May 2012, p. 30.

42 Mr Ben Rimmer, Department of Human Services, *Committee Hansard,* 1 May 2012, p. 32.

43 Mr Ben Rimmer, Department of Human Services, *Committee Hansard,* 1 May 2012, p. 33.

44 Mr Ben Rimmer, Department of Human Services, *Committee Hansard,* 1 May 2012, p. 31.

Responsibility for public money

2.39 The ADA and ADA (NSW) acknowledged that individuals had a responsibility if they were accessing public money available under legislated requirements:

> The law is the law and even though this is bad law it is still the law. We as individuals and the community have to take responsibility.[45]

2.40 The ADA (NSW) stated:

> I think that is an entirely reasonable proposition, but the nature of the compliance and the ramifications of noncompliance were such that I do not think that has been clearly educated at all in the processes that have been delivered.[46]
>
> As to the question about whether the profession bears some responsibility, we would say no. We bear no responsibility for this. This is a situation that has been made by Medicare Australia and the Department of Health and Ageing.[47]

Operation of the CDDS

2.41 A number of issues in relation to the operation of the scheme were raised in evidence. These ranged from problems with the requirements of the scheme which do not reflect dental practices and procedures to administrative problems when dealing with Medicare.

2.42 Many submitters commented on the restriction on treatment available when the patient first consulted the dental practitioner. The ADA (NSW) noted that section 10 requirements 'severely limits' the services which can be provided to a patients at the initial consultation. Failure to comply with these requirements resulted in all subsequent services being non-compliant making the dentist liable to repay all Medicare benefits.[48] However, many dentists indicated that they would treat patients at their initial consultation. Dr Pinchback, ADA (NSW), stated:

> If we access our member survey where we asked practitioners what they would routinely do at an initial consultation, 86 per cent of them indicated that they would attend to the patient's presenting complaint, and that would automatically render them non-compliant in an audit situation.[49]

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45 Dr Shane Fryer, Australian Dental Association, *Committee Hansard,* 1 May 2012, p. 8.

46 Dr Mark Sinclair, Australian Dental Association (NSW), *Committee Hansard,* 1 May 2012, p. 17.

47 Dr Bernard Rupasinghe, Australian Dental Association (NSW), *Committee Hansard,* 1 May 2012, p. 17.

48 Australian Dental Association (NSW), *Submission 343,* p. 13.

49 Dr Jane Pinchback, Australian Dental Association (NSW), *Committee Hansard,* 1 May 2012, p. 14.

2.43 The need to be compliant with section 10 has resulted in some distressing outcomes for patients with Dr Sinclair reporting cases where ambulatory patients in pain have been transported 300 kilometres for treatment and been advised that, because of paperwork requirements, their pain cannot be treated on that day.[50] Dr Sinclair went on to acknowledge that this could be solved by immediately faxing or emailing the plan to the GP.[51]

2.44 A further requirement of section 10 is the provision of the treatment plan to a general practitioner. Many dentists submitted that GPs appeared to have little interest in the treatment plans and few dentists indicated that GPs had contacted them regarding a treatment plan.[52]

2.45 Another area of concern was the poorly defined linkages between chronic disease and dental health.[53] Some submitters commented that patients were referred with conditions were it was unclear that there was, or was likely to be, an impact on dental health.[54] There was a general view that the lack of rigour around the basis of referral meant that the most needy members of the community were not receiving care. Dr Fryer argued that a government dental scheme:

> ...should be targeted and means tested, should provide long-term effective care to those that are not able to access it and should focus funding and care delivery on that 30 per cent of the population that is not accessing care now.[55]

2.46 The ADA did not support the universal nature of the CDDS and supported the closure of the scheme but argued 'it should not be closed down until an adequate scheme is put in place to address the dental needs of that disadvantaged group, that 30 per cent of the population who are not getting to the dentist now'.[56]

2.47 Other matters of an administrative nature were raised with the committee. These included:

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50 Dr Mark Sinclair, Australian Dental Association (NSW), *Committee Hansard,* 1 May 2012, p. 11.

51 Dr Mark Sinclair, Australian Dental Association (NSW), *Committee Hansard,* 1 May 2012, p. 11.

52 Dr Susan Wise, *Submission 88*, pp 1–2*;* Dr Bradley Harwood, *Submission 121*, pp 1–2; Name withheld, *Submission 167*, p. 1.

53 Dr Susan Wise, *Submission 88*, p. 1; and Name withheld, *Submission 167*, p. 1.

54 Dr M. Mustafa, *Submissions 87*, pp 1–2*;* Name withheld, *Submission 123*, p. 2*;* Name withheld, *Submission 218*, p. 1.

55 Dr Shane Fryer, Australian Dental Association, *Committee Hansard,* 1 May 2012, p. 1.

56 Dr Shane Fryer, Australian Dental Association, *Committee Hansard,* 1 May 2012, p. 7.

- whether the nature of the CDDS contract is clear, i.e. whether it is between Medicare and the dentist or Medicare and the patient;[57]
- problems with reimbursement to dentists not occurring in a timely way or correctly;[58] and
- lack of accurate advice concerning status of a patient, leading so some work not being eligible for reimbursement.[59]

Over-servicing

2.48 The committee heard of some concerns about over-servicing occurring in the dental sector, but did not pursue these in detail during the inquiry. For example, Dr Sinclair commented:

> I think that, if you drill down hard enough into these figures with any publicly funded scheme, it would be naive of us to say there has been, without question, no over-servicing. I think that is a naive proposition, but what I can say is that on balance I think the treatment needs of this group that previously had not had any access to care have been well met.[60]

Audits

2.49 DHS indicated that, as with all Medicare claiming, compliance activities commence on the day the scheme takes effect. The first targeted compliance activity for the CDDS commenced in September 2009. In June 2010, the former Minister for Health announced the establishment of a task force to look into compliance arrangements associated with the scheme.[61]

2.50 In the earliest audits dental practitioners were selected randomly. As complaints were received about the operation of the scheme, the circumstances of providers who had individual complaints were also considered.[62] The ADA (NSW) described the nature of the audits as they saw them evolve:

> The dentists were sent a letter which indicated a two-year period. They were provided with a schedule of 20 patients that they had seen during the two-year period and were asked a series of questions which related to section 10 compliance. The questions included: was a valid referral from a provider provided prior to the beginning of treatment? Was a written quote

57 Mr Iain Indian, *Submission 239,* p. 2.

58 Dr Linda Steinberg, *Submission 148,* p. 2.

59 See for example, Dr Medhat Ramzy, *Submission 222,* p. 2; Dr Gregory Morris, *Submission 234,* p. 2.

60 Dr Mark Sinclair, Australian Dental Association (NSW), *Committee Hansard,* 1 May 2012, p. 16.

61 Mr Ben Rimmer, Department of Human Services, *Committee Hansard,* 1 May 2012, p. 31.

62 Mr Ben Rimmer, Department of Human Services, *Committee Hansard,* 1 May 2012, p. 27.

> provided to the patient prior to the course of treatment? Was a written treatment plan provided to the patient prior to the course of treatment? Was a treatment plan or summary provided to the referring GP prior to the course of treatment?
>
> The practitioners could answer the schedule by putting a yes or no in a box, signing it, sending it off and providing supporting documentation.[63]

2.51 The ADA informed the committee that in December 2009, it was advised by Medicare of its concerns that dentists were not complying with the requirements of the CDDS. Following this advice, the ADA issued information to members that non-compliant practitioners could be required to repay benefits received.[64] Mr Boyd-Boland added:

> ...we then embarked upon an education program for our members seeking to educate them in relation to the compliance requirements of the scheme. That was done through both our written publication and an educational CD that we provide to all of our members...indicated in that discussion that the audits had been conducted over a period of time and had revealed some noncompliance for a period of about 12 months prior to that date, but that was the first time we became aware of compliance issues within the association—or on the part of dentists within the association.[65]

2.52 The committee heard a range of concerns about the audits of the CDDS, including the methods used to audit dentists, such as asking family members of deceased patients for audit information or seeking information from patients who have a poor understanding of English;[66] delays in finalisation of audits;[67] and difficulties of accessing information required by the auditors.[68] The committee also heard about poor communication during the audit process. Ms Harrup, ADPA, stated:

> The audit process in itself has caused a lot of stress for members. There are members whose audits have not been finalised despite its seeming that the actual audit activity has been complete for some months. So those members are in limbo with the fear of possible financial ruin. They have had no closure on that. It also appears that there is a contravention of Medicare's own compliance philosophy where in their compliance brochure they talk about cases of accidental noncompliance being treated with the recognition

63 Dr Jane Pinchback, Australian Dental Association (NSW), *Committee Hansard*, 1 May 2012, p. 13.

64 Australian Dental Association, *Submission 231*, p. 7.

65 Mr Robert Boyd-Boland, Australian Dental Association, *Committee Hansard*, 1 May 2012, p. 3.

66 See for example, Dr Dragan Flajnik, *Submission 147*, p. 3; Dr Tony Andrianopoulos, *Submission 132*, p. 1; Mr Iain Indian, *Submission 239*, p. 4.

67 See for example, Dr Richard Minc, *Submission 3*, p. 1.

68 See for example, Dr Heba Ibrahim, *Submission 260*, pp, 1–2.

> that people make honest mistakes and that the response is that they provide counselling and feedback.[69]

2.53 The DHS responded to some of the above concerns, noting that:

> On the information that is available to us, the overwhelming majority of practitioners, their stakeholder groups and, for that matter, the department have approached the task of compliance and education in this area in good faith.[70]

2.54 The committee received many comments that the action taken for non-compliance was extreme. Submitters noted the administrative oversights had not had an adverse impact on the care provided with patients happy with the work done and many accessing dental care for the first time in many years. In these circumstances, the repayment of the full benefit was seen as being unfair and harsh. The ADPA, for example, commented that 'for those dental prosthetists who have committed accidental noncompliance we believe that repayment of the entire Medicare benefit is inappropriate'.[71]

2.55 The ADA, while acknowledging that 70 per cent of audited dental practitioners have been deemed to have failed to comply with the administrative compliance requirements of the scheme,[72] indicated that in its view, Medicare had not followed its compliance framework.[73] The ADA stated that where non-compliance is accidental, Medicare will counsel and provide feedback. The level and seriousness of action by Medicare then escalates matching the level of non-compliance. However, the ADA argued that the compliance program model articulated by Medicare has not been followed with respect to its audits of dentists.[74]

2.56 In response DHS stated that:

> The diagram that the Australian Dental Association has in their submission reflects the broad strategic approach we take to our compliance activities and, in particular, that we use every opportunity available to us within the law to educate, to provide early intervention and to work with the professions in a collaborative way to ensure that any issues are identified early and that there is an opportunity to address those matters early in the proceedings. What guides us more...is the legal framework that surrounds our compliance activities and, in this context in particular, the operation of

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69 Ms Sara Harrup, Australian Dental Prosthetists Association, *Committee Hansard*, 1 May 2012, p. 18.

70 Mr Ben Rimmer, Department of Human Services, *Committee Hansard,* 1 May 2012, p. 29.

71 Ms Sara Harrup, Australian Dental Prosthetists Association, *Committee Hansard*, 1 May 2012, p. 18.

72 Dr Shane Fryer, Australian Dental Association, *Committee Hansard,* 1 May 2012, p. 2.

73 Dr Shane Fryer, Australian Dental Association, *Committee Hansard,* 1 May 2012, p. 9.

74 Australian Dental Association, *Submission 231*, p. 8.

> the Health Insurance Act, the Health Insurance (Dental Services) Determination 2007 and obviously the Financial Management and Accountability Act.[75]

Recovery and re-education

2.57 The ADA (NSW) summarised the concerns of its members on the inflexible nature of the financial recovery process that was triggered once non-compliance had been identified. Dr Sinclair stated:

> Despite repeated assertions by Medicare that auditors were prepared to be flexible in individual cases, our experience suggests quite markedly otherwise. No flexibility or leniency has been shown where section 10 requirements of the Health Insurance (Dental Services) Determination 2007 are not met.[76]

2.58 Submitters indicated that the recovery of benefits where there had been non-compliance with section 10, would result in financial difficulties. It was noted that dental treatment incurred significant costs to the dentist including laboratory fees and staff costs and the repayment of the full benefit did not acknowledge that the dentist had not received the full benefit. This is exacerbated in the case of employee dentists who only receive a percentage of the fee charged, generally 35 to 45 per cent.[77] Dr Fryer, ADA, noted:

> The expenses of running a dental practice are at about 70 per cent. It can be a little higher and it can be a little lower. For every dollar that has been received from a member, shall we say, from Medicare, the dentist has kept only 30 per cent and the rest has gone on expenses to provide that dental service. Medicare is requesting the whole dollar back so it is a significant financial imposition.[78]

2.59 The committee was advised that recovery of benefit funds from non-compliant dentists is undertaken where it is economical to do so and the debt is legally recoverable. In instances where only a small proportion of the total claims made are non-compliant, recovery is not sought on the basis that it would be uneconomical to do so.[79] DHS explained the basis for the financial recovery process:

> Under the Financial Management and Accountability Act when a debt to the Commonwealth becomes ascertainable and certain then the secretary of the department is obliged under that act to pursue recovery of that debt in

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75 Mr Ben Rimmer, Department of Human Services, *Committee Hansard,* 1 May 2012, p. 25.

76 Dr Mark Sinclair, Australian Dental Association (NSW), *Committee Hansard,* 1 May 2012, p. 10.

77 Dr Mehrdad Abolghassemi, *Submission 70,* p. 1. Dr Wilma Johnson, *Submission 97,* p. 1.

78 Dr Shane Fryer, Australian Dental Association, *Committee Hansard,* 1 May 2012, p. 5.

79 Response to 24 November 2011 Senate Motion on *Health – Medicare – Chronic Disease Dental Scheme – Audits – Report – Order for production of document*, Item 87, *Journals of the Senate*, No. 73, 7 February 2012, p. 2035.

> full. In particular, the chief executive—the secretary, in our case—has to satisfy themselves that the debt is legally recoverable or, to put it the other way, if the debt is not legally recoverable then clearly there is no obligation to pursue it...
>
> In addition, the chief executive or the secretary needs to ensure that it is economical to pursue recovery of that debt...Effectively the secretary is obliged to take into that litigation process a view about whether the debt is legally recoverable and whether it is economical to pursue. As you would know, in some circumstances the question of legal recoverability is actually relatively open. We do not believe that to be the case in this circumstance.[80]

2.60 Mr Rimmer concluded:

> Once noncompliance has been found in relation to an MBS claim, by operation of statute—not by operation of official decision but by operation of the dental services determination and the Financial Management Act—the department is obliged to pursue recovery.[81]

2.61 DHS informed the committee of the strong emphasis it places on re-education where possible and noted that it may have been more lenient in the past than it should have been. Mr Rimmer stated:

> The compliance arrangements established by Medicare Australia, and now carried on by the Department of Human Services, place a heavy emphasis on an educative approach. Officers of the department, in good faith, have tried to apply that to this scheme to try to respond to the facts and circumstances that are in front of them and the facts and circumstances of the individual audits. More recent legal advice says to us that, in the course of that decision making, officers exercised a discretion that was not available to them under the determination. That is a matter that is obviously of concern to us, because we are very focused on making sure that we act precisely within the legal framework that applies to us. And it is obviously a concern in relation to the individual cases of the 17 who we have written to, and that is one of the factors that has led the minister to ask us to inform the committee that he believes that some of the matters that are under discussion today do require further consideration.[82]

80 Mr Ben Rimmer, Department of Human Services, *Committee Hansard,* 1 May 2012, pp 25–26.

81 Mr Ben Rimmer, Department of Human Services, *Committee Hansard,* 1 May 2012, p. 28.

82 Mr Ben Rimmer, Department of Human Services, *Committee Hansard,* 1 May 2012, p. 28.

The Bill

2.62 As can been seen from the issues discussed above, there were many submitters who supported the Bill, including relevant dental associations[83] and the ADPA.[84]

2.63 There were also other submitters, such as the AMA, who did not support the Bill because, in their view, it would create inequities between different types of health professionals. The AMA stated:

> The AMA does not support the Bill because it seeks to exonerate one class of health practitioner from the legal requirements applying to a particular set of Medicare items. If passed the Bill would create an inequity between dentists and other health practitioners (whose services attract Medicare benefits) to meet the legal requirements when billing Medicare items.
>
> We do not consider it appropriate that dentists can use "I did not know" as a defence against future non-compliance with the Determination. Nor do we consider it appropriate for Parliament to provide this defence by passing the Bill, particularly as we are not aware that this defence exists in any other Commonwealth law.[85]

2.64 Another submitter opposed the Bill on the grounds that the CDDS administrative processes were not a problem and that in his view there is a need for ongoing audits:

> As a matter of principle, I oppose any legislation or regulation that would serve to reduce the compliance parameters currently required for dental practitioners to seek Medicare funding under the Chronic Disease Dental Scheme (CDDS).
>
> I refute any assertions that the current administrative processes are cumbersome and unnecessary, and that Medicare did not provide dental practitioners with adequate information about the scheme.
>
> The importance of maintaining the current protocols and rules set for the CDDS, and the need for ongoing expansive audits of high-billing CDDS dentists in order to ensure that over-servicing has not taken place at the cost of public health or the public purse.[86]

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83 Australian Dental Association (Victorian Branch), *Submission 164*, p. 1; Australian Dental Association (Queensland Branch), *Submission 208*, p. 2; Australian Dental Association, *Submission 231*, p. 1; Australian Dental Association (NSW Branch), *Submission 343*, p. 20.

84 Ms Sara Harrup, Australian Dental Prosthetists Association, *Committee Hansard*, 1 May 2012, p. 18.

85 Australian Medical Association, *Submission 209*, pp 1–2.

86 Dr Kia, Pajouhesh, *Submission 429*, pp 1, 3.

2.65 DHS advised the committee that the first and most fundamental premise is that there is a requirement on all health professionals to ensure that they are complying with the requirements for the payment of Medicare benefits.[87]

2.66 DoHA indicated that the Government's stated intention is that it would like to close this particular scheme, so there is a reluctance to change the determination.[88] The department also raised concerns about whether the Bill would have unintended consequences in other areas. Ms Flanagan explained:

> One of the concerns that certainly we would have in a policy sense about the legislation is the duty of care changing quite significantly. The thing that I suppose would give us concern is the test that is applied.
>
> That, to us, would be a very worrying development across the expectations that we would apply to health professionals...This actually changes the burden of responsibility very clearly, and that would be a worrying development.[89]

2.67 The committee was informed that the government has accepted that some of the concerns raised may need to be addressed fairly across different professions. Mr Rimmer stated:

> The minister has asked us to advise the committee that, notwithstanding the government's intention to close the scheme completely, he accepts that some but not all of the concerns that have been raised do require further consideration and that is a matter that is now underway within normal departmental processes.
>
> As a matter of administrative practice, if there is a changed approach, as a hypothetical, then obviously we would need to apply that changed approach fairly across particular cohorts. But as I stress, no decision has been made about that.[90]

Conclusion

2.68 The committee acknowledges that the CDDS scheme has assisted many in the community. However, it considers that the scheme is not adequately targeted at those most in need of dental services particularly pensioners and people on concession cards. The committee notes the Government's commitment to closing the scheme.

2.69 During the inquiry a range of issues in relation the CDDS scheme were identified by a large number of dentists. These issues included the conduct of audits

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87 Mr Ben Rimmer, Department of Human Services, *Committee Hansard,* 1 May 2012, p. 29.

88 Ms Kerry Flanagan, Department of Health and Ageing, *Committee Hansard,* 1 May 2012, p. 30.

89 Ms Kerry Flanagan, Department of Health and Ageing, *Committee Hansard,* 1 May 2012, p. 30.

90 Mr Ben Rimmer, Department of Human Services, *Committee Hansard,* 1 May 2012, p. 26.

and the impact on practitioners and patients. However, of particular concern were matters related the adequacy of consultation before the scheme commenced, the information and education about the scheme provided by Medicare and the Department of Health and Ageing and the lack of consideration of the practice and procedures of dentistry. Submitters argued that these had contributed to the high level of non-compliance in relation to the requirements of section 10 of the Health Insurance (Dental Services) Determination 2007. Further, it was argued that the requirement to repay all the benefits received from non-compliant claims was 'unjust'. The Bill before the committee is seeking to address perceived 'inequities' that have arisen because of the operation of subsection 10(2) of the Determination. The committee observes that the Determination has been in place since the CDDS was introduced by the Howard Government in 2007.

2.70 The committee notes that not all dentists shared these views. In addition, the committee acknowledges that submitters were strongly supportive of measures to address opportunistic non-compliance, inappropriate claim behaviour or fraudulent behaviour of any kind.

2.71 The committee notes that evidence received from the Department of Human Services indicates that information was provided to dentists and dental prosthetists at the commencement of the scheme and since that time. Further, Medicare is required to enforce requirements, including compliance provision, contained in legislation. The committee notes that the Department of Human Services stated that it had tried to, during compliance activity, place more emphasis on an educative approach. However, legal advice indicated that officers did not have a discretion under the Determination.

2.72 However, the committee notes that the Minister accepts that some but not all of the concerns that have been raised do require further consideration and that is a matter that is now underway within normal departmental processes. The committee therefore considers that the Bill may not be the best way to deal with the problems that have arisen, as the proposed actions would create further inequities.

Recommendation 1

2.73 The committee recommends that the Health Insurance (Dental Services) Bill 2012 not be passed.

Senator Helen Polley
Chair