Australian Government
Department of Health and Ageing

INFORMATION FOR DENTISTS AND DENTAL SPECIALISTS

DENTAL SERVICES UNDER MEDICARE FOR PEOPLE WITH CHRONIC AND COMPLEX CONDITIONS

This fact sheet is a summary of the new Medicare dental items. The fact sheet should be read in conjunction with the item descriptors and explanatory notes for Medicare items 85011 to 87777 (as set out in the *Medicare Benefits Schedule Dental Services* book). There are also separate fact sheets for dental prosthetists, GPs and patients.

Summary:

- New Medicare dental items (items 85011-87777) commence on 1 November 2007. These items cover services by dentists, dental specialists and dental prosthetists.
- 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.
- The new items replace the Enhanced Primary Care (EPC) dental items 10975-10977.

Provider eligibility

Most dentists and dental specialists will already have a Medicare provider number (eg to order diagnostic imaging or pathology tests under Medicare, or to use the existing EPC dental items). Where this is the case, the dental practitioner will not need to re-register with Medicare Australia to use the new dental items.

Some dental specialists (including Oral and Maxillofacial Surgeons, Dento-maxillofacial Radiologists, Oral Surgeons and Special Needs Dentists) may need to register with Medicare Australia in their particular specialty to provide services using the dental specialist items.

Information about eligibility and registration is set out in the *Medicare Benefits Schedule Dental Services* book. Further information is available from Medicare Australia on 132 150.

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Patient eligibility
It is up to the GP to determine whether a patient is eligible for referral to a dental practitioner, with reference to the following criteria:

- a patient must have a chronic medical condition and complex care needs (this involves being managed by a GP under the following Medicare care planning items); and
- the patient's oral health must also be impacting on, or likely to impact on, their general health.

A patient is being managed under a care plan if their GP has prepared and billed the following Medicare chronic disease management items in the previous two years:

- GP Management Plan (item 721 or a review under item 725) **and** Team Care Arrangements (item 723 or a review under item 727); **or**
- for residents of an aged care facility, their GP must have contributed to or reviewed a multidisciplinary care plan prepared for the resident by the facility (item 731).

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.

Chronic medical conditions and complex care needs
For Medicare purposes, a chronic medical condition is one that has been (or is likely to be) present for six months or longer. It includes, but is not limited to conditions such as asthma, cancer, cardiovascular disease, diabetes, mental illness, musculoskeletal conditions and stroke.

Patients are considered to have complex care needs if they need ongoing care from a multidisciplinary team consisting of their GP and at least two other health or care providers.

Types of dental services covered
A comprehensive range of services are covered by the Medicare dental items, including dental assessments, preventive services, restorative services such as fillings, crowns, bridges and implants, extractions and other oral surgery (other than hospital services), orthodontic services, and dentures.

Similar to the DVA items, the Medicare dental items are based on the ADA's *Australian Schedule of Dental Services and Glossary, 8th Edition*. The Medicare dental items use an additional two digit prefix to distinguish between services by dentists, dental specialists and dental prosthetists.

There are separate schedules for dentists (items 85011-85986), dental specialists (items 86012-86986) and dental prosthetists (87011-87777).

The Medicare dental items can only be used where the primary objective of the treatment is to improve oral health or function. The items cannot be claimed for treatment that is predominantly for the improvement of the appearance of the patient (eg cosmetic). Services where the primary aim is to improve the health or function of the patient, but which also comprise a cosmetic component, may be claimed.

The items are not available to admitted hospital patients (ie the items apply to out-of-hospital dental services only). The items also do not generally apply to services that are provided by Commonwealth or State funded dental services.

Medicare benefits payable
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 under items 85011 to 87777. Further information about the Extended Medicare Safety Net is set out in the *Medicare Benefits Schedule Dental Services* book.

Referral arrangements
All patients must be referred by a GP to a dental practitioner. There is a referral form available to GPs for this purpose.

In most cases, the patient will be referred to a dentist in the first instance. The GP may refer the patient directly to a dental prosthetist where the patient has no natural teeth and requires dental prosthetic services only (eg full dentures), or requires repairs or maintenance to full or partial dentures. A GP cannot refer a patient directly to a dental specialist.

A dentist can refer the patient onto a dental specialist, another dentist or to a dental prosthetist, where required.

The GP referral remains valid for two consecutive calendar years from the date of the patient's first dental service (eg if the first dental service is on 15 November 2007, the GP referral is valid to 31 December 2008). Where a patient requires additional treatment after this period, they will need to obtain a new referral from their GP.

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 at the commencement of the course of treatment (ie 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.

Claiming from Medicare
Dental practitioners can bill Medicare patients in one of three ways:

- bulk bill (where the patient cannot be charged a co-payment);
- the patient pays upfront and then claims a rebate from Medicare; or
- the patient is given an invoice for an unpaid account and obtains a cheque from Medicare to pay the dental practitioner. Any additional amount that is not reimbursed by Medicare is paid by the patient.

The patient may have an out-of-pocket cost (not covered by Medicare) in the second and third cases.

More detailed information about electronic and manual billing/claiming is set out in the *Medicare Benefits Schedule Dental Services* book (effective 1 November 2007). If you have further questions, please contact Medicare Australia on 132 150.

Patients cannot use private health insurance ancillary cover to 'top up' the Medicare rebate for a service.

EPC dental items 10975-10977
Some dentists may have been using the EPC dental items 10975-10977 introduced in 2004.

These items will remain in place for a short time to enable patients to complete treatment they have already commenced under the items (if they wish). These items will not be available after 31 December 2007.

Patients currently receiving services under the EPC dental items can still receive dental services under the new dental items from 1 November 2007, as long as they have a new referral from their GP.

Further information
The *Medicare Benefits Schedule Dental Services* book (effective 1 November 2007) will be distributed to all dental practitioners in October 2007. This book will also be available at www.health.gov.au/epc or by phoning the Department of Health and Ageing on (02) 6289 4297.

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