GP REFERRALS FOR DENTAL SERVICES UNDER MEDICARE

FOR PEOPLE WITH CHRONIC AND COMPLEX CONDITIONS

This fact sheet is a summary of the new Medicare dental items and what these arrangements mean for GPs. There are also separate fact sheets for dentists/dental specialists, dental prosthetists and patients. More detailed information is available in the *Medicare Benefits Schedule (MBS) Book* and the *MBS Dental Services* book.

Summary:

- New Medicare dental items (items 85011-87777) commence on 1 November 2007. These items cover services by dentists, dental specialists and dental prosthetists.
- The patient must be referred by their GP for dental services.
- 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 their GP under a GP Management Plan and Team Care Arrangements, or a multidisciplinary care plan for residents of aged care facilities.
- The patient's oral health must also be impacting on, or likely to impact on, their general health.
- Dental practitioners may set their own fees. In some cases, patients may have out-of-pocket costs.
- The new items replace the Enhanced Primary Care (EPC) dental items 10975, 10976 and 10977.

Eligible patients

To be eligible, a person must have a chronic medical condition and complex care needs (ie be managed by a GP under the following care plans). The patient's oral health must also be impacting on, or likely to impact on, their general health.

Whether the patient is eligible for referral for dental services is a clinical judgement for the GP, taking into account the patient's condition and care needs.

The care planning requirements are the same as those under the EPC allied health items, and the existing EPC dental items, ie the patient must have received the following services from a GP within 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).

Further information on these chronic disease management items is set out in the MBS Book at note A.30.

If these GP 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. The care plans cannot be done retrospectively, ie after the dental services have been provided to the patient.

Types of dental services covered
A comprehensive range of services are covered by the 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.

The 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.

Eligible dental practitioners
The dental items can be used by dentists, dental specialists and dental prosthetists registered with Medicare Australia. GPs are encouraged to establish links with local dental practitioners and check whether they will accept referrals under the new Medicare dental items.

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.

The two-year period is counted from the calendar year of the patient's first eligible dental service. For example, if the patient's first dental service is on 15 November 2007, the applicable two-year period will be the 2007 and 2008 calendar years.

Patients, GPs and dental practitioners will be able to call Medicare Australia to check how much the patient has already received in Medicare benefits for dental services over the relevant period. GPs may call the Provider Enquiry Line on 132 150. Patients may call the Patient Enquiry Line on 132 011.

Referrals by a GP to a dental practitioner
In most cases, the GP will refer the patient to an eligible dentist in the first instance.

GPs may refer a 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.

GPs cannot refer patients directly to a dental specialist. A dentist will refer the patient onto a dental specialist, another dentist or a dental prosthetist, where required.

Referral form
GPs must use the *Referral Form for Dental Services under Medicare* issued by the Department of Health and Ageing, or a form the substantially complies with this referral form. This referral form replaces the Department's EPC referral form used for dental items 10975 -10977. The form can be downloaded from **www.health.gov.au/epc** or obtained by calling the Department on (02) 6289 4297.

New referrals
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 further dental services are required to treat a new or existing oral health problem at the end of a patient's two calendar year period, the patient will need to obtain a new referral from their GP.

Informing patients about the cost of dental services
When referring patients for dental services, GPs should inform patients that the dental services may not be bulk billed. 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.

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.

Cessation of EPC dental items 10975-109677
The EPC dental items 10975-10977 will remain in place until 31 December 2007 to enable patients to complete treatment they have already commenced under these items (if they wish). Existing patients can also 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

- *Medicare Benefits Schedule Book* (effective 1 November 2007) – see note A.30. This book is distributed to all GPs and is also available at www.health.gov.au/mbsonline.
- *Medicare Benefits Schedule Dental Services* book (effective 1 November 2007) – mainly intended for dental practitioners. Available at www.health.gov.au/epc or by phoning the Department of Health and Ageing on (02) 6289 4297.
- GPs can call the Medicare Provider Enquiry Line on 132 150 for further information about the referral process and patient entitlements.