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[<h2>]Important note[</h2>] On 19 June 2008, the Senate blocked the Australian Government's closure of the scheme. On 16 September 2008, the Senate blocked the Government's second attempt to close the scheme.

Therefore, currently the scheme remains open and all eligible claims will be paid.

[]This fact sheet is a summary of the 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 dentists/dental specialists, GPs and patients.[]

PDF printable version of Fact sheet for Dental Prosthetists (PDF 234 KB)
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[]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).
- Items 87011-87777 are for use by dental prosthetists. There are separate items for dentists and dental specialists.
- 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 (including dental prosthetists) may choose to either bulk bill the patient or set their own fees for services.

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[<h2>]Provider eligibility[</h2>]As a new group of providers under Medicare, dental prosthetists will need to apply for a provider/registration number with Medicare Australia to use the dental items 87011-87777.

Dental prosthetists cannot use their DVA or private health insurance provider number to provide services under Medicare.

To be eligible to use the Medicare dental items, a dental prosthetist must be:

- an individual;
- registered or licensed to practice as a dental prosthetist under state or territory law (subject to some limitations); and
- registered with Medicare Australia (this means having a provider/registration number for each practice location).

Where conditions or limits are imposed under relevant State or Territory law which prohibit a dental prosthetist from providing dental prosthetic services to patients, the dental prosthetist is not eligible to register with Medicare Australia.
Students who are registered or licensed under relevant State or Territory law in order to complete a course of study or supervised training in dental prosthetics are not eligible to register with Medicare Australia.
Further information about eligibility and registration for dental prosthetists is set out in the Medicare Benefits Schedule Dental Services book.

Application forms and registration information will be available from Medicare Australia in late-October on []132 150[] and at www.medicareaustralia.gov.au [then follow the links to Health Care Providers – Forms – Medicare Forms].

Registration with Medicare Australia only enables dental prosthestists to provide services to patients under Medicare items 87011-87777. Dental prosthetists will not be able to order diagnostic imaging tests under Medicare or access other Medicare items.

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[<h3>]Patient eligibility[</h3>]It is up to the GP to determine whether a patient is eligible for referral to a dental practitioner (including a dental prosthetist) 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 prosthetist (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 prosthetist (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. []

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[<h3>]Chronic medical conditions and complex care needs[</h3>]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.

[<h3>]Types of dental services covered[</h3>]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 Australian Dental Association'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, even if the patient is admitted to a hospital solely for the purpose of that dental treatment (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.

[<h3>]Dentures[</h3>]Patients will generally only be able to claim for one set of dentures every eight years under these Medicare items. However, patients may receive a second set within this

period in exceptional circumstances (where there has been a significant change in the clinical condition of the patient which requires new dentures, or where a patient's existing dentures are irreparably damaged or lost).

[<h3>]Medicare benefits payable[</h3>]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.
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[<h3>]Referral arrangements[</h3>]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. A dentist can refer the patient onto a dental specialist, another dentist or to a dental prosthetist, where required.

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. The dental prosthetist may provide services to the patient themselves and/or refer the patient onto another dental prosthetist or dentist (but not refer the patient directly to a dental specialist).

The GP referral remains valid for two consecutive calendar years from the date of the patient's first dental service. Where a patient requires additional treatment after this period, they will need to obtain a new referral from their GP.

[<h3>]Reporting by the dental prosthetist to the GP [</h3>]Dental prosthetists must provide a copy or summary of the patient's treatment plan to the referring GP []before beginning the course of treatment[] (following an examination and assessment of the patient).

[<h3>]Informing patients about the cost of dental services[</h3>]Dental prosthetists 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 prosthetists are required to provide a written quote or cost estimate to the patient prior to commencing a course of treatment.
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[<h3>]Claiming from Medicare [</h3>][]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).[]
Dental prosthetists can bill services provided to Medicare patients in one of three ways:

- bulk bill (where the patient cannot be charged a co-payment);
- the patient pays in full at the time of a visit 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 prosthetist. 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 2009). 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.

[]Further information
The []Medicare Benefits Schedule Dental Services[] book (effective 1 November 2009) is available at www.health.gov.au/dental.
Dental prosthetists can call the Medicare Provider Enquiry Line on []132 150[] for further information on provider registration, claiming, and checking patient entitlements.[]
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