EXPLANATORY STATEMENT

Issued by the Authority of the Minister for Health and Ageing

Health Insurance Act 1973

Health Insurance (Dental Services) Determination 2007

Subsection 3C(1) of the *Health Insurance Act 1973* (the Act) provides that the Minister may, by writing, determine that a health service not listed in the general medical services table (the Table) shall, in specified circumstance and for specified statutory provisions, be treated as if it were so listed. This Table is set out in the *Health Insurance (General Medical Services Table) Regulations 2007*.

A determination made under subsection 3C(1) of the Act is a legislative instrument for the purposes of the *Legislative Instruments Act 2003*.

Subsection 3C(8) of the Act provides that the health services that may be subject to a determination made under subsection 3C(1) of the Act include dental services and the supply of dental prostheses.

Subsection 3C(2A) of the Act provides that a determination made under subsection 3C(1) of the Act may specify a monetary limit on the amount of Medicare benefits paid or payable to a patient for dental services over a specific time period.

Subsection 3C(2B) of the Act confirms that no further Medicare benefits are payable to the patient in the specified period once the patient reaches the monetary limit.

The purpose of the *Health Insurance (Dental Services) Determination 2007* (the Determination) is to set out the schedule of Medicare items for dental services for people with chronic conditions and complex care needs and the provisions that govern how the items are to be used. These provisions include:

- the specified amount and specified period of the monetary limit on Medicare dental benefits per patient, being $4,250 over two consecutive calendar years;
- the eligibility requirements for dental providers and patients;
- referral and reporting arrangements between general practitioners (GPs) and dental providers;
- the requirement for dental providers to provide patients with a treatment plan and itemised quotation prior to commencing a course of treatment; and
- other administrative requirements.

Details of this Determination are set out in the Attachment.

This Determination commences on 1 November 2007.

Consultation

In developing the implementation arrangements for the Medicare dental items, the Department of Health and Ageing consulted with the relevant professional groups representing dentists, dental specialists and dental prosthetists (Australian Dental Association and the Australian Dental Prosthetists Association).

The Department also consulted with professional groups representing general practitioners (Australian Medical Association, Australian General Practice Network, Royal Australian College of General Practitioners, Rural Doctors Association of Australia), and with other government agencies (Department of Veterans' Affairs and Medicare Australia).

ATTACHMENT

DETAILS OF THE HEALTH INSURANCE (DENTAL SERVICES) DETERMINATION 2007

Preliminary

Section 1 provides for the Determination to be referred to as the *Health Insurance (Dental Services) Determination 2007*.

Section 2 provides for the Determination to commence on 1 November 2007.

Section 3 defines specific terms used in the Determination.

Section 4 confirms that the Medicare dental items set out in Schedule 1 of the Determination are to be treated for the purposes of the relevant acts and regulations as if they were both professional services and medical services, and as if they were items in the general medical services table.

Section 5 provides that no more than $4,250 in Medicare benefits for dental services can be paid to a patient over two consecutive calendar years. The two year period commences from the date of the patient's first dental service.

Section 6 defines the patient eligibility criteria for the Medicare dental items set out in Schedule 1. A person is considered to be an eligible patient if:

- the person has in place a GP Management Plan (Medicare item 721 or review item 725) and Team Care Arrangements (Medicare item 723 or review item 727), or for a resident of an aged care facility, their GP must have contributed to or reviewed a multidisciplinary care plan prepared for the resident by the facility (Medicare item 731);
- the person's oral health is impacting on, or likely to impact on, their general health;
- the person has been referred for dental services (initially by their GP); and
- the person is not an admitted patient of a hospital.

Section 7 specifies that a person cannot claim a Medicare benefit for a dental service if they have claimed a private health insurance benefit for the same service.

Section 8 specifies that certain items (as set out in Parts 1, 2 and 3 of Schedule 1) only apply to services provided by the relevant type of dental provider.

- Items in Part 1 only apply to services provided by eligible dentists.
- Items in Part 2 only apply to services provided by eligible dental specialists.
- Items in Part 3 only apply to services provided by eligible dental prosthetists.

Section 9 specifies the referral arrangements that apply between GPs and dental providers, and between the different types of dental providers. As part of the referral arrangements, GPs are required to use a form, "Referral Form for Dental Services under Medicare", or a document that substantially complies with this form. The referral form is available from the Department of Health and Ageing's website at www.health.gov.au/epc or by phoning (02) 6289 4297.

Section 10 specifies that the dental provider is required to provide the patient with a written treatment plan and a written itemised quote before beginning a course of treatment. The dental provider is also required to provide the referring GP with a copy or written summary of the treatment plan before commencing a course of treatment for the patient.

Section 11 specifies that the Medicare dental items can only be used where the primary purpose of the service is to improve oral health or function. The primary purpose of the service cannot be to improve the patient's appearance.

Section 12 specifies that Medicare benefits are only payable for one set of dentures per patient every eight years. There is provision for patients to receive Medicare benefits for a second set of dentures in "exceptional circumstances" (as set out in this section).

Sections 13 and 14 set out time limitations on the payment of Medicare benefits for certain services. The tables in these sections need to be read in conjunction with the relevant Medicare items set out in Schedule 1.

Sections 15, 16, 18, 20, 21, 23 prevent the payment of Medicare benefits for certain items where the service is provided on the same day as other specific items. Generally, these limitations apply where the service is a component of the other service/s, or of a similar nature.

Sections 17 and 22 specify that Medicare benefits for certain items are limited to a maximum of five single surface restorations provided on one day.

Section 19 specifies that Medicare benefits are limited to a maximum of 12 teeth per partial denture base for each patient.

Schedule 1 – Eligible dental services and fees

This Schedule sets out the relevant Medicare items (including the item numbers, service descriptors and fees) for services provided by eligible dentist, dental specialists and dental prosthetists.

- Part 1 applies to services provided by eligible dentists.
- Part 2 applies to services provided by eligible dental specialists.
- Part 3 applies to services provided by eligible dental prosthetists.

Schedule 2 - Specialties

This Schedule lists the specialties in which a dental specialist must be registered or licensed to practice under a law of a State or Territory in order to be an eligible dental specialist for the purposes of this Determination. (Also refer to the definition of 'eligible dental specialist' in Section 3 – Definitions).