

INFORMATION FOR PATIENTS DENTAL SERVICES UNDER MEDICARE FOR PEOPLE WITH CHRONIC AND COMPLEX CONDITIONS

Some patients may be able to receive dental services under Medicare.

Medicare benefits will be available for most services provided by a dentist, dental specialist or dental prosthetist in private dental surgeries.

To receive a Medicare benefit for dental services, you will first need to meet certain eligibility criteria and be referred by your GP to a dentist. In some cases, your GP will be able to refer you directly to a dental prosthetist for denture work.

Which patients are eligible for dental services under Medicare?

To be eligible, you must have a chronic medical condition and complex care needs and your oral health must be impacting on, or likely to impact on, your general health.

- A chronic medical condition is one that has been or is likely to be present for at least six months. It may include, but is not limited to, conditions such as asthma, cancer, cardiovascular illness, diabetes mellitus, arthritis, mental illness, musculoskeletal conditions and stroke.
- Complex care needs means that you are receiving ongoing care from a multidisciplinary team, which includes your GP and at least two other health or care providers.

In practice, this means that you will need to be managed by your GP under certain care plans. For most people, this involves the preparation of a “GP Management Plan” and “Team Care Arrangements”. For residents of aged care facilities, it involves the GP contributing to a multidisciplinary care plan prepared for the resident by the facility.

You should talk to your GP about whether you are eligible for these plans. If you are eligible, your GP must complete the plans and bill you prior to you having your first dental service.

You may already have care plans in place. If so, you should talk to your GP about whether you are eligible for referral for dental services under these plans.

Once you have been referred by your GP to a dental practitioner, you should call Medicare Australia on 132 011 to check that the necessary GP care planning items have been claimed and paid before commencing dental treatment – even where your GP has signed a referral form. If the relevant items have not been claimed and recorded, Medicare Australia cannot pay benefits for dental services.

What dental services will Medicare cover?

A comprehensive range of dental services will be covered, including dental assessments, preventive services, extractions, fillings, restorative work and dentures.

The primary purpose of the dental treatment must be to improve oral health or function. Medicare rebates will not be paid for dental services that are purely cosmetic in nature.

Medicare rebates cannot be claimed for dental treatment provided by public dental clinics or where the patient is an in-patient (ie an admitted patient) in a hospital.

Who can provide the services?

Most privately practising dentists, dental specialists and dental prosthetists will be eligible to provide services under the Medicare dental items, but some may choose not to treat patients under Medicare.

You should check with dental practitioners in your local area whether they are registered with Medicare Australia and willing to take referrals for dental services under Medicare.

How do the GP referral arrangements work?

If you meet the eligibility criteria, your GP can refer you to a dental practitioner for further assessment and treatment.

In most cases, you will be referred to a dentist. If you have no natural teeth and only need to have a full denture made, or a partial or full denture repaired or maintained, your GP can refer you directly to a dental prosthetist.

The referral will last for two consecutive calendar years from your first dental service. If you require additional treatment after this period, you will need a new referral from your GP.

The dentist can refer you onto a dental specialist, if required, or to another dentist or dental prosthetist. The dental prosthetist can refer you onto a dentist or another dental prosthetist.

To refer you onto another dental practitioner, your dental practitioner can write a letter or note. There is no need to obtain another referral from your GP.

What will I have to pay for the dental services?

Dental practitioners are free to set their own fees for services. To ensure you are aware of the potential costs, your dental practitioner will be required to provide you with a written quote prior to commencing a course of treatment.

The dental practitioner may decide to bulk bill you, but this will not always be the case. If you are not bulk billed, there may be an amount that is not covered by Medicare. This amount will vary depending on the treatment required and fee charged by the dental practitioner.

What Medicare benefits will I be able to claim?

You will be able to claim up to **\$4,250** in Medicare Benefits for eligible dental services over two consecutive calendar years. This includes any benefits payable under the Extended Medicare Safety Net.

The two calendar year period is counted from the calendar year of your first dental service.

The services can be provided within one of the calendar years, or across both calendar years. Either way, the total amount of Medicare benefits available to you for the two-year period is \$4,250.

You will be able to receive a further \$4,250 in Medicare benefits for dental services in a subsequent two-year period provided you continue to meet the eligibility criteria.

What is the Extended Medicare Safety Net?

The Extended Medicare Safety Net (EMSN) aims to minimise out-of-pocket costs for patients. The EMSN applies to Medicare services provided outside of a hospital (eg GP, specialist, allied health, dental, x-ray and pathology services). It has two main elements:

- out-of-pocket costs incurred for eligible services count towards a patient's (or their family's) annual Medicare Safety Net threshold. The threshold is currently \$519.50 for concession cardholders and eligible families, and \$1,039 for all other individuals and families. These amounts are indexed on 1 January each year); and
- once a patient / family reaches their threshold, the Government meets 80% of the out-of-pocket costs incurred for eligible services provided in the remainder of that calendar year.

No further benefits are payable for dental services (including benefits under the EMSN) once you have received the maximum of \$4,250 in the relevant two calendar year period.

This limit on benefits only applies to dental services. It does not affect the amount of EMSN benefits available to you for other (non-dental) Medicare services.

How will I know when I am close to the benefit limit?

You will be able to call Medicare Australia's Patient Enquiry Line on **132 011** to check how much you have already received in Medicare benefits for dental services for the two-year period. Your GP or dental practitioner can also call Medicare Australia's Provider Enquiry Line on **132 150** to check for you.