

Dental services table of costs

Effective 1 July 2010

Service	Descriptor	Item number	Fee – GST not included ¹
Comprehensive oral examination (ADA 011)	Evaluation all teeth, their supporting tissues and the oral tissues in order to record the current condition of these structures. This evaluation includes recording an appropriate medical history and any other relevant information	200011	\$54.85
Periodic oral examination (ADA 012)	An evaluation performed on a patient of record to determine any changes in the patient's dental and medical health status since a previous comprehensive or periodic examination	200012	\$46.32
Oral examination – limited (ADA 013)	A limited problem-focused oral evaluation carried out immediately prior to required treatment. This evaluation includes recording an appropriate medical history and any other relevant information	200013	\$41.43
Consultation (<30 minutes) (ADA 014)	A consultation to seek advice or discuss treatment options regarding a specific dental or oral condition. This consultation includes recording an appropriate medical history and any other relevant information	200014	\$73.14
Consultation – extended (>30 minutes) (ADA 015)	An extended consultation to seek advice or discuss treatment options about a specific dental or oral complaint. This consultation includes recording an appropriate medical history and any other relevant information	200015	\$123.10
Intraoral periapical or bitewing radiograph (ADA 022)	Taking and interpreting a radiograph made with the film inside the mouth NB. Per exposure	200022	\$40.22 per film
Intraoral radiograph – occlusal, maxillary, mandibular (ADA 025)	Taking and interpreting an occlusal, maxillary or mandibular intraoral radiograph. This radiograph shows a more extensive view of teeth and maxillary or mandibular bone. Can be used to show maxillary sinuses NB. Per exposure	200025	\$41.43 per film
Panoramic radiograph (OPG) (ADA 037)	Taking and interpreting an extraoral radiograph presenting a panoramic view of part or all of the mandible and/or the maxilla and/or adjacent structures NB. Per exposure	200037	\$102.38
Diagnostic model (ADA 071)	The preparation of a model from an impression. The model is used for examination and treatment planning procedures. This item should not be used to describe a working model NB. Per model	200071	\$76.79 per model
Removal of a tooth or part(s) thereof (ADA 311)	A procedure consisting of the removal of a tooth or part(s) thereof	200311	\$134.08
Sectional removal of a tooth (ADA 314)	The removal of a tooth in sections. Bone removal may be necessary	200314	\$218.18

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Surgical removal of a tooth or tooth fragment not requiring removal of bone or tooth division (ADA 322)	Removal of a tooth or a tooth fragment, where an incision of the mucosa and the raising of a mucoperiosteal flap is required, but where the removal of bone or sectioning of the tooth is not necessary to remove the tooth	200322	\$234.03
Surgical removal of a tooth or tooth fragment requiring removal of bone (ADA 323)	Removal a tooth or tooth fragment where removal of bone is required after an incision has been made and a mucoperiosteal flap raised	200323	\$266.95
Fracture of maxilla or mandible – not requiring splinting (ADA 352)	Conservative treatment a fracture of the maxilla or mandible where there is no marked displacement or mobility of the fragments. No physical reduction or fixation is required	200352	\$169.43
Replantation and splinting of a tooth (ADA 387)	Replantation of a tooth which has been avulsed or intentionally removed. It may be held in the correct position by splinting	200387	\$281.57
Control of reactionary or secondary post-operative haemorrhage (ADA 399)	This procedure describes the control of reactionary or secondary post-operative haemorrhage	200399	\$31.69
Direct pulp capping (ADA 411)	A procedure where an exposed pulp is directly covered with a protective dressing or cement	200411	\$96.29
Extirpation of pulp or debridement of root canal(s) – emergency or palliative (ADA 419)	The partial or thorough removal of pulp and/or debris from the root canal system of a tooth. This is an emergency or palliative procedure distinct from visits for scheduled endodontic treatment. Temporization, other than the closure of an access cavity, should be itemised separately	200419	\$123.10
Additional visit for irrigation and/or dressing of the root canal system – per tooth (ADA 455)	Additional debridement irrigation and short-term dressing required where evidence of infection or inflammation persists following prior opening of the root canal and removal of its contents	200455	\$91.42
Metallic restoration – one surface – direct (ADA 511)	Direct metallic restoration involving one surface of a tooth	200511	\$109.70
Metallic restoration – two surfaces – direct (ADA 512)	Direct metallic restoration involving two surfaces of a tooth	200512	\$134.08

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Complete maxillary denture (ADA 711)	Provision of a removable dental prosthesis replacing the natural teeth and adjacent tissues in the maxilla	200711	\$1,030.01
Complete mandibular denture (ADA 712)	Provide a removable dental prosthesis replacing the natural teeth and adjacent tissues in the lower jaw mandible	200712	\$1,076.32
Partial maxillary denture – resin base (ADA 721)	Provision of a resin base for a removable dental prosthesis for the maxilla where some natural teeth remain. Other components of the denture such as teeth, rests, retainers and immediate tooth replacements should be appropriately itemised	200721	\$555.84
Partial mandibular denture – resin base (ADA 722)	Provision of a resin base for a removable dental prosthesis for the mandible where some natural teeth remain. Other components of the denture such as teeth, rests, retainers and immediate tooth replacements should be appropriately itemised	200722	\$555.84
Partial mandibular denture – cast metal framework (ADA 728)	Provision of the framework for a removable dental prosthesis made with a cast metal, which usually incorporates the clasps and retainers, on which to replace teeth from the mandible where some natural teeth remain. Other components of the denture such as teeth, retainers or rests and immediate tooth replacements should be appropriately itemised	200728	\$1,270.14
Retainer – per tooth (ADA 731)	A retainer or attachment to a tooth to aid retention of a partial denture. The number of retainers should be indicated	200731	\$41.43 per tooth
Occlusal rest – per rest (ADA 732)	A unit of partial denture that rests upon a tooth surface to provide support for the denture. The number of rests should be indicated	200732	\$41.43 per rest
Tooth/teeth (partial denture) (ADA 733)	An item to describe each tooth added to the base of new partial denture. The number of teeth should be indicated	200733	\$29.25
Repairing broken base of a partial denture (ADA 764)	Repair, insertion and adjustment of a broken resin partial denture base	200764	\$120.68
Adding tooth to partial denture to replace an extracted or decoronated tooth – per tooth (ADA 768)	Modification, insertion and adjustment of a partial denture involving an addition to accommodate the loss of a natural tooth or its coronal section	200768	\$166.99 per tooth
Impression – dental appliance repair/ modification (ADA 776)	An item to describe taking an impression where required for the repair or modification of a dental appliance	200776	\$42.67
Palliative care (ADA 911)	An item to describe interim care to relieve pain, infection, bleeding or other problems not associated with other treatment	200911	\$80.45
Provision of medication/ medicament (ADA 927)	An additional item to describe the actual supply, prescription or administration of appropriate medications and medicaments required for dental treatments	200927	\$31.69

¹ Rates do not include GST. Check with the Australian Taxation Office if GST should be included.

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Reports

All reports must be requested by the insurer. The report fee includes the report only and does not include a consultation. Insurers may request a report from either the treating practitioner or in connection with an independent dental assessment.

Descriptor	Report timeframe	Item number	Fee – GST not included ¹
Complete forms (sent with request) – for treating dental practitioners to provide basic information as set out in forms provided by the insurer. The treating dental practitioner to indicate the need for telephone contact or full report if additional pertinent information is available. Basic fee payable for each form completed.	None	210001	\$56.08
Short report – written in response to a request for specific information—for example a statement of attendance/history/diagnosis/record of visits, including results of an investigation. These reports should only address the information requested but should include any comments necessary to make the position clear to a lay person such as a claims officer. Expected length – half page to one page.	Received by insurer within 10 working days*	210002	\$110.92
Short report – as above	Received by insurer after 10 working days*	210003	\$56.08
Basic report – includes summing up and an opinion helpful to the insurer. A basic report should include all of the relevant items listed in the outline for the short report and also a case summary. Details would only be given where this assists in determining the merits of a claim, establishing a need for a particular line of treatment or rehabilitation, understanding the development of the condition and the prognosis, or clarifying early treatment and return to work goals. Expected length – one to two pages.	Received by insurer within 10 working days*	210005	\$221.85
Basic report – as above.	Received by insurer after 10 working days*	210006	\$110.92
Substantial report – includes extensive research or case discussion and opinion helpful to the insurer or assessment of impairment on request; or if the claim is rejected, to compensate for clinical input to the report. To qualify as substantial, a report must include, in addition to the case summary and comments required for a basic report, at least one of the following: an assessment of impairment at the insurer's request; a report on an injury where the claim is subsequently rejected as a result of the report; evidence of extensive research into clinical, technical or scientific papers; considerable case discussion outlining the merits of the claim; or advice on the future management of the case which assists the insurer and/or rehabilitation providers to manage the claim appropriately. Expected length – one and a half to two pages.	Received by insurer within 10 working days*	210008	\$443.69
Substantial report – as above.	Received by insurer after 10 working days*	210009	\$221.85

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Descriptor	Report timeframe	Item number	Fee – GST not included ¹
Expert specialist opinion – includes above elements essential to the insurer in determining or managing claims. To attract the fee for an expert specialist report there should be evidence of two or more of the requirements for a substantial report; or the preparation of a report of a medico-legal standard for use a medical assessment tribunal or a court. Expected length three or more pages. Note: only to be paid to specialists	Received by insurer within 10 working days*	210011	\$554.62
Expert specialist opinion – as above	Received by insurer after 10 working days*	210012	\$277.92

¹ Rates do not include GST. Check with the Australian Taxation Office if GST should be included.

*A doctor or registered person attending a worker who has sustained an injury must give the insurer a detailed report on the worker's condition within 10 days after receiving an insurer's request to do so. (*Workers' Compensation and Rehabilitation Regulation 2003 Sections 86(3) and 88(3)*).

Who can provide dental services to injured workers?

All dental services performed must be provided by a dentist who has a current registration with the Dental Board of Australia.

Service conditions

Services provided to injured workers are subject to the following conditions:

- **Urgent and immediate treatment** – where the dental injury sustained by the worker requires urgent and immediate treatment, the practitioner does not need to obtain prior approval from the insurer. This treatment is limited to relieving acute dental pain and immediate symptoms— extractions, sedative dressings and suturing of oral soft tissue injuries.
- **Services not covered by this table of costs** – due to the diversity of dental services, there may be other dental expenses not covered in this document. The practitioner must negotiate these services with the insurer and receive written approval before commencing treatment.
- **Follow-up treatment** – if the item for follow-up dental treatment appears in this table of costs, the practitioner does not need prior approval from the insurer.
- **Workers' compensation certificate** – the injured worker must have a current workers' compensation certificate to cover any dental services provided. If the injury is dental or oral only, the dentist may issue a workers' compensation certificate to certify if the injury is work-related. If the injury is of a non-dental nature the certificate must be issued by a medical practitioner or nurse practitioner.

Payment for services

The worker's compensation claim must have been accepted by the insurer for the injury or condition being treated. If the application for compensation is pending or has been rejected, the responsibility for payment for any services provided is a matter between the practitioner and the worker (or the employer, where services have been requested by a Rehabilitation and Return to Work Coordinator).

All invoices are to be sent to the relevant insurer for payment—check whether the worker is employed by a self-insured employer or an employer insured by WorkCover Queensland.

Identify the appropriate item in the *Dental services table of costs* for services or treatment provided. The insurer will only consider payment for services or treatments for the compensable injury, not other pre-existing conditions. Insurers will not pay for general communication such as receiving and reviewing referrals.

Dental services table of costs

Fees listed in the *Dental services table of costs* do not include GST. The practitioner is responsible for incorporating any applicable GST on taxable supplies into the invoice. Refer to a taxation advisor or the Australian Taxation Office for assistance if required.

Self-insurers require separate tax invoices for services to individual workers. WorkCover Queensland will accept billing for more than one worker on a single invoice.

To ensure payment, the invoice must contain the following information:

- the words 'Tax Invoice' stated prominently
- practice details and Australian Business Number (ABN)
- invoice date
- worker's name, residential address and date of birth
- worker's claim number (if known)
- referring medical practitioner's or nurse practitioner's name
- date of each service
- item number/s and treatment cost
- a brief description of each service item supplied, including areas treated
- name of the practitioner who provided the service.

Dental reports

The following notes are designed to assist practitioners to prepare and submit reports which achieve the best outcomes for all concerned.

- Typed reports are best, including the written request for approval to conduct follow-up dental treatment. Reports should be as clear and as informative as possible. When insurers evaluate the report against the fee charged, they consider its usefulness for determining liability, assessing incapacity, or whether rehabilitation or other special services are needed to manage the claim.
- Delays in determining liability or the need for treatment or rehabilitation add considerably to the total costs of claims. As an incentive for early replies to requests for dental reports, a staged fee schedule based on time has been developed. The date the request was received will be the date from which the insurer will calculate the time taken to reply.
- The date of examination of the worker will be the date from which the insurer will calculate the time taken for reports associated with independent dental assessments (examination and report).
- In general, reports delayed longer than six (6) weeks are of little use to the insurer and will not be paid for without prior approval from the insurer.
- If an insurer requests an independent dental assessment (examination and report), they will always pay the fee for the examination. However, if the insurer does not receive the report within six (6) weeks of the examination, the insurer will not pay for the report unless they have given their prior approval.
- The insurer will only pay for non-requested reports at the base rate—provided they are satisfied the report is of value to them.
- Where the insurer requests a report from the treating dentist and subsequently rejects the claim, the insurer will pay the appropriate report fee to compensate for the clinical input necessary to provide the report.
- The 'expected length' is given as a guide only—this is not a measure of the report's value.

Assistance

Contact the relevant insurer for claim related information such as:

- payment of invoices and account inquiries
- claim numbers/status
- rehabilitation status.

For a current list of insurers or general advice about the tables of costs visit www.qcomp.com.au or call 1300 789 881.