

together

working
together
and moving
forward



Table of Costs

Dental Services

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1.0 Introduction

This document outlines the general standards and expectations, procedures and conditions for delivering dental services to workers. It also explains and clarifies the use of specific item codes. This information should assist the treating medical practitioner, the employer, the insurer, and you, the dentist, by promoting quality service provision and timely, relevant rehabilitation information.

In the majority of occasions the treatment of oral or dental injuries will not prevent a worker completing their pre-injury duties. However, in the event that dental injuries/treatment prevents the worker returning to work or requires the worker to undertake suitable duties, then workplace rehabilitation should focus on safely returning the worker to work or maximising functional independence.

2.0 Procedures and Conditions

2.1 Payment of dental services

Payment for services outlined in this document is subject to the following procedures and conditions:

- The workers' 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, responsibility for payment for any services provided during any period remains a matter between you and the worker.
- If the employer or their agent has requested services, the responsibility for payment for any services provided remains a matter between you and the employer or their agent.
- Send all invoices to the relevant insurer for payment—check whether the worker is employed by a self-insured employer or an employer insured by WorkCover Queensland. For a current list of insurers visit Q-COMP's website at www.qcomp.com.au/insurers or call Q-COMP on 1300 789 881.
- Identify the appropriate item in the *Dental Services Table of Costs* for services or treatments provided. The insurer will only consider payment for services or treatments for the compensable dental injury (not other pre-existing dental conditions).

2.2 Dental services

- **Services and treatment not covered by the *Dental Services Table of Costs***
 - Due to the diversity of dental services, there may be other dental expenses not covered in this document. You should negotiate these expenses—you must receive **written approval from the insurer** before commencing treatment.
- **Urgent and immediate treatment**
 - Where the dental injury sustained by the worker requires **urgent and immediate** treatment, you do 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.
- **Follow-up dental treatment**
 - If the item for follow-up dental treatment appears in the *Dental Services Table of Costs*, you do not need prior approval from the insurer.
 - If the item for follow-up dental treatment **does not** appear in the *Dental Services*

Table of Costs, you must write to the insurer (prior to any subsequent dental follow-up) requesting approval to conduct follow-up dental treatment, outlining the dental therapy necessary to restore the injured worker's dental condition to its pre-injury standard.

- **Workers Compensation Medical Certificate**

The injured worker must have a **current** *Workers' Compensation Medical Certificate* to cover compensation for any dental services provided.

- If the injury is dental or oral only, you may issue a *Workers' Compensation Medical Certificate* to certify if the injury is work-related.
- The *Workers' Compensation Medical Certificate* must only relate to a **dental or oral injury**. A registered medical practitioner must certify any other condition or injury of a non-dental nature.

3.0 Dentist invoice

Insurers will pay for services in accordance with the *Dental Services Table of Costs*. To ensure payment, your invoice must contain the following information:

- the words 'Tax Invoice' stated prominently
 - your name and practice details
 - tax invoice issue date
 - your Australian Business Number (ABN)
 - worker's name, residential address and date of birth
 - worker's claim number (if known)
 - referring medical practitioner's name
 - date of each attendance
 - appropriate *Table of Costs* item number/s
 - a brief description of each service item supplied, including areas treated
 - treatment cost
 - name of your staff member who provided the service.
- Fees listed in the *Table of Costs* do not include GST. You are responsible for incorporating any applicable GST on taxable supplies into your invoice. Refer to a taxation advisor or the Australian Taxation Office for help on the taxability of certain services.
 - Self-insurers require separate tax invoices for services to individual workers. The self-insurer will return an invoice to you where the services are for more than one injured worker. For a current list of self-insurers, visit Q-COMP's website at www.qcomp.com.au/insurers.
 - WorkCover Queensland will accept billing for more than one worker on a single invoice.

4.0 Dental reports

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

- Reports, including the written request for approval to conduct follow-up dental treatment are best typed.
- 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.
- When an insurer requests a dental report during or following treatment, the date you receive the request will be the date from which the insurer will calculate the time taken for you to reply.
- The date of your 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 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 examination and report (E & R) from an independent dentist, 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 unsolicited reports at the base rate—, provided they are satisfied the report was 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—do not interpret this as a measure of the report's value.

5.0 Inquiries

5.1 Claims issues

Contact the appropriate insurer for claims issues, including:

- payment of invoices and account inquiries
- claim numbers
- claim status
- rehabilitation status
- approval of *Provider Management Plans*.

For a current list of insurers, visit Q-COMP's website at www.qcomp.com.au/insurers or call Q-COMP on 1300 789 881.

5.2 General inquiries

For advice about the *Table of Costs*, call Q-COMP on 1300 789 881.

5.3 GST/Tax invoice issues

Seek clarification from a taxation advisor or the Australian Taxation Office.

6.0 Dental Services Fee Schedule

The following table relates to dental services provided within the dental practitioner's rooms, private hospital or at the injured worker's place of work.

All procedures described in this schedule include the insertion of sutures, normal post-operative aftercare and suture removal.

Please refer to the preceding explanatory notes which apply to the table of costs below.

Item Number	Service Type	Service Description	Fee GST Excluded
200011	Comprehensive oral examination (ADA 011)	Evaluate all teeth, their supporting tissues and the oral tissues to record the current condition of these structures. This evaluation includes recording an appropriate medical history and any other relevant information.	\$49.71
200012	Periodic oral examination (ADA 012)	Evaluate a patient of record to determine any changes in the patient's dental and medical health status since a prior comprehensive or periodic examination.	\$41.98
200013	Oral examination – limited (ADA 013)	Carry out a limited problem-focused oral evaluation immediately prior to required treatment. This examination includes recording an appropriate medical history and any other relevant information.	\$37.55
200014	Consultation (<30 minutes) (ADA 014)	Seek advice or discuss treatment options about a specific dental or oral condition. This consultation includes recording an appropriate medical history and any other relevant information.	\$66.28
200015	Consultation -extended (>30 minutes) (ADA 015)	Seek advice or discuss treatment options about a specific dental or oral condition. This consultation includes recording an appropriate medical history and any other relevant information.	\$111.56
200022	Intraoral periapical or bitewing radiograph-per exposure (ADA 022)	Take and interpret a small radiograph made with the film inside the mouth.	\$36.45 per film
200025	Intraoral radiograph – occlusal, maxillary, mandibular – per exposure (ADA 025)	Take and interpret an occlusal, maxillary or mandibular intraoral radiograph. This radiograph shows a more extensive view of teeth and maxillary or mandibular bone.	\$37.55 per film

Item Number	Service Type	Service Description	Fee GST Excluded
200037	Panoramic radiograph – per exposure (OPG) (ADA 037)	Take and interpret an extraoral radiograph presenting a panoramic view of part or all of the mandible and/or the maxilla and/or adjacent structures.	\$92.78
200071	Diagnostic model – per model (ADA 071)	Prepare 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 for prosthodontic services or those used for fabricating appliances, mouthguards or trays.	\$69.59 per model
200311	Removal of a tooth or part/s thereof (ADA 311)	Remove a tooth or part/s thereof.	\$121.51
200314	Sectional removal of a tooth (ADA 314)	Remove a tooth in sections. Bone removal may be necessary.	\$197.72
200322	Surgical removal of a tooth or tooth fragment not requiring removal of bone or tooth division (ADA 322)	Remove a tooth or a tooth fragment, where an incision of the mucosa and the raising of a mucoperiosteal flap are required, but where the removal of bone or sectioning of the tooth is not necessary to remove the tooth.	\$212.08
200323	Surgical removal of a tooth or tooth fragment requiring removal of bone (ADA 323)	Remove a tooth or tooth fragment where the removal of bone is required after an incision has been made and a mucoperiosteal flap raised.	\$241.91
200352	Fracture of maxilla or mandible-not requiring splinting (ADA 352)	Conservatively treat a fracture of the maxilla or mandible where there is no marked displacement or mobility of the fragments. No splinting, physical reduction or fixation is required.	\$153.54
200387	Replantation and splinting of a tooth (ADA 387)	Replant a tooth which has been avulsed or intentionally removed. It may be held in the correct position by splinting.	\$255.16
200399	Control of reactionary or secondary post operative haemorrhage (ADA 399)	Control reactionary or secondary post-operative haemorrhage.	\$28.72
200411	Direct pulp capping (ADA 411)	Directly cover an exposed pulp with a protective dressing or cement.	\$87.26
200419	Extirpation of pulp or debridement of root canal(s) – emergency or palliative (ADA 419)	Partial or thorough removal of pulp and/or debris from the root canal system of a tooth. This is an emergency procedure or palliative procedure distinct from visits for scheduled endodontic treatment. Temporization, other than the closure of an access cavity, should be itemised separately.	\$111.56

Item Number	Service Type	Service Description	Fee GST Excluded
200455	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.	\$82.85
200511	Metallic restoration – one surface - direct (ADA 511)	Direct metallic restoration of a cavity involving one surface of a tooth.	\$99.41
200512	Metallic restoration – two surfaces - direct (ADA 512)	Direct metallic restoration of a cavity involving two surfaces of a tooth.	\$121.51
200711	Complete maxillary denture (ADA 711)	Provide a removable dental prosthesis replacing the natural teeth and adjacent tissues in the upper jaw (maxilla).	\$933.39
200712	Complete mandibular denture (ADA 712)	Provide a removable dental prosthesis replacing the natural teeth and adjacent tissues in the lower jaw (mandible).	\$975.36
200721	Partial maxillary denture – resin base (ADA 721)	Provide 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.	\$503.70
200722	Partial mandibular denture – resin base (ADA 722)	Provide 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.	\$503.70
200728	Partial mandibular denture – cast metal framework (ADA 728)	Provide 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 replacements must be appropriately itemised.	\$1,150.99
200731	Retainer – per tooth (ADA 731)	Fit a retainer or attachment to a tooth to aid retention of a partial denture. The number of retainers must be indicated.	\$37.55 per tooth
200732	Occlusal rest – per rest (ADA 732)	Provide support for a denture through a unit of a partial denture that rests upon a tooth surface to. The number of rests must be indicated.	\$37.55 per rest

Item Number	Service Type	Service Description	Fee GST Excluded
200733	Tooth/teeth (partial denture) (ADA 733)	Add a tooth or teeth to the base of new partial denture. The number of teeth must be indicated.	\$26.51
200764	Repairing broken base of a partial denture (ADA 764)	Repair, insert and adjust a broken resin partial denture base.	\$109.36
200768	Adding tooth to partial denture to replace an extracted or decoronated tooth – per tooth (ADA 768)	Modify, insert and adjust a partial denture involving an addition to accommodate the loss of a natural tooth or its coronal section.	\$151.33 per tooth
200776	Impression – dental appliance repair/ modification (ADA 776)	Taking of an impression where required for the repair or modification of a dental appliance.	\$38.67
200911	Palliative care (ADA 911)	Provision of interim care to relieve pain, infection, bleeding or other problems not associated with any other treatment.	\$72.91
200927	Provision of medication/ medicament (ADA 927)	Actual supply, prescription or administration of appropriate medications and medicaments required for dental treatments.	\$28.72

7.0 Dental Reports

Report fee only – does not include consultation

Applies to dental reports requested by an insurer from treating practitioner or in connection with independent professional examination.

Item Number	Service Description	Report Timeframe	Fee GST Excluded
210001	Complete forms (sent with request) – for treating dental practitioners to provide basic information as set out in forms provided by the insurer. Requesting officer to indicate area of particular interest. Provision for treating dental practitioner to indicate need for telephone contact or full report if additional pertinent information is available. Basic fee payable for each form completed.	None	\$50.82
210002	Short report – normally 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 up to 10 working days*	\$100.52
210003	Short report – as above	Received after 10 working days*	\$50.82
210005	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. In the majority of cases, it will simply be 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, as these are helpful to the insurer in managing claims. Expected length one to two pages.	Received up to 10 working days*	\$201.04
210006	Basic report – as above.	Received after 10 working days*	\$100.52

* 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)).

Item Number	Service Description	Report Timeframe	Fee GST Excluded
210008	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 up to 10 working days*	\$402.07
210009	Substantial report – as above.	Received after 10 working days*	\$201.04
210011	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 up to 10 working days*	\$502.60
210012	Expert specialist opinion – as above.	Received after 10 working days*	\$251.85

*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)).