

DENTAL SERVICES TABLE OF COSTS

1. INTRODUCTION

This document outlines Q-COMP's requirements in relation to the procedures, conditions and fees payable for dental service delivery to workers' compensation claimants in Queensland. The aim of this information is to ensure delivery of quality, cost-effective dental services to injured workers, employers and insurers, including the provision of timely and relevant information for case management.

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 should require a worker to need time off work or require suitable duties, then workplace rehabilitation should focus on safely returning the worker to work or maximising functional independence.

2. PROCEDURES AND CONDITIONS

2.1 Payment of Dental services

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

- **The workers' compensation claim must be accepted by the insurer for the injury or condition being treated.**
 - (i) 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 the Dentist and the worker.
 - (ii) If the employer or their agent has requested services, the responsibility for payment for any services provided remains a matter between the Dentist and the employer or their agent.
 - (iii) If the injured worker is employed by a self-insured employer, the Dentist should forward all invoices for payment to the relevant self-insurer.
- The Dentist should 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 relating to 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 will be other dental expenses, which are not covered in this document. The Dentist should negotiate these expenses and **must receive written approval from the insurer prior to commencing treatment.**

- **Urgent and Immediate Treatment**

- (i) Where the dental injury sustained by the worker requires **urgent and immediate** treatment, it is not necessary to obtain prior approval from the insurer.
- (ii) This treatment is limited to relieving acute dental pain and immediate symptoms, i.e. extractions, sedative dressings and suturing of oral soft tissue injuries.

- **Follow-up Dental Treatment**

- (i) If the item for follow-up dental treatment appears in the Dental Services Table of Costs, the treating Dentist does not need to gain approval from the insurer prior to treatment.
- (ii) If the item for follow-up dental treatment **does not** appear in the Dental Services Table of Costs, the treating Dentist must forward to the insurer (prior to any subsequent dental follow-up) a written request for approval to conduct follow-up dental treatment. The treating Dentist must outline the dental therapy necessary to restore the injured worker's dental condition to their 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.

- (i) If the injury is dental or oral only, a Dentist may issue a Workers' Compensation Medical Certificate to certify if the injury is work-related.
- (ii) 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. DENTIST INVOICE

3.1 Insurers must have regard to the Dental Services Table of Costs when considering payment of fees for dental services.

- All invoices must be in the form of a **Tax Invoice** and must contain the following:

- (i) The words 'Tax Invoice' stated prominently;
- (ii) The name of the provider and practice details;
- (iii) The date the tax invoice was issued;
- (iv) The Dentist's Australian Business Number (ABN);
- (v) The injured worker's name, residential address and date of birth;
- (vi) Claim Number (if known);
- (vii) Referring medical practitioner's name;
- (viii) Date of each attendance;
- (ix) Appropriate item number/s from the Table of Costs;
- (x) A brief description of each dental item supplied, including areas treated; and
- (xi) Cost of treatment; and
- (xii) Name of the service provider's staff member who provided the service.

Fees listed in the Table of Costs are **exclusive** of GST. It is the responsibility of a supplier to incorporate into invoices any applicable GST on taxable supplies. For guidance on the taxability of certain services, providers are advised to refer to a taxation advisor or the Australian Taxation Office.

3.2 Please note that the insurer requires individual tax invoices for services relating to individual workers. The insurer will return an invoice to you where the services relate to more than one injured worker.

4. 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. Usefulness in determining liability, assessing incapacity or the need for rehabilitation or other special services to manage the claim will count when insurers/case managers are evaluating the report against the fee charged.
- 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 report during or following treatment the insurer will take the date of receipt of the report request, as the date from which time will be calculated for requested reports from treating Dentists.
- The date of the examination by a Dentist will be the date from which, time will be calculated 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.
- In the case of an insurer's request for an examination and report (E & R) from an independent Dentist, the fee for the examination will always be paid. However, if the report is not received by the insurer within six (6) weeks of the examination, the report will not be paid for without prior approval from the insurer.
- Unsolicited reports will be paid at the base rate only, providing the insurer is satisfied that the report has been of value to them.
- Where a report is requested by the insurer from the treating Dentist and the claim is subsequently rejected, the appropriate report fee is payable to compensate for the clinical input necessarily required to provide the report.
- The "expected length" is given as a guide only and is not to be interpreted as a measure of the report's value.

5. ENQUIRIES

5.1 Claims Issues

For billing enquiries or for enquiries relating to claims, e.g. claim numbers, claim status, prior approval for further dental treatment, rehabilitation status or payment of invoices, the Dentist should contact the appropriate insurer.

5.2 GST/Tax Invoice Issues

For guidance on the taxability of certain services, Dentists are advised to refer to s.38-7 and 38-10 of the *A New Tax System (Goods and Services Tax) Act 1999*. Any further clarification should be sought from a taxation advisor or the Australian Taxation Office.

5.3 Policy Enquiries

Any Dentist seeking advice on policy issues relating to the Table of Costs should contact Q-COMP, by telephone on 1300 789 881.

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 No	Service Type	Service Description	Fee Excl. GST
200011	Comprehensive oral examination (ADA 011)	Evaluation of 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.	\$47.30
200012	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 prior comprehensive or periodic examination.	\$39.94
200013	Oral examination – limited (ADA 013)	A limited problem-focussed oral evaluation carried out immediately prior to required treatment. This examination includes recording an appropriate medical history and any other relevant information.	\$35.73
200014	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.	\$63.06
200015	Consultation - extended (>30 minutes) (ADA 015)	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.	\$106.15
200022	Intraoral periapical or bitewing radiograph-per exposure (ADA 022)	Taking and interpreting a small radiograph made with the film inside the mouth.	\$34.68 per film
200025	Intraoral radiograph – occlusal, maxillary, mandibular – per exposure (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.	\$35.73 per film

Item No	Service Type	Service Description	Fee Excl. GST
200037	Panoramic radiograph – per exposure (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.	\$88.28
200071	Diagnostic model – per 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 for prosthodontic services or those used for the fabrication of appliances, mouthguards or trays.	\$66.21 per model
200311	Removal of a tooth or part(s) thereof (ADA 311)	A procedure consisting of the removal of a tooth or part(s) thereof.	\$115.61
200314	Sectional removal of a tooth (ADA 314)	The removal of a tooth in sections. Bone removal may be necessary.	\$188.13
200322	Surgical removal of a tooth or tooth fragment not requiring removal of bone or tooth division (ADA 322)	Removal of a tooth or 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.	\$201.79
200323	Surgical removal of a tooth or tooth fragment requiring removal of bone (ADA 323)	Removal of a tooth or tooth fragment where the removal of bone is required after an incision has been made and a mucoperiosteal flap raised.	\$230.17
200352	Fracture of maxilla or mandible-not requiring splinting (ADA 352)	Conservative treatment of 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.	\$146.09
200387	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.	\$242.78
200399	Control of reactionary or secondary post operative haemorrhage (ADA 399)	This procedure describes the control of reactionary or secondary post-operative haemorrhage.	\$27.33
200411	Direct pulp capping (ADA 411)	A procedure where an exposed pulp is directly covered with a protective dressing or cement.	\$83.03
200419	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 procedure or palliative procedure distinct from visits for scheduled endodontic treatment. Temporization, other than the closure of an access cavity, should be itemised separately.	\$106.15
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.	\$78.83

Item No	Service Type	Service Description	Fee Excl. GST
200511	Metallic restoration – one surface - direct (ADA 511)	Direct metallic restoration of a cavity involving one surface of a tooth.	\$94.59
200512	Metallic restoration – two surfaces - direct (ADA 512)	Direct metallic restoration of a cavity involving two surfaces of a tooth.	\$115.61
200711	Complete maxillary denture (ADA 711)	Provision of a removable dental prosthesis replacing the natural teeth and adjacent tissues in the upper jaw (maxilla).	\$888.10
200712	Complete mandibular denture (ADA 712)	Provision of a removable dental prosthesis replacing the natural teeth and adjacent tissues in the lower jaw (mandible).	\$928.03
200721	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.	\$479.26
200722	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.	\$479.26
200728	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 replacements must be appropriately itemised.	\$1,095.14
200731	Retainer – per tooth (ADA 731)	A retainer or attachment fitted to a tooth to aid retention of a partial denture. The number of retainers must be indicated.	\$35.73 per tooth
200732	Occlusal rest – per rest (ADA 732)	A unit of a partial denture that rests upon a tooth surface to provide support for the denture. The number of rests must be indicated.	\$35.73 per rest
200733	Tooth/teeth (partial denture) (ADA 733)	An item to describe each tooth added to the base of new partial denture. The number of teeth must be indicated.	\$25.22
200764	Repairing broken base of a partial denture (ADA 764)	Repair, insertion and adjustment of a broken resin partial denture base.	\$104.05
200768	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.	\$143.99 per tooth
200776	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.	\$36.79

Item No	Service Type	Service Description	Fee Excl. GST
200911	Palliative care (ADA 911)	An item to describe interim care to relieve pain, infection, bleeding or other problems not associated with any other treatment.	\$69.37
200927	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.	\$27.33

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 No.	Service Description	Report Time-frame	Fee GST Excl.
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	\$48.35
210002	Short Report – normally written in response to a request for specific information. Examples include: statement of attendance/history/diagnosis/record of visits, including results of 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 0.5 to one page.	Rec'd up to 10 working days*	\$95.64
210003	Short Report – as above	Rec'd after 10 working days*	\$48.35
210005	Basic Report including summing up and 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. Detail 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 1 to 2 pages.	Rec'd up to 10 working days*	\$191.28
210006	Basic Report – as above.	Rec'd after 10 working days*	\$95.64

* 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 No.	Service Description	Report Time-frame	Fee GST Excl.
210008	Substantial report including extensive research or case discussion and opinion helpful to the insurer or assessment of impairment on request; or if claim 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: an assessment of impairment at the insurer's request; or a report on an injury where the claim is subsequently rejected as a result of the report; or evidence of extensive research into clinical, technical or scientific papers; or 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 1.5 to 2 pages.	Rec'd up to 10 working days*	\$382.56
210009	Substantial report - as above.	Rec'd after 10 working days*	\$191.28
210011	Expert specialist opinion including 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 in Medical Assessment Tribunals or the Courts. Expected length 3 or more pages. *TO BE PAID TO SPECIALISTS ONLY	Rec'd up to 10 working days*	\$478.21
210012	Expert specialist opinion – as above.	Rec'd after 10 working days*	\$239.63

* 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)*).