INTRODUCTION

This book provides information on the arrangements for the payment of Medicare benefits for services rendered by eligible dental practitioners, orthodontists and oral surgeons for the treatment of cleft lip and cleft palate conditions. These arrangements operate under the *Health Insurance Act 1973* (as amended).

Section 1 of this book contains explanatory notes on the Scheme together with an outline of the arrangements under which it operates, including addresses of Medicare Australia and Cleft Lip and Cleft Palate Clinics.

The Schedule in Section 2 shows for each service the item number, description of the service, the Schedule fee and Medicare benefits. The fees shown in the Schedule are the fees which apply to services rendered on and after 1 November 2006.

This edition of the book has been printed for use by eligible dental practitioners, orthodontists, oral surgeons, Medicare Australia and other interested authorities.

CHANGES INCLUDED IN THIS EDITION

General Fee Increase

Schedule fees for services by eligible dental practitioners in the treatment of cleft lip and cleft palate conditions increase by 2.1% from 1 November 2006.

Maximum Patient Gap

The maximum patient gap between the Schedule fee and the benefits payable for out-of-hospital services increases to $63.90 as at 1 November 2006. The 85% benefit level will apply for all fees up to $426.00, after which, benefits are calculated at the Schedule fee less $63.90.

Special Arrangements - Transitional Period

Where an item refers to a service in which treatment continues over a period of time in excess of one day and treatment commenced before 1 November 2006 and continues beyond that date, the general rule is that the 1 November 2005 level of fees and benefits would apply.

OUTLINE OF CLEFT LIP AND CLEFT PALATE SCHEME AND NOTES FOR GUIDANCE

CA. INTRODUCTION

CA.1 Medicare Benefits

CA.1.1 The Medicare Benefits Schedule includes certain professional services in respect of the treatment of cleft lip and cleft palate conditions for which Medicare benefits are payable. These services are normally described as dental services. However, for the purposes of these Notes the word "medical" is to be interpreted to include "dental". The definition of professional service as contained in the *Health Insurance Act 1973* provides that such a service must be "clinically relevant". A clinically relevant service means a service rendered by a medical or dental practitioner or optometrist that is generally accepted in the medical, dental or optometrical profession (as the case may be) as being necessary for the appropriate treatment of the patient to whom it is rendered.

CA.1.2 Medicare benefits are payable in respect of services listed in the Schedule (contained in Section 2 of this booklet), when the services are rendered by eligible dental practitioners to prescribed dental patients (see paragraph CC).

CA.1.3 The Schedule lists three categories of professional services:

- Group C1 Orthodontic Services
- Group C2 Oral and Maxillofacial Surgical Services
- Group C3 General and Prosthodontic Services

CB. DENTAL PRACTITIONER ELIGIBILITY

CB.1 Eligible Practitioners

CB.1.1 In order to attract Medicare benefits, all treatment must be carried out by eligible dental practitioners who are resident in Australia. Practitioner eligibility is covered under the provisions of Subsection 3(1) of the *Health Insurance Act 1973*.

CB.1.2 All State registered dental practitioners are entitled to perform simple extraction services covered by Items 75200-75206 listed in Group C2 of the Schedule (see paragraph CG.6 of these notes) and the general and prosthodontic services listed in Group C3 of the Schedule. Practitioners do not need to apply for accreditation or approval to perform these services.

CB.1.3 Dental practitioners who wish to be accredited for the purposes of Subsection 3(1) of the *Health Insurance Act 1973* to perform those orthodontic services listed in Group C1 of the Schedule must submit an application for consideration by the Medical Benefits (Dental Practitioners) Advisory Committee. This Committee will recommend to the Minister the names of those dental practitioners who, in its opinion, should be accredited by the Minister to provide orthodontic services.

CB.1.4 The criteria used in granting accreditation for orthodontic services are that the dental practitioner is a practitioner who is either -

- registered by one of the State Dental Boards as an orthodontist; or
- can substantiate by qualifications and experience a level of competence in the field of orthodontics equivalent to the above criterion.

CB.1.5 Dental practitioners holding the FRACDS (OMS) or equivalent who were approved by the Minister prior to 1 November 2004 for the purposes of Subsection 3 (1) of the *Health Insurance Act 1973* to carry out prescribed medical services (oral and maxillofacial surgery) contained in the Medicare Benefits Schedule book may perform prescribed medical services (oral and maxillofacial surgery) listed in Group C2 (on referral by an accredited orthodontist).

CB.1.6 The Medical Benefits (Dental Practitioners) Advisory Committee considers applications lodged by dental practitioners and recommends to the Minister the names of those dental practitioners who, in its opinion, should be approved by the Minister for the purposes of subsection 3(1) of the *Health Insurance Act 1973*. Such dental practitioners must be State registered oral and maxillofacial surgeons in the State in which he/she is practising. In making its recommendations, the Committee may take into account a practitioner’s training and experience in the field of oral and maxillofacial surgery and other factors which it may consider relevant.

CB.1.7 Practitioners who wish to be considered for approval or accreditation for the purposes of subsection 3(1) of the *Health Insurance Act 1973*, should write to the Manager (Eligibility), Medicare Australia, PO Box 1001, Tuggeranong, ACT 2901 for an application form. Any enquiries may be directed to Medicare Australia on (02) 6124 6328.

CB.1.8 Where the Minister decides that a dental practitioner should not be accredited for orthodontic services, the dental practitioner may appeal to the Medical Benefits (Dental Practitioners) Appeals Committee, which is composed of dental practitioners who are not on the Advisory Committee. The Committee's address is the same as the Advisory Committee.

CB.1.9 Both the Advisory and the Appeals Committees are composed of dental practitioners nominated by the Australian Dental Association.

CC. PATIENT ELIGIBILITY

CC.1 Eligible Patients

CC.1.1 To be eligible to claim benefits for Schedule services performed by eligible dental practitioners, a patient must satisfy the following criteria:

(a) The patient must be an Australian resident or any other person or class of persons whom the Minister declares to be eligible. All eligible persons will be issued with a Medicare card on application as evidence of their eligibility.

(b) Under the provisions of Section 3BA of the *Health Insurance Act 1973* a patient must be a prescribed dental patient, ie

- a person aged up to twenty-two years, in respect of whom, a certificate has been issued by a medical practitioner or dental practitioner approved by the Minister, stating that the person is suffering from a cleft lip or cleft palate condition*;
- a person aged up to twenty-eight years, in respect of whom, prior to turning twenty-two years,
  - a certificate has been issued by a medical practitioner or dental practitioner approved by the Minister, stating that the person is suffering from a cleft lip or cleft palate condition*, and
  - that person commenced treatment for a cleft lip or cleft palate condition;
- a person aged twenty-eight and over requiring a specific course of treatment for the repair of previous reconstructive surgery, provided that:
  - prior to turning twenty-two years, a certificate has been issued by a medical practitioner or dental practitioner approved by the Minister, stating that the person is suffering from a cleft lip or cleft palate condition*, and
  - the person received treatment for a cleft lip or cleft palate condition prior to turning twenty-eight years, and
  - if the Minister has declared in writing that he or she is satisfied that:
    (i) because of exceptional circumstances, the person required repair of previous reconstructive surgery in connection with the condition, and
    (ii) the person therefore needs to undergo that course of treatment.
  - a person aged up to twenty-two years in respect of whom a certificate has been issued by a medical practitioner or dental practitioner approved by the Minister, stating that the person is suffering from a condition determined by the Minister to be a condition to which the definition of a prescribed dental patient under Section 3BA of *Health Insurance Act 1973* applies.

* Conditions for which a patient may be prescribed include the following:

- Branchial Arch Syndrome
- Craniosynostosis Syndrome
- Apert's Syndrome
- Pierre Sequence
- Treacher-Collins' Syndrome
- Golden Har Syndrome
- Ectodermal Dysplasia

Please contact Medicare Australia by telephone on 1300 652 492 if the condition is not listed here.

Applications for approval for repairs to previous reconstructive work

Applicants aged 28 and over seeking approval for repairs to previous reconstructive work under the Cleft Lip and Cleft Palate Scheme will be required to provide clinical details outlining the need for the repair of previous reconstructive surgery.

Applications should include the following:

- a treatment plan devised by the treating professional, for the repair of the reconstructive surgery to be performed, including an indicative time period for which eligibility for claiming related treatments should be reinstated. The plan should note the dates the treatment is expected to commence and be completed;
- proof of previous eligibility and treatment under the Cleft Lip and Cleft Palate Scheme. This should take the form of a letter from the treating practitioner, which lists the patient details as follows:
  - full name
  - date of birth
  - address
  - condition
  - Cleft Palate Number
  - date (or approximate) of original surgery

This information will be forwarded to Medicare Australia for confirmation of eligibility;

- a clinical report from the treating professional, describing the nature of the repair, information detailing the previous reconstructive surgery provided and an outline of the work to be undertaken.

Applications made under Section 3BA(2A) of the *Health Insurance Act 1973* should be addressed to:

The Assistant Secretary
Medicare Benefits Branch
Department of Health and Ageing
PO Box 9848
Canberra ACT 2601

Assessment of Applications
Assessment will take into account the information provided by the applicant and consider the circumstances surrounding each individual application. In the assessment, "previous reconstructive surgery" means surgery undertaken to repair structural defects in connection with a cleft lip or cleft palate condition. Repairs to this surgery must be in relation to the failure or deterioration of this surgery and due to that failure or deterioration, the patient requires further surgical intervention to restore optimal function.

Repair to previous reconstructive surgery may involve items in both the main Medicare Benefits Schedule, and items in the Cleft Lip and Cleft Palate Schedule. Under Section 3BA (2A) of the *Health Insurance Act 1973*, upon gaining the Minister's approval, applicants will have full access to items in the Cleft Lip and Cleft Palate Schedule that are necessary for the restoration of optimal function (provided the items are rendered by suitably qualified / approved practitioners).

Please note patients approved under the over 28 provisions of the Cleft Lip and Cleft Palate Scheme will be eligible for Medicare benefits from the date the declaration is signed by the Minister's delegate.

CC.1.2 The identification of the cleft condition and the issue of the Certificate can be undertaken through a special cleft lip and cleft palate clinic or by a medical or dental practitioner authorised for this purpose by the Minister. Cleft lip and cleft palate clinics operate in at least one public hospital in each Australian State/Territory capital city. A list of these clinics and their addresses appears at the end of these Notes.
CC.1.3 Practitioners whose patients are unable to attend the hospital clinic should send records of the cleft condition to the Clinic for identification of the condition and issue of the Certificate.
CC.1.4 The Certificate is a formal document required under the provisions of the *Health Insurance Act 1973*. Because the Certificate may have to last for up to twenty-eight years, each eligible patient will also be issued with a plastic identification card. These cards, which are more durable than the paper Certificates, can be used by patients (or parents or guardians) to claim Medicare benefits. Facsimiles of the Certificate and card appear at the end of these Notes.
CC.1.5 Patients are eligible for Medicare benefits for treatment received from the date of issue of their Certificate. Where treatment is required immediately after birth, practitioners should telephone a Clinic or approved practitioner so that a Certificate can be prepared which will be effective from that day.

CC.2 Visitors to Australia
CC.2.1 Medicare benefits are generally not payable to visitors to Australia or temporary residents.

CC.3 Health Care Expenses Incurred Overseas
CC.3.1 Medicare does not cover medical or hospital expenses incurred outside Australia.

CD. SCHEDULE FEES AND MEDICARE BENEFITS

CD.1 Schedule Fees and Medicare Benefits
CD.1.1 Medicare benefits are based on fees determined for each Schedule service. These fees are shown in the Schedule in Section 2 of this Book. The fee is referred to in these notes as the "Schedule fee". The fee for any item listed in the Schedule is that which is regarded as being reasonable on average for that service having regard to usual and reasonable variations in the time involved in performing the service on different occasions and to reasonable ranges of complexity and technical difficulty encountered.
CD.1.2 The Medicare benefits for each medical service are the amounts shown immediately after the Schedule fee. There are presently two levels of Medicare benefit payable, that is:-

(i) for professional services rendered while hospital treatment (ie, accommodation and nursing care) is provided to a patient who has been admitted to a hospital or day hospital facility (other than public patients), the level of Medicare benefit is 75% of the Schedule fee for each item with no maximum patient gap between the Medicare benefit and the Schedule fee. The Health Insurance Regulations provide that medical practitioners must indicate on their accounts, etc, where a medical service is rendered in these circumstances. This requirement will be met by placing the word "admitted patient" immediately preceding the description of each service or, alternatively, where an item number is used, by placing an asterisk "*" directly after the item number for each service.

(ii) for all other professional services, the Medicare benefit is 85% of the Schedule fee, or the Schedule fee less $63.90 (indexed annually) whichever is the greater.

Where appropriate the calculated benefit has been rounded to the nearest higher 5 cents. However, in no circumstances will the benefit payable for any service exceed the amount of the fee actually charged for that service.

CD.1.3 It should be noted that the *Health Insurance Act 1973* makes provision for private medical insurance to cover the "patient gap" (ie, the difference between the Medicare benefit and the Schedule fee) for services attracting benefit at the 75% level. Patients may insure with private health insurance organisations for the gap between the 75% Medicare benefit and the Schedule fee or for amounts in excess of the Schedule fee where the patient has an agreement with their health fund.

CD.1.4 Where it can be established that payments for out-of-hospital services of $345.50 (indexed annually from 1 January) have been made for a family group or an individual during a calendar year in respect of the difference between the Medicare benefit and the Schedule fee, benefits will be paid for expenses incurred for professional services rendered during the rest of that year up to 100% of the Schedule fee. This does not apply to the Assignment of Benefit arrangements. A family group includes a spouse and dependent children under 16 years of age or dependent students under the age of 25.

CD.1.5 Under the extended safety net, Medicare will meet 80% of the out-of-pocket costs (ie the difference between the fees charged by the doctor and the Medicare benefits paid) for out-of-hospital medical services, once an annual threshold of $500 for families in receipt of the Family Tax Benefit Part A and concession card holders, or $1,000 (indexed annually from 1 January) for all other individuals and families is reached. A family group includes a spouse and dependent children under 16 years of age or dependent students under the age of 25. Individuals do not need to register with Medicare for the safety net threshold. However, families are required to register with Medicare to be eligible. Registration forms can be obtained from Medicare offices or completed online at www.health.gov.au or www.medicareaustralia.gov.au .

CD.2 Where Medicare Benefits are not Payable

CD.2.1 Medicare benefits are not payable in respect of a professional service in the following circumstances:-

(i) where the medical expenses for the service are paid or payable to a recognised (public) hospital;

(ii) where the service is a medical examination for the purposes of - life insurance, superannuation or provident account scheme, or admission to membership of a friendly society;

(iii) where the service was rendered in the course of carrying out of mass immunisation.

CD.2.2 Unless the Minister otherwise directs, Medicare benefit is not payable in respect of a professional service where:-

(a) the service has been rendered by or on behalf of, or under an arrangement with, the Commonwealth, a State or a local governing body or an authority established by a law of the Commonwealth, a law of a State or a law of an internal Territory;

(b) the medical expenses were incurred by the employer of the person to whom the service was rendered;

(c) the person to whom that service was rendered was employed in an industrial undertaking and that service was rendered to him for purposes connected with the operation of that undertaking; or

(d) the service was a health screening service.

CD.2.3 Benefits are not payable for items 75150 to 75621 unless the patient was referred in the manner outlined at paragraph CG.6.

CD.3 Limiting Rule

CD.3.1 In no circumstances will the benefit payable for a professional service exceed the fee charged for the service.

CE. PENALTIES

CE.1 Penalties

CE.1.1 Penalties of up to $10,000 or imprisonment for up to five years may be imposed on any person who makes a statement (either orally or in writing) or who issues or presents a document that is false or misleading in a material particular and which is capable of being used in connection with a claim for benefits. In addition, any practitioner who is found guilty of such offences by a Court on or after 22 February 1986 shall be subject to an examination by a Medicare Participation Review Committee and may be counselled or reprimanded or may have services wholly or partially disqualified from the Medicare benefit arrangements.

CE.1.2 A penalty of up to $1,000 or imprisonment for up to three months, or both, may be imposed on any person who obtains a patient's signature on a direct billing form without the necessary details having been entered on the form before signature or who fails to cause a copy of the completed form to be given to the patient.

CF. BILLING PROCEDURES

CF.1 Billing of the Patient - Itemised Accounts

CF.1.1 Where the practitioner bills the patient for medical services rendered, the patient needs a properly itemised account/receipt to enable a claim to be made for Medicare benefits.

CF.1.2 Under the provisions of the *Health Insurance Act 1973* and Regulations, Medicare benefits are not payable in respect of a professional service unless there is recorded on the account setting out the fee for the service or on the receipt for the fee in respect of the service, the following particulars:-

(i) Patient's name;

(ii) The date on which the professional service was rendered;

(iii) A description of the professional service sufficient to identify the item that relates to that service, including an indication where the service is rendered to a person while hospital treatment is provided in a hospital or day-hospital facility (other than a Medicare hospital patient), that is, the words (ie, accommodation and nursing care) "admitted patient" immediately preceding the description of the service or an asterisk "*" directly after an item number where used;

(iv) The name and practice address or name and provider number of the practitioner who actually rendered the service; (Where the practitioner has more than one practice location recorded with Medicare Australia, the provider number used should be that which is applicable to the practice location at or from which the service was given).

(v) Where the professional service was rendered by a consultant physician or a specialist in the practice of his/her speciality to a patient who has been referred:- (a) the name of the referring medical practitioner; (b) the address of the place of practice or provider number in respect of that place of practice; (c) the date of the referral; and (d) the period of referral (where other than for 12 months) expressed in months, e.g. "3", "6" or "18" months, or "indefinitely".

CF.1.3 Each account must also carry a certification by the accredited dental practitioner that:-

(i) the patient's eligibility certificate or identification card has been sighted (this can be done by quoting the number on the identification card); and

ii) the service was required for the treatment associated with the cleft condition.

CF.1.4 Where a practitioner wishes to apportion the total fee between the appropriate professional fee for the particular service and any balance outstanding in respect of services rendered previously, the practitioner should ensure that the balance is described in such a way (eg balance of account) that it cannot be mistaken as being a separate service. In particular no item number should be shown against the balance.

CF.1.5 Only one original itemised account should be issued in respect of any one medical service and any duplicates of accounts or receipts should be clearly marked "duplicate" and should be issued only where the original has been lost. Duplicates should not be issued as a routine system for "accounts rendered".

CF.1.6 Practitioners should note that payment of claims could be delayed or disallowed where it is not possible from account details to clearly identify the service as one which qualifies for Medicare benefits, or the practitioner as a registered medical practitioner at the address the service was rendered. Practitioners are therefore encouraged to provide as much detail as possible on their accounts, including Medicare Benefits Schedule item number and provider number.

CF.2 Claiming Benefits

CF.2.1 The patient, upon receipt of a practitioner's account, has three courses open for paying the account and receiving benefits as outlined below.

CF.3 Paid Accounts

CF.3.1 The patient may pay the account and subsequently present the receipt at a Medicare Office for assessment and payment of the Medicare benefit in cash.

CF.3.2 In these circumstances, where a claimant personally attends a Medicare Office to obtain a cash or EFT deposit for the payment of Medicare benefits, the claimant is not required to complete a Medicare Patient Claim Form (PC1).

CF.3.3 In circumstances where the claimant is seeking a cheque payment of the Medicare benefit or is arranging for an agent to receive the Medicare benefit on the claimant’s behalf, completion of a Medicare Patient Claim Form (PC1) is still required.

CF.4 Unpaid Accounts

CF.4.1 Where the patient has not paid the account, the unpaid account may be presented to Medicare with a Medicare claim form. In this case Medicare will forward to the claimant a benefit cheque made payable to the practitioner.

CF.4.2 It will be the patient's responsibility to forward the cheque to the practitioner and make arrangements for payment of the balance of the account if any. "Pay doctor" cheques involving Medicare benefits cannot be sent direct to practitioners or to patients at a practitioner's address (even if requested by the patient to do so). "Pay doctor" cheques will be forwarded to the claimant’s last known address.

CF.4.3 When issuing a receipt to a patient in respect of an account that is being paid wholly or in part by a Medicare "pay doctor" cheque the practitioner should indicate on the receipt that a "Medicare" cheque for $.....was involved in the payment of the account.

CF.5 Assignment of Benefits (Direct-Billing) Arrangements

CF.5.1 Under the Health Insurance Act the Assignment of Benefit (direct-billing) facility for professional services is available to all persons in Australia who are eligible for benefit under the Medicare program. This facility is NOT confined to pensioners or people in special need. If a practitioner direct-bills, the practitioner undertakes to accept the relevant Medicare

benefit as full payment for the service. Additional charges for that service (irrespective of the purpose or title of the charge) cannot be raised against the patient. Under these arrangements:-

- The patient's Medicare card number must be quoted on all direct-bill forms for that patient.
- The basic forms provided are loose leaf to enable the patient details to be imprinted from the Medicare card.
- The forms include information required by Regulations under Subsection 19(6) of the Health Insurance Act.
- The practitioner must cause the particulars relating to the professional service to be set out on the assignment form before the patient signs the form and cause the patient to receive a copy of the form as soon as practicable after the patient signs it.
- Where a patient is unable to sign the assignment form the signature of the patient's parent, guardian or other responsible person (other than the practitioner, practitioner's staff, hospital proprietor, hospital staff, residential aged care facility proprietor or residential aged care facility staff) is acceptable. The reason the patient is unable to sign should also be stated. In the absence of a "responsible person" the patient signature section should be left blank and in the section headed "Practitioner's Use" or on the back of the assignment form, an explanation should be given as to why the patient was unable to sign (eg unconscious, injured hand, etc) and this note should be signed or initialled by the doctor. If in the opinion of the practitioner the reason is of such a "sensitive" nature that revealing it would constitute an unacceptable breach of patient confidentiality or unduly embarrass or distress the recipient of the patient's copy of the assignment of benefits form, a concessional reason "due to medical condition" to signify that such a situation exists may be substituted for the actual reason. However, this should not be used routinely and in most cases it is expected that the reason given will be more specific.

CF.5.2 The administration of the direct-billing arrangements under Medicare as well as the payment of Medicare benefits on patient claims is the responsibility of Medicare Australia. Any enquiries in regard to these matters should therefore be directed to Medicare offices or enquiry points.

CF.5.3 Under Medicare any eligible dental practitioner can accept assignment of benefit and direct-bill for any eligible person.

CF.6 Use of Medicare Cards in Direct Billing

CF.6.1 An eligible person who applies to enrol for Medicare benefits (using a Medicare Enrolment/Amendment Application) will be issued with a uniquely numbered Medicare card which shows the Medicare card number, the patient identification number (reference number), the applicant's first given name, initial of second given name, surname and an effective "valid to" date. These cards may be issued on an individual or family basis. Up to 5 persons may be listed on the one Medicare card, and up to 9 persons may be listed under the one Medicare card number.

CF.6.2 The Medicare card plays an important part in direct billing as it can be used to imprint the patient details (including Medicare number) on the basic direct-billing forms. A special Medicare imprinter has been developed for this purpose and is available free of charge, on request, from Medicare.

CF.6.3 The patient details can of course be entered on the direct-bill forms by hand, but the use of a card to imprint patient details assists practitioners and ensures accuracy of information. The latter is essential to ensure that the processing of a claim by Medicare is expedited.

CF.6.4 The Medicare card number must be quoted on direct-bill forms. If the number is not available, then the assignment of benefit facility should not be used. To do so would incur a risk that the patient is not eligible and Medicare benefits not payable.

CF.6.5 Where a patient presents without a Medicare card and indicates that he/she has been issued with a card but does not know the details, the practitioner may contact a Medicare telephone enquiry number to obtain the number.

CF.7 Assignment of Benefit Forms

CF.7.1 To meet varying requirements the following types of stationery are available from Medicare. Note that these forms are approved forms under the Health Insurance Act, and no other forms can be used to assign benefits without the approval of Medicare Australia.

(a) *Form DB2.* This form is used to assign benefits for services other than requested pathology. It is loose leaf for imprinting and comprises a throw away cover sheet (after imprinting), a Medicare copy, a Patient copy and a Practitioner copy.

(b) *Form DB4.* Is a continuous stationery version of Form DB2, and has been designed for use on most office accounting machines.

CF.8 The Claim for Assigned Benefits (Form DB1, DB1H)

CF.8.1 Practitioners who accept assigned benefits must claim on Medicare using Form DB1 or DB1H, the Claim for Assigned Benefits. The DB1H form should be used where services are rendered to persons while hospital treatment is provided in a hospital or day hospital facility (other than Medicare hospital patients). Both forms have been designed to enable benefit for a claim to be directed to a practitioner other than the one who rendered the services. The facility is intended for use in situations such as where a short term locum is acting on behalf of the principal practitioner and setting the locum up with a provider number and pay-group link for the principal practitioner's practice is impractical. Practitioners should note that this facility cannot be used to generate payments to or through a person who does not have a provider number.

CF.8.2 The claim form must be accompanied by the Assignment forms to which the claim relates.
CF.8.3 Forms DB1 and DB1H are also loose leaf similar to form DB2 to enable imprinting of practitioner details using the special Medicare imprinter. For this purpose, practitioner cards showing the practitioner's name, practice address and provider number are available from Medicare on request.

CF.9 Direct-Bill Stationery
CF.9.1 Medical practitioners and eligible dental practitioners wishing to direct-bill may obtain direct-bill stationery by contacting any Medicare Office or by telephoning Medicare Australia on 132 150. Information on the completion of the forms and direct-bill procedures are provided with the forms. Information on direct-billing is available from any Medicare office.

CF.10 Time Limits Applicable to Lodgement of Claims for Assigned Benefits
CF.10.1 A time limit of six months applies to the lodgement of claims with Medicare under the direct-billing (assignment of benefit) arrangements. This means that Medicare benefits are not payable for any service where the service was rendered more than six months earlier than the date the claim was lodged with Medicare.
CF.10.2 Provision exists whereby in certain circumstances (eg hardship cases), the Minister may waive the time limits. Special forms for this purpose are available, if required, from the processing centre to which assigned claims are directed.

CG. COMPILATION AND INTERPRETATION OF THE SCHEDULE

CG.1 Compilation of the Schedule
CG.1.1 Section 2 of this Book lists the item number, description of medical service, the Schedule fee for those services in the treatment of cleft lip and cleft palate conditions for which Medicare benefits are payable and the Medicare benefits.
CG.1.2 The prescribed services have been grouped according to the general nature of the services: orthodontic, oral surgical and general and prosthodontic.

CG.2 Principles of Interpretation
CG.2.1 Each professional service listed in the Schedule is a complete medical service in itself. Where a service is rendered partly by one practitioner and partly by another, only the one amount of benefit is payable.

CG.3 Multiple Operation Rule
CG.3.1 The Schedule fee for two or more operations performed on a patient on the one occasion is calculated by the following rule:-

- 100% for the item with the greatest Schedule fee, plus 50% for the item with the next greatest Schedule fee, plus 25% for each other item.

NOTE:
1. Fees so calculated which result in a sum which is not a multiple of 5 cents are taken to the next higher multiple of 5 cents.
2. Where two or more operations performed on the one occasion have fees which are equal, one of these amounts shall be treated as being greater than the other or others of those amounts.
3. The Schedule fee for benefits purposes is the aggregate of the fees calculated in accordance with the above formula.

CG.3.2 The above rule does not apply to an operation which is one of two or more operations performed under the one anaesthetic on the same patient by different dental practitioners unless either practitioner assists the other. In this case, the fees and benefits specified in the Schedule apply. For these purposes the term “operation” includes items 75200- 75615.
CG.3.3 If the operation comprises a combination of procedures which are commonly performed together and for which a specific combined item is provided in the Schedule, it is regarded as the one item and service in applying the multiple operation rule.

CG.4 Administration of Anaesthetics by Medical Practitioners
CG.4.1 When a medical practitioner administers an anaesthetic in connection with a dental procedure prescribed for the payment of Medicare benefits (and the procedure has been performed by an eligible dental practitioner), Medicare benefits are payable for the administration of the anaesthetic on the same basis as if the procedure had been rendered by a medical practitioner.
CG.4.2 To ascertain the Schedule fee for the anaesthetic, medical practitioners should refer to Group T10 of the Medicare Benefits Schedule Book.

CG.5 Definitions
CG.5.1 Orthodontic treatment planning is defined as the measurement and analysis of the face and jaws and occlusion providing a diagnosis and planned prescription of appliances and treatment required.
CG.5.2 Study models are defined as orthodontic plaster casts of the upper and lower teeth and alveolar processes.

CG.6 Oral and Maxillofacial Surgical Services - Referral (75150 - 75621)

CG.6.1 Benefits are payable for items 75150 to 75621 only where the service has been rendered to a patient who has been referred by letter of Referral by a dental practitioner accredited for orthodontic services.

CG.7 General and Prosthodontic Services (75800)

CG.7.1 Item number 75800 refers to a consultation by a dentist for prevention and prophylaxis and includes such services as dietary advice, oral hygiene and fluoride treatment.

CG.8 Over-servicing

CG.8.1 Over-servicing must be avoided. In the case of denture services, examples of over-servicing might be:-

- Unjustifiably frequent replacement of dentures;
- Provision of new dentures when relining or re-modelling of an existing prosthesis would meet the clinical need;
- Provision of metal dentures where an acrylic denture would meet the clinical need.

CG.8.2 The Schedule includes an item for metal dentures to allow for the provision of a precise, long-term prosthesis. The item is not intended for use during the period of growth, where prostheses must be replaced or altered frequently, unless there is some definite and extraordinary clinical requirement.

	GROUP C1 - ORTHODONTIC SERVICES
	Note: In this Group, benefit is only payable where the service has been rendered to a patient by a dental practitioner who has been accredited by the Minister to provide orthodontic services, except for the services covered by Items 75009-75023 which may also be rendered by a dental practitioner approved by the Minister to provide oral surgical services.
	CONSULTATIONS
75001	INITIAL PROFESSIONAL ATTENDANCE in a single course of treatment by an accredited orthodontist **Fee:** $75.60 **Benefit:** 75% = $56.70 85% = $64.30
75004	PROFESSIONAL ATTENDANCE by an accredited orthodontist subsequent to the first professional attendance by the orthodontist in a single course of treatment **Fee:** $37.95 **Benefit:** 75% = $28.50 85% = $32.30
75006	PRODUCTION OF DENTAL STUDY MODELS (not being a service associated with a service to which item 75004 applies) prior to provision of a service to which: (a) item 75030, 75033, 75034, 75036, 75037, 75039, 75045 or 75051 applies; or (b) an item in Group T8 or Groups 03 to 09 applies; in a single course of treatment **Fee:** $67.40 **Benefit:** 75% = $50.55 85% = $57.30
	RADIOGRAPHY
75009	ORTHODONTIC RADIOGRAPHY orthopantomography (panoramic radiography), including any consultation on the same occasion **Fee:** $60.25 **Benefit:** 75% = $45.20 85% = $51.25
75012	ORTHODONTIC RADIOGRAPHY ANTEROPOSTERIOR CEPHALOMETRIC RADIOGRAPHY with cephalometric tracings OR LATERAL CEPHALOMETRIC RADIOGRAPHY with cephalometric tracings including any consultation on the same occasion **Fee:** $95.45 **Benefit:** 75% = $71.60 85% = $81.15
75015	ORTHODONTIC RADIOGRAPHY ANTEROPOSTERIOR AND LATERAL CEPHALOMETRIC RADIOGRAPHY, with cephalometric tracings including any consultation on the same occasion **Fee:** $131.25 **Benefit:** 75% = $98.45 85% = $111.60
75018	ORTHODONTIC RADIOGRAPHY ANTEROPOSTERIOR AND LATERAL CEPHALOMETRIC RADIOGRAPHY, with cephalometric tracings and orthopantomography including any consultation on the same occasion **Fee:** $167.20 **Benefit:** 75% = $125.40 85% = $142.15
75021	ORTHODONTIC RADIOGRAPHY hand-wrist studies (including growth prediction) including any consultation on the same occasion **Fee:** $205.05 **Benefit:** 75% = $153.80 85% = $174.30
75023	INTRAORAL RADIOGRAPHY - single area, periapical or bitewing film **Fee:** $41.05 **Benefit:** 75% = $30.80 85% = $34.90
	PRESURGICAL INFANT MAXILLARY ARCH REPOSITIONING
75024	PRESURGICAL INFANT MAXILLARY ARCH REPOSITIONING including supply of appliances and all adjustments of appliances and supervision - WHERE 1 APPLIANCE IS USED **Fee:** $530.30 **Benefit:** 75% = $397.75 85% = $466.40
75027	PRESURGICAL INFANT MAXILLARY ARCH REPOSITIONING including supply of appliances and all adjustments of appliances and supervision WHERE 2 APPLIANCES ARE USED **Fee:** $727.10 **Benefit:** 75% = $545.35 85% = $663.20
	DENTITION TREATMENT
75030	MAXILLARY ARCH EXPANSION not being a service associated with a service to which item 75039, 75042, 75045 or 75048 applies, including supply of appliances, all adjustments of the appliances, removal of the appliances and retention **Fee:** $647.50 **Benefit:** 75% = $485.65 85% = $583.60

ORTHODONTIC		ORTHODONTIC
75033	MIXED DENTITION TREATMENT - incisor alignment using fixed appliances in maxillary arch, including supply of appliances, all adjustments of appliances, removal of the appliances and retention **Fee:** $1,061.20 **Benefit:** 75% = $795.90 85% = $997.30	
75034	MIXED DENTITION TREATMENT - incisor alignment with or without lateral arch expansion using a removable appliance in the maxillary arch, including supply of appliances, associated adjustments and retention **Fee:** $540.10 **Benefit:** 75% = $405.10 85% = $476.20	
75036	MIXED DENTITION TREATMENT - lateral arch expansion and incisor alignment using fixed appliances in maxillary arch, including supply of appliances, all adjustments of appliances, removal of appliances and retention **Fee:** $1,465.75 **Benefit:** 75% = $1,099.35 85% = $1,401.85	
75037	MIXED DENTITION TREATMENT - lateral arch expansion and incisor correction - 2 arch (maxillary and mandibular) using fixed appliances in both maxillary and mandibular arches, including supply of appliances, all adjustments of appliances, removal of appliances and retention **Fee:** $1,846.05 **Benefit:** 75% = $1,384.55 85% = $1,782.15	
75039	PERMANENT DENTITION TREATMENT SINGLE ARCH (mandibular or maxillary) TREATMENT (correction and alignment) using fixed appliances, including supply of appliances - initial 3 months of active treatment **Fee:** $490.60 **Benefit:** 75% = $367.95 85% = $426.70	
75042	PERMANENT DENTITION TREATMENT - SINGLE ARCH (mandibular or maxillary) TREATMENT (correction and alignment) using fixed appliances, including supply of appliances - each 3 months of active treatment (including all adjustments and maintenance and removal of the appliances) after the first for a maximum of a further 33 months **Fee:** $183.40 **Benefit:** 75% = $137.55 85% = $155.90	
75045	PERMANENT DENTITION TREATMENT 2 ARCH (mandibular and maxillary) TREATMENT (correction and alignment) using fixed appliances, including supply of appliances - initial 3 months of active treatment **Fee:** $982.20 **Benefit:** 75% = $736.65 85% = $918.30	
75048	PERMANENT DENTITION TREATMENT - 2 ARCH (mandibular and maxillary) TREATMENT (correction and alignment) using fixed appliances, including supply of appliances - each subsequent 3 months of active treatment (including all adjustments and maintenance, and removal of the appliances) after the first for a maximum of a further 33 months **Fee:** $251.90 **Benefit:** 75% = $188.95 85% = $214.15	
75049	RETENTION, FIXED OR REMOVABLE, single arch (mandibular or maxillary) - supply of retainer and supervision of retention **Fee:** $294.75 **Benefit:** 75% = $221.10 85% = $250.55	
75050	RETENTION, FIXED OR REMOVABLE, 2-arch (mandibular and maxillary) - supply of retainers and supervision of retention **Fee:** $569.10 **Benefit:** 75% = $426.85 85% = $505.20	
	JAW GROWTH GUIDANCE	
75051	JAW GROWTH guidance using removable or functional appliances, including supply of appliances and all adjustments to appliances **Fee:** $873.65 **Benefit:** 75% = $655.25 85% = $809.75	

	GROUP C2 - ORAL AND MAXILLOFACIAL SERVICES
	Note: (i) In this Group, benefit is only payable where the service has been rendered to a patient who has been referred by an accredited orthodontist. ***(ii) While benefit is payable for simple extractions performed by a registered dental practitioner, benefit is only payable for surgical extractions and other surgical procedures where the service is rendered by a dental practitioner who has been approved by the Minister to provide oral surgical services. (see para CB1.5)***
	CONSULTATIONS
75150	INITIAL PROFESSIONAL attendance in a single course of treatment by an accredited oral and maxillofacial surgeon where the patient is referred to the surgeon by an accredited orthodontist *(See para CG of explanatory notes to this Category)* **Fee:** $75.60 **Benefit:** 75% = $56.70 85% = $64.30
75153	PROFESSIONAL ATTENDANCE by an accredited oral and maxillofacial surgeon subsequent to the first professional attendance by the surgeon in a single course of treatment where the patient is referred to the surgeon by an accredited orthodontist *(See para CG of explanatory notes to this Category)* **Fee:** $37.95 **Benefit:** 75% = $28.50 85% = $32.30
75156	PRODUCTION OF DENTAL STUDY MODELS (not being a service associated with a service to which item 75153 applies) prior to provision of a service: (a) to which item 52321, 53212 or 75618 applies; or (b) to which an item in the series 52330 to 52382, 52600 to 52630, 53400 to 53409 or 53415 to 53429 applies; in a single course of treatment *(See para CG of explanatory notes to this Category)* **Fee:** $67.40 **Benefit:** 75% = $50.55 85% = $57.30
	SIMPLE EXTRACTIONS
75200	REMOVAL OF TOOTH OR TOOTH FRAGMENT not being treatment to which item 75400, 75403, 75406, 75409, 75412 or 75415 applies *(See para CG of explanatory notes to this Category)* **Fee:** $48.55 **Benefit:** 75% = $36.45 85% = $41.30
75203	REMOVAL OF TOOTH OR TOOTH FRAGMENT under general anaesthesia *(See para CG of explanatory notes to this Category)* **Fee:** $72.85 **Benefit:** 75% = $54.65 85% = $61.95
75206	REMOVAL OF EACH ADDITIONAL TOOTH OR TOOTH FRAGMENT at the same attendance at which a service to which item 75200 or 75203 applies is rendered *(See para CG of explanatory notes to this Category)* **Fee:** $24.15 **Benefit:** 75% = $18.15 85% = $20.55
	SURGICAL EXTRACTIONS
75400	SURGICAL REMOVAL OF ERUPTED TOOTH *(See para CG of explanatory notes to this Category)* **Fee:** $145.65 **Benefit:** 75% = $109.25 85% = $123.85
75403	SURGICAL REMOVAL OF TOOTH with soft tissue impaction *(See para CG of explanatory notes to this Category)* **Fee:** $167.20 **Benefit:** 75% = $125.40 85% = $142.15
75406	SURGICAL REMOVAL OF TOOTH with partial bone impaction *(See para CG of explanatory notes to this Category)* **Fee:** $190.55 **Benefit:** 75% = $142.95 85% = $162.00
75409	SURGICAL REMOVAL OF TOOTH with complete bone impaction *(See para CG of explanatory notes to this Category)* **Fee:** $215.85 **Benefit:** 75% = $161.90 85% = $183.50

75412	SURGICAL REMOVAL OF TOOTH FRAGMENT involving soft tissue only *(See para CG of explanatory notes to this Category)* **Fee:** $120.55	**Benefit:** 75% = $90.45	85% = $102.50
75415	SURGICAL REMOVAL OF TOOTH FRAGMENT involving bone *(See para CG of explanatory notes to this Category)* **Fee:** $145.65	**Benefit:** 75% = $109.25	85% = $123.85
	OTHER SURGICAL PROCEDURES		
75600	SURGICAL EXPOSURE, STIMULATION AND PACKING OF UNERUPTED TOOTH *(See para CG of explanatory notes to this Category)* **Fee:** $205.05	**Benefit:** 75% = $153.80	85% = $174.30
75603	SURGICAL EXPOSURE OF UNERUPTED TOOTH for the purpose of fitting a traction device *(See para CG of explanatory notes to this Category)* **Fee:** $241.00	**Benefit:** 75% = $180.75	85% = $204.85
75606	SURGICAL REPOSITIONING OF UNERUPTED TOOTH *(See para CG of explanatory notes to this Category)* **Fee:** $241.00	**Benefit:** 75% = $180.75	85% = $204.85
75609	TRANSPLANTATION OF TOOTH BUD *(See para CG of explanatory notes to this Category)* **Fee:** $359.75	**Benefit:** 75% = $269.85	85% = $305.80
75612	SURGICAL PROCEDURE for intra oral implantation of osseointegrated fixture (first stage) *(See para CG of explanatory notes to this Category)* **Fee:** $445.25	**Benefit:** 75% = $333.95	85% = $381.35
75615	SURGICAL PROCEDURE FOR FIXATION of trans-mucosal abutment (second stage of osseointegrated implant) *(See para CG of explanatory notes to this Category)* **Fee:** $164.80	**Benefit:** 75% = $123.60	85% = $140.10
	OTHER		
75618	PROVISION AND FITTING OF A BITE RISING APPLIANCE or DENTAL SPLINT for the management of temporomandibular joint dysfunction syndrome *(See para CG of explanatory notes to this Category)* **Fee:** $204.70	**Benefit:** 75% = $153.55	85% = $174.00
75621	THE PROVISION AND FITTING OF SURGICAL TEMPLATE in conjuction with orthognathic surgical procedures in association with: (a) an item in the series 52342 to 52375; or (b) item 52380 or 52382 *(See para CG of explanatory notes to this Category)* **Fee:** $204.70	**Benefit:** 75% = $153.55	85% = $174.00

	GROUP C3 - GENERAL AND PROSTHODONTIC SERVICES		
	Note: Benefit is payable for services listed in this Group where they are rendered by a State registered dental practitioner		
	CONSULTATIONS		
75800	ATTENDANCE BY AN ELIGIBLE DENTAL PRACTITIONER involving consultation, preventive treatment and prophylaxis, of not less than 30 minutes' duration each attendance to a maximum of 3 attendances in any period of 12 months **Fee:** $72.85	**Benefit:** 75% = $54.65	85% = $61.95
	PROSTHODONTIC		
75803	PROVISION AND FITTING OF ACRYLIC BASE PARTIAL DENTURE, including retainers 1 TOOTH **Fee:** $291.40	**Benefit:** 75% = $218.55	85% = $247.70
75806	2 TEETH **Fee:** $341.75	**Benefit:** 75% = $256.35	85% = $290.50
75809	3 TEETH **Fee:** $404.65	**Benefit:** 75% = $303.50	85% = $344.00
75812	4 TEETH **Fee:** $449.65	**Benefit:** 75% = $337.25	85% = $385.75
75815	5 TO 9 TEETH **Fee:** $548.65	**Benefit:** 75% = $411.50	85% = $484.75
75818	10 TO 12 TEETH **Fee:** $647.50	**Benefit:** 75% = $485.65	85% = $583.60
75821	PROVISION AND FITTING OF CAST METAL BASE (cobalt chromium alloy) PARTIAL DENTURE including casting and retainers 1 TOOTH **Fee:** $521.50	**Benefit:** 75% = $391.15	85% = $457.60
75824	2 TEETH **Fee:** $602.50	**Benefit:** 75% = $451.90	85% = $538.60
75827	3 TEETH **Fee:** $692.50	**Benefit:** 75% = $519.40	85% = $628.60
75830	4 TEETH **Fee:** $764.45	**Benefit:** 75% = $573.35	85% = $700.55
75833	5 TO 9 TEETH **Fee:** $935.20	**Benefit:** 75% = $701.40	85% = $871.30
75836	10 TO 12 TEETH **Fee:** $1,070.10	**Benefit:** 75% = $802.60	85% = $1,006.20
75839	PROVISION AND FITTING OF RETAINERS not being a service associated with a service to which item 75803, 75806, 75809, 75812, 75815, 75818, 75821, 75824, 75827, 75830, 75833 or 75836 applies each retainer **Fee:** $24.15	**Benefit:** 75% = $18.15	85% = $20.55
75842	ADJUSTMENT OF PARTIAL DENTURE not being a service associated with a service to which item 75803, 75806, 75809, 75812, 75815, 75818, 75821, 75824, 75827, 75830, 75833 or 75836 applies **Fee:** $36.00	**Benefit:** 75% = $27.00	85% = $30.60
75845	RELINING OF PARTIAL DENTURE by laboratory process and associated fitting **Fee:** $179.95	**Benefit:** 75% = $135.00	85% = $153.00

GENERAL AND PROSTHODONTIC		GENERAL AND PROSTHODONTIC
75848	REMODELLING AND FITTING OF PARTIAL DENTURE of more than 4 teeth **Fee:** $215.85 **Benefit:** 75% = $161.90 85% = $183.50	
75851	REPAIR TO CAST METAL BASE OF PARTIAL DENTURE 1 or more points **Fee:** $107.90 **Benefit:** 75% = $80.95 85% = $91.75	
75854	ADDITION OF A TOOTH OR TEETH to a partial denture to replace extracted tooth or teeth including taking of necessary impression **Fee:** $107.90 **Benefit:** 75% = $80.95 85% = $91.75	