Australian Government
Department of Health and Aged Care

Guide to the Child Dental Benefits Schedule (CDBS)

Version 12

Effective 1 January 2024

Important Information

This guide is for dental practitioners and explains the arrangements and requirements for the CDBS

This guide is not a legal document

In cases of discrepancy, the legislation will be the source document for the requirements of the program.

This guide is periodically updated. For the most current version of the guide please refer to Services Australia's website:
www.servicesaustralia.gov.au/individuals/services/medicare/child-dental-benefits-schedule

Contents

What is the CDBS?

The CDBS is a program for eligible children that provides up to $1,095 in benefits (the benefit cap) over a relevant two calendar year period for basic dental services.

Services that receive a benefit under the program include examinations, x-rays, cleaning, fissure sealing, fillings, root canals, extractions and partial dentures. The full list of services is listed alongside item numbers, description, benefit amounts and applicable restrictions in the Dental Benefits Schedule (Attachment A).

Services can be provided in a public or private setting. However, benefits are not available for orthodontic, cosmetic dental work or any services provided in a hospital.

Claims under the CDBS are processed by Services Australia.

Which children are eligible for dental services?

A child is eligible if they are:

- eligible for Medicare, and
- aged 0-17 years at any point in the calendar year, and
- receive a relevant Australian government payment, such as Family Tax Benefit Part A, at any point in the calendar year.

Services Australia assesses a child's eligibility from the start of each calendar year and routinely check for newly eligible children. A notification of eligibility will be sent to the child or their parent/guardian either by post or electronically through MyGov.

It is optional for a parent/guardian or patient to present this notification to the practice at the time of the appointment.

How long does eligibility last?

Once a child has been assessed as eligible, they are eligible for that entire calendar year (even if they turn 18) or stop receiving the relevant government payment. However, they must be eligible for Medicare on the day the service is provided.

How do I check if a patient is eligible?

You can check a child's eligibility online through Health Professional Online Services or by calling Services Australia on 132 150 (call charges may apply).

How does the patient's benefit cap work?

The amount of dental benefits available to an eligible patient is capped per eligible patient over two consecutive calendar years. This maximum amount of dental benefits is known as the benefit cap and the two consecutive calendar years is known as the relevant two year period.

The relevant two year period commences from the calendar year in which the patient first receives an eligible dental service. For example, if the patient's first dental service is on 15 May 2024, the relevant two year period will be the entire 2024 calendar year and, if the patient is eligible the following year, the entire 2025 calendar year. If the patient is eligible in 2025 or a later year they will then have access to a new benefit cap.

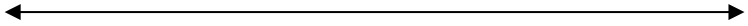
A patient's entire benefit cap can be used in the first year if needed. If the entire benefit cap is not used in the first year, the balance can be used in the following year if the child is still eligible.

Scenario 1: If a child receives CDBS services and benefits to the value of $550 in 2024, then in 2025 if they are still eligible for the CDBS they can receive more dental services and benefits to the value of $545.

Scenario 2: If the child receives all of the services in 2024 they would reach their $1,095 benefit cap in first year of the relevant two year period, and would have to wait until 2025 before they can access a new benefit cap.

The relevant two year period of a patient who receives their first service in 2024

Benefit cap of $1,095 over two consecutive calendar years.



2024	2025	2026
First year services are provided.	Second year where the patient can access any remaining balance if they are still eligible.	The patient will have access to a new benefit cap starting from this year, if they are eligible.

Any balance remaining at the end of the relevant two year period cannot be used to fund services that are provided outside that period. A new benefit cap will become available only if the relevant two year period has elapsed and the child is eligible in a following year.

A patient's benefit cap can only be used for eligible services provided to that patient: family members cannot share their entitlements.

What happens when the benefit cap is reached?

Once a patient reaches their benefit cap over the relevant two year period, no further benefits are payable in that benefit cap period.

This means that, where a patient is charged for a dental service that would take the patient over the benefit cap, only the amount of unused benefits will be paid for that service.

For example, if a patient has only $51.50 remaining in their benefit cap and is provided a service that has a benefit of $115.45 in the Dental Benefits Schedule:

If this service is bulk billed (see the 'How do I charge, and bill/claim for dental services?' section of this guide), the dental provider will only receive $51.50 for this service and the dental provider cannot charge the patient anything further for the service.

If this service is not bulk billed (privately billed), the patient will need to pay the dental provider the amount charged for the service and the patient will only be able to receive a benefit of $51.50 for the service. In this case, the costs not covered by the available benefit are paid by the patient.

Services Australia can tell you how much is left in your patient's benefit cap, to allow you to plan treatment and advise patients of any out-of-pocket costs accordingly.

How do I check a patient's cap balance?

A patient's benefit cap balance can be checked online through Health Professional Online Services or by phoning Services Australia on 132 150 (call charges may apply). It is recommended that you check the cap balance at each visit.

Am I eligible to provide services under the CDBS?

You can provide services under the CDBS if you are a registered dental practitioner. This includes if you are a:

- Dentist,
- Dental hygienist,
- Dental therapist,
- Dental prosthetist, and
- Oral health therapist.

The division you are registered in will determine whether you can directly claim for services you have provided, if you can claim for services provided by other dental practitioner, or if you can only provide services on behalf of a dentist.

Your scope of practice depends on your education, qualifications, training, experience and competence. You are expected to know your scope of practice and not provide services that exceed it.

Am I eligible to directly claim for CDBS services that I have provided?

You are eligible to directly claim for CDBS services that you have provided if you are a:

- Dentist, or
- Dental hygienist, dental therapist, or oral health therapist who is opting in to directly claim for services you provide, and
- have a Medicare provider number that you are using to claim for CDBS services that you have provided.

If you satisfy these criteria are referred to as a dental provider throughout this document.

Am I eligible to claim for CDBS services provided by another dental practitioner?

If you are a dentist, you may claim for CDBS services provided on your behalf by a dental hygienist, dental therapist, dental prosthetist, or oral health therapist.

All services provided under this arrangement must be performed in accordance with relevant state and territory law, conform to accepted dental practice and be provided under appropriate supervision or oversight.

Under this arrangement, the dentist is the dental provider and claims can be submitted for services provided on their behalf using their Medicare provider number.

Specific arrangements for public sector dental practitioners

If you are a dental practitioner providing services in the public sector, you may provide services on behalf of a representative public dentist. Under this arrangement all services must be bulk billed and are claimed under the Medicare provider number of the relevant representative public dentist.

For more information, you should contact the relevant Department of Health in your state or territory.

Specific arrangements for dental hygienists, dental therapists and oral health therapists

From 1 July 2022, dental hygienists, dental therapists, oral health therapists can opt-in to access Medicare provider numbers to directly claim for certain services under the CDBS. The services that may be are listed in the Dental Benefits Schedule (Attachment A).

In addition, dental hygienists, dental therapists, dental prosthetists, and oral health therapists are eligible to provide CDBS services on behalf of a dentist.

Specific arrangements for Dental Prosthetists

Dental prosthetists may only claim by providing CDBS services on behalf of a dentist.

How do I apply for a Medicare provider number?

To claim for services, dental providers need to have a Medicare provider number linked to the location where the CDBS services will be provided.

Eligible dental practitioners apply for an initial Medicare provider number by completing the HW093 form and returning the form to Services Australia. Subsequent Medicare provider numbers can be applied for through Health Professional Online Services portal. Services Australia will send you a letter with your provider numbers for each of your new practice locations. You need this letter before you can provide CDBS services. You can also manage your provider numbers, practice details and locations through the Health Professional Online Services portal.

There are specific claiming arrangements for dental practitioners who work in public dental clinics. Information on those arrangements can be obtained from state and territory government dental services.

What dental services are covered by the CDBS?

The CDBS provides benefits for a range of basic dental services.

Each service that can receive a benefit has its own item number. These items and associated descriptors, restrictions and benefits are set out in the Dental Benefits Schedule (Attachment A).

The Dental Benefits Schedule is based on the Australian Dental Association Australian Schedule of Dental Services and Glossary, 12th Edition. The CDBS dental items use an additional two-digit prefix of 88. For example, the CDBS item 88011 corresponds to Australian Dental Association item 011.

There are some differences between the Dental Benefits Schedule and the Australian Dental Association Schedule.

You need to read the Dental Benefits Schedule carefully before providing CDBS services to ensure you use the correct item number; that this number coincides with the service you have provided and that you have understood any restrictions or limitations that apply to providing that service.

Clinically relevant services

The *Dental Benefits Act 2008* requires that for a dental benefit to be payable a service must be ‘clinically relevant’. A ‘clinically relevant’ service means a service that is generally accepted in the dental profession as being necessary for the appropriate care or treatment of the patient to whom it is rendered.

Hospital services

Dental benefits are not payable where the person requires dental services in a hospital.

Limits on individual services

Many of the dental items have specific limitations or rules unique to the CDBS (for example, frequency of the service, linkages between items, restrictions on who can claim for the dental service, and other conditions on claiming).

Limits and rules are set out in the individual item descriptors in the Dental Benefits Schedule (Attachment A).

Restorative services / fillings

Under the CDBS, only one metallic or adhesive restoration (88511-88535) can be claimed per tooth per day. Restorations can only be claimed using the relevant item that represents the number of restored surfaces that were placed on that day – this includes if separate restorations are placed on different surfaces of the tooth on that day.

If multiple restorations are placed on the same surface on the same day, that surface can only be counted once.

For example, if two separate two-surface fillings are placed on the same day, but one of the surfaces is common between them, only a three-surface filling can be claimed as three surfaces in total have been restored.

When two materials are used in the same restoration, the predominant material type should be used for claiming the restoration. For example, if:

- one metallic two-surface filling is provided; and
- one adhesive one-surface filling is done on a separate, third surface of the same tooth on the same day; then
- only a three-surface metallic filling can be claimed.

This is because three surfaces in total have been restored and the predominant material used is metallic.

Sedation

The CDBS provides benefits for intravenous sedation (88942) and inhalation sedation (88943) but these items are used differently compared to the Australian Dental Association Schedule.

Under the CDBS, intravenous sedation can be claimed only once in a twelve month period.

For inhalation sedation, the sedative gas to be used is specified as nitrous oxide mixed with oxygen. A benefit is not payable for the use of other sedative gases.

Do I have to quote for services?

Since many CDBS patients are from financially disadvantaged families, it is important that they are informed of the likely costs so they can plan for any out-of-pocket costs.

If you wish to participate in the CDBS it is a requirement of the program that you inform the patient or the patient's parent/guardian of the proposed costs of treatment as well as the dental practice's proposed billing arrangements.

Prior to performing any services, you must have a discussion with the patient or the patient's parent/guardian about:

- the proposed treatment;
- the likely treatment costs, including out-of-pocket costs; and
- the billing arrangements of the practice (i.e. bulk billed).

After you have informed the patient or the patient's parent/guardian of the likely treatment and costs, you must obtain consent from the patient or patient's parent/guardian to both the treatment and costs before commencing any treatment.

Consent from the patient or the patient's parent/guardian needs to be recorded in writing before the end of the appointment, either through an Informed Financial Consent- Bulk Billing Patient Consent Form or an Informed Financial Consent- Non-Bulk Billing Patient Consent Form (see the 'When and what Patient Consent Form needs to be used?' section of this guide).

If you fail to obtain and document consent for services, these services will not comply with the legal requirements of the program.

When should I inform the patient?

It is the responsibility of the billing/claiming dental provider that the patient or the patient's parent/guardian is informed of the likely costs before commencing any CDBS service including examinations, diagnostic services and emergency treatment. This includes services rendered by a dental hygienist, oral health therapist, dental prosthetist or dental therapist on behalf of a dentist. If the dentist has another eligible dental practitioner perform the service, the dentist must ensure compliance by that other practitioner.

For example, in the case of an initial examination, the patient or the patient's parent/guardian needs to be informed that an examination will be performed and the likely cost of the examination and consent is obtained for the dental provider to proceed. If, subsequent to that examination, further services are required, the patient or the patient's parent/guardian needs to be informed of what services are required and the likely cost, and further consent must be given prior to the provision of those subsequent services.

All instances of patient consent must be documented. Instances of consent can be documented together on a single consent form on the day of treatment (see the 'When and what Patient Consent Form needs to be used?' section of this guide).

Examples of informed consent

The following examples are of appointments with an ongoing conversation around treatment, cost and consent that would comply with all the provider requirements for obtaining and recording informed financial consent under the CDBS.

Conversations on treatment, cost and consent will vary. It is the responsibility of the billing/claiming dental provider to ensure information provided to the patient and consent provided by the patient is sufficient to ensure the patient can appropriately consider signing the consent form.

Example of an appointment with Bulk Billed Services

Process	Example conversation
On arriving at a practice for the first time, a new patient is informed by the receptionist/dental assistant that they will undergo an initial examination, which costs $X and will be bulk billed under the CDBS. The receptionist/assistant informs the patient that this exam may lead to the dentist recommending other treatment.	Receptionist: "…the check-up costs $X and if the dentist finds anything that needs treatment, she'll let you know. We bulk bill, which means you will not be charged for services as long as you have money left in your benefit cap."
The patient verbally consents to the exam and the associated cost.	Patient: "That's fine."

Process	Example conversation
In the chair, the dentist does the exam and advises that further x-rays should be done. The dentist explains what the x-rays are and that they would cost around $X and be bulk billed. The dentist informs the patient that the x-rays might indicate that further treatment is required.	Dentist: “There’s something wrong with this tooth – I’ll need to x-ray it and then I might need to do a filling. The x-ray costs about $X but we bulk bill.”
The patient verbally consents to the x-rays and the associated cost.	Patient: “Okay.”
Based on the x-rays, the dentist considers that some restorative services are required. The dentist explains what those services are (e.g. fillings etc.) and advises that this costs around $X and will be bulk billed.	Dentist: “It turns out that the tooth does need a filling, which will cost $X but we’ll bulk bill you.”
The patient verbally consents to the restorative treatment and cost.	Patient: “I understand – let’s do it.”
The patient returns to reception after all services are completed for that visit then reads and signs a single Bulk Billing Patient Consent Form, which confirms that they have understood and agreed to the services, charges and billing arrangements for that visit.	Receptionist: “So as we discussed, we bulk bill and you won’t need to pay anything. Please read and sign this patient consent form to show that you agree/d to the treatment and associated costs so we can bulk bill you.” Patient: “No problem.” Signs the consent form.

Example of an appointment with Non-Bulk Billed (privately billed) services

Process	Example conversation
On arriving at a practice for the first time, a new patient is informed by the receptionist/dental assistant that they will undergo an initial examination. The practice charges the same as the available benefit under the CDBS. The receptionist/assistant informs the patient that this exam may lead to the dentist recommending other treatment.	Receptionist: “…the check-up costs $X, which is fully covered by the CDBS benefit. If the dentist finds anything that needs treatment during the check-up, she’ll let you know about any additional costs.”
The patient verbally consents to the exam and the associated cost.	Patient: “That’s fine.”

Process	Example conversation
In the chair, the dentist does the exam and advises that further x-rays should be done. The dentist explains what the x-rays are and that the practice charges $X, which is the same as the available benefit under the CDBS. The dentist informs the patient that the x-rays might indicate that further treatment is required.	Dentist: “There’s something wrong with this tooth – I’ll need to x-ray it and then I might need to do a filling. The x-ray costs $X, which is covered by the CDBS. I’ll talk to you about any further treatment and costs once I have a look at the x-ray.
The patient verbally consents to the x-rays and the associated cost.	Patient: “Okay.”
Based on the x-rays, the dentist considers that some restorative services are required. The dentist explains what those services are (e.g. fillings etc.) and advises that the practice charges $X, which is more than the available benefit under the CDBS, meaning the patient will have to pay an out-of-pocket.	Dentist: “It turns out that the tooth does need a filling, which will cost $X. The benefit under the CDBS is $Y. This means that you will have to pay an out-of-pocket of $Z for the filling.”
The patient verbally consents to the restorative treatment and cost.	Patient: “I understand – let’s do it.”
The patient returns to reception after all services are completed for that visit and signs a single Non-Bulk Billing Patient Consent Form, which confirms that they have understood and agreed to the services, charges and billing arrangements for that visit.	Receptionist: “So as we discussed, we charge more than the benefits available under the CDBS for some services, this means you will have to pay an out-of-pocket. Please read and sign this patient consent form to show that you agree/d to the treatment and associated costs so we can bill you.” Patient: “No problem.” Signs the consent form.

How should the patient be informed?

How you choose to inform patients of the likely costs and payment procedures is ultimately a decision for you. Reception staff can have preliminary conversations, for example about whether you bulk bill and the cost of examinations. If it suits you, reception staff can also finalise the consent paperwork. Patients will still need to be informed of any treatment identified in the chair and the associated costs, and consent must still be obtained prior to providing the services.

It is not required, but you may choose to summarise this information in writing and provide it to the patient or the patient’s parent/guardian for consideration before treatment.

Regardless of what arrangements a practice puts in place to manage the CDBS consent process, it is the responsibility of the billing/claiming dental provider that the consent requirements are met.

How does patient consent need to be recorded?

Consent to treatment and costs must be recorded in writing by the patient or the patient’s parent/guardian by signing a patient consent form. Consent forms are available for

download, the link to these forms is available from the Services Australia website CDBS for health professionals - dental practitioner requirements - Services Australia.

There are different forms for bulk billed and non-bulk billed services.

If you privately bill the patient, you need to obtain a signed consent form each day that you provide a service to the patient. If you bulk bill, you only need to obtain a signed consent form on the first visit in the calendar year.

When and what Patient Consent Form needs to be used?

Non-bulk billed services

You must use the Informed Financial Consent- Non-Bulk Billing Patient Consent Form in instances where you bill the patient for services under the CDBS.

In such instances, you must ensure the patient or the patient's parent/guardian is aware of and agrees to the likely out-of-pocket costs they will be charged at each dental appointment for CDBS services.

The Informed Financial Consent- Non-Bulk Billing Patient Consent Form must be completed on each day of service provision under the program.

See Attachment B at the back of this guide for an example of an Informed Financial Consent- Non-Bulk Billing Patient Consent Form.

Bulk billed services

When you choose to bulk bill CDBS services and the patient or the patient's parent/guardian signs an 'assignment of benefit form', you must record consent through the Informed Financial Consent- Bulk Billing Patient Consent Form on the first day of service in a calendar year.

For each day of service provision thereafter in the calendar year, you still have to advise the patient or the patient's parent/guardian of the likely treatment and that services will be bulk billed before commencing treatment. However, it is not mandatory for you to record this consent through a patient consent form. The patient consent form from the first visit will apply for the entire calendar year as long as the patient is bulk billed.

See Attachment C at the back of this guide for an example of an Informed Financial Consent- Bulk Billing Patient Consent Form.

Translated Patient Consent Forms

The Non-Bulk Billing and Bulk Billing Patient Consent Forms have now been translated into 20 community languages and are available from Services Australia's website CDBS for health professionals - dental practitioner requirements - Services Australia

How do I charge, and bill/claim for dental services?

Deciding what to charge the patient

Like providers under Medicare, private dental providers are free to set their own fees for services. You may choose to either:

- bulk bill the patient (see the 'Bulk billing' section of this guide); or
- charge the patient (dental providers set their own fee and charges the patient directly).

If you directly charge the patient an amount above the CDBS benefit for a service, additional charges have to be met by the patient.

How to seek payment for a service

You can bill CDBS patients in the following ways.

Bulk billing

In the case of bulk billing, you accept the relevant CDBS benefit as full payment for the service.

By law, you cannot charge the patient a co-payment of any kind for a bulk billed service.

Patient claim

At the end of a visit, you can request the patient to pay, in full, for the services provided. You will need to provide the patient with an itemised account/receipt containing all of the necessary details (see the 'What information must be included in billing/claiming for services?' section of this guide) so that they can claim the benefit from Medicare.

Your patient can then **claim the benefit** from Services Australia.

At the end of a visit, you can provide the patient with an itemised account (invoice) for the services provided. The account must contain all of the information listed in the 'What information must be included in billing/claiming for services?' section in this guide.

In this case, the patient does not pay for the service at the time of the visit. Instead, the patient takes or sends the unpaid account to Medicare for a benefits cheque to be issued in your name (for the total benefit payable to the patient for the service).

It is then the patient's responsibility to provide the Medicare cheque to you and pay the balance of the account, if any. When the patient presents your cheque and any balance and you issue a receipt, you should indicate on the receipt that a 'Medicare cheque for $…. was included in the payment of the account'.

How to lodge a claim

Electronic claiming

Dental providers can lodge claims electronically with Services Australia.

The claiming channel you choose can make a big difference to your practice's productivity, cash-flow and patient service. The many benefits associated with moving from manually lodging claims to using electronic claiming include:

- less paperwork and faster payment;
- streamlined billing processes;
- increased cash-flow;
- greater patient satisfaction; and
- processing both Patient and Bulk Bill claims.

Services Australia offers a choice of:

- Medicare Online; and
- Medicare Easyclaim.

To discuss electronic claiming options that would suit your practice, you can contact the eBusiness Service Line on 1800 700 199 (calls from mobile phones may be charged at a higher rate). The eBusiness Service Line is available Monday to Friday, between 8.30 am and 5.00 pm, Australian Eastern Standard Time.

More information about the different types of online claiming and the benefits is available at the Services Australia website CDBS for health professionals – Claiming – Services Australia

Manual claiming

If you are unable to submit an electronic claim, approved bulk billing/Medicare claim forms can be ordered using the Medicare stationery order form (DB6Ba).

It is recommended that you submit manual claims as soon as possible after the patient visit.

What information must be included in billing/claiming for services?

There are requirements on the information that needs to be on the account or receipt in order for the claim to be paid. A valid account or receipt needs to include:

- the patient's name;
- the date of service;
- the item number in the Dental Benefits Schedule that corresponds to the service;
- the dental provider's name and provider number; and
- the amount charged in respect of the service, total amount paid and any amount outstanding in relation to the service.

For bulk billed services, a Medicare approved bulk billing form must be used. The form requires:

- the patient's name;
- the date of service;
- the item number in the Dental Benefits Schedule that corresponds to the service;
- the dental provider's name and provider number; and
- the amount of the dental benefit being assigned to the dental provider.

Record Keeping

Dental providers must maintain adequate records for four years from the date of service including:

- patient consent form(s); and
- clinical notes (including noting the particular tooth or teeth a CDBS service relates to, where relevant).
- Any other relevant document/s such as itemised accounts or receipts verifying the service(s) claimed where provided should also be retained.

What billing/claiming practices are not permitted?

You cannot bill/claim before services are provided

Under the CDBS, patients cannot be charged for a service until it has been provided. That is, dental providers cannot charge patients for services that are identified as needed later but have not yet been provided. This includes taking a deposit for a proposed service.

For example, a benefit for dentures cannot be claimed until the dentures have been provided to the patient.

You cannot bill/claim for services that are not clinically relevant

The CDBS cannot pay benefits for a service that is not 'clinically relevant'. 'Clinically relevant' means a service that is generally accepted in the dental profession as being necessary for the appropriate care or treatment of the patient to whom it is rendered. If a dental practitioner chooses to use a procedure that is not generally accepted in their profession as necessary for the treatment of the patient, the cost of this procedure cannot be included in the fee for a CDBS item.

Treatment that is predominantly for the improvement of the appearance of the patient (i.e. cosmetic) is not considered clinically relevant and cannot be claimed.

You cannot substitute items

The account you issue to a patient must truly reflect the services provided.

The CDBS only covers basic dental care. Services that are not part of the Schedule and not eligible for a benefit cannot be claimed under the program. Patients may pay for ineligible services privately, for example with the assistance of private health insurance.

The benefit entitlement cannot be shared

Each eligible patient has access to a benefit entitlement, capped over a relevant two year period. The benefit cap applies to each child individually, and benefit caps cannot be shared between children (for example, between siblings in a family).

Consequences of non-compliance

Where a benefit for a CDBS service has been incorrectly paid, the Department of Health and Aged Care may request recovery of that benefit from the practitioner concerned. Beyond the recovery of benefits, making or authorising false or misleading statements relating to dental benefits is an offence, and penalties including fines and imprisonment (in the case of deliberately misleading statements) may apply

Can private health insurance be used for CDBS services?

Patients with private health insurance covering dental services cannot claim a benefit from both the private health insurer and the CDBS for the same dental service. Patients cannot use private health insurance to ‘top up’ the CDBS benefit they have received for a service. However, private health insurance can be used for any services not provided under the program, but these items must be billed separately.

Where do I get more information?

For further information visit the Services Australia website or phone Services Australia on 132 150 (call charges may apply).

Glossary

Benefit cap means the amount of dental benefits available to eligible patients is capped per eligible patient over two consecutive calendar years. This maximum amount of dental benefits is known as the benefit cap. (see the 'How does the patient's benefit cap work?' section of this guide).

Bulk billing is where the patient assigns the available benefit for the service to the dental practitioner and the dental practitioner accepts the benefit as full payment. As the dental practitioner accepts the available benefit as full payment, a co-payment cannot be charged to the patient.

Dental practitioner means a person who is registered under the National Law in the dental profession. This includes dentists, dental therapists, dental hygienists, dental prosthetists, and oral health therapists.

Dental provider refers to a dentist, dental hygienist, dental therapist, or oral health therapist, who has been allocated a Medicare provider number, and uses that number to directly bill for services under the CDBS (see the 'Am I eligible to provide CDBS services?' section of this guide).

Note: when a dentist claims for services rendered by a dental hygienists, dental therapist, dental prosthetists, or oral health therapist, on their behalf, the dentist is the dental provider (see the 'Who can perform services on behalf of a dentist or dental specialist?' subsection of this guide).

Eligible patient means a person who is deemed eligible for the CDBS (see the 'Which children are eligible for dental services?' section of this guide).

Eligible service means an item in the Dental Benefits Schedule that can receive a benefit under the CDBS. See Attachment A for the Dental Benefits Schedule for a list of services, service restrictions and benefit amounts.

Health Professional Online Services is an internet based portal for health professionals such as general practitioners, specialists, allied health professionals, dental practitioners, practice managers and practice staff.

Health Professional Online Services provides online self-service access to programs, payments and services and perform functions or enquiries relevant to patient treatment and claiming or other business needs.

Out-of-pocket/co-payment means the difference between the amount charged by the dental practitioner and the available CDBS benefit for a provided service. This difference needs to be paid by the patient (refer to definition of Private billing).

Private billing means is where a dental practitioner charges the patient directly for services under the CDBS. Any amount not covered by the benefit is known as an out-of-pocket expense. This is different from 'bulk billing'.

Private dental sector/clinic means a clinic that is not funded or operated by state or territory governments and operates independently. For example, a dentist who works in this sector is a private dentist.

Public dental sector/clinics means a clinic funded and operated by a state or territory government to provide treatment to patients. Generally only certain patients can access public dental services and are charged little or no fee for these services. For example, a dentist who works in this sector is a public dentist.

Relevant two year period means the amount of dental benefits available to eligible patients is capped per eligible patient over two consecutive calendar years. The two consecutive

calendar years is known as the relevant two year period (see the ‘How does the patient’s benefit cap work?’ section of this guide).

Treatment, for the purposes of the CDBS, means the provision of any service in the Dental Benefits Schedule, including any examination, diagnostic or preventive service.

Attachment A: Dental Benefits Schedule

Notes about the Dental Benefits Schedule and provider claiming restrictions

- **Dentists** that have been issued a Medicare provider number can claim all items on the Dental Benefits Schedule
- **Dental hygienists, dental therapists and oral health therapists**, that have been issued a Medicare provider number and are using that provider number, the items you can directly claim under the CDBS are based on the division you are registration in.
- When reviewing the items on the following pages, if there is a **provider claiming restriction**, only those dental providers listed can directly claim for that item under the CDBS
- If there is no **provider claiming restriction**, then all dental providers i.e., dentists, dental hygienists, dental therapists, and oral health therapists, can claim for that item under the CDBS.

Diagnostic Services

88011 Comprehensive oral exam

88012 Periodic oral examination

88013 Oral examination – limited

88022 Intraoral periapical or bitewing radiograph – per exposure

88025 Intraoral radiograph – occlusal, maxillary, mandibular – per exposure

Item	Service – Radiological examination and interpretation	Benefit ($)
88011	**Comprehensive oral examination** Evaluation of all teeth, their supporting tissues and the oral tissues in order to record the condition of these structures. This evaluation includes recording an appropriate medical history and any other relevant information. **Applicable restrictions** Limit of one (1) examination service (88011, 88012 or 88013) per day. Limit of one (1) per provider every 24 months.	**57.65**
88012	**Periodic oral examination** 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. **Applicable restrictions** Limit of one (1) examination service (88011, 88012 or 88013) per day. Limit of one (1) per provider every 5 months. Limit of two (2) per provider per calendar year. A benefit does not apply if the service is provided within 5 months of a service under item 88011 by the same provider.	**47.90**
88013	**Oral examination – limited** A limited oral problem-focussed evaluation carried out immediately prior to required treatment. This evaluation includes recording an appropriate medical history and any other relevant information. **Applicable restrictions** Limit of one (1) examination service (88011, 88012 or 88013) per day. Limit of three (3) per 3 month period.	**30.10**

Item	Service – Radiological examination and interpretation	Benefit ($)
88022	**Intraoral periapical or bitewing radiograph – per exposure** Taking and interpreting a radiograph made with the film inside the mouth. Applicable restrictions Limit of four (4) per day.	**33.35**

Item	Service – Radiological examination and interpretation	Benefit ($)
88025	**Intraoral radiograph – occlusal, maxillary, mandibular – per exposure** Taking and interpreting an occlusal, maxillary or mandibular intraoral radiograph. This radiograph shows a more extensive view of teeth and maxillary or mandibular bone.	**67.40**

Preventive Services

88111 Removal of plaque and/or stain

88114 Removal of calculus – first visit

88115 Removal of calculus – subsequent visit

88121 Topical application of remineralisation and/or cariostatic agents, one treatment

88161 Fissure and/or tooth surface sealing – per tooth (first four services on a day)

88162 Fissure and/or tooth surface sealing – per tooth (subsequent services)

Item	Service – Dental Prophylaxis	Benefit ($)
88111	**Removal of plaque and/or stain** Removal of dental plaque and/or stain from the surfaces of all teeth and/or implants. **Applicable restrictions** Limit of one (1) per 5 month period. Limit of two (2) per calendar year. Limit of one (1) dental prophylaxis service (88111, 88114 or 88115) per day.	**58.90**
88114	**Removal of calculus – first visit** Removal of calculus from the surfaces of teeth. **Applicable restrictions** Limit of one (1) per 5 month period. Limit of two (2) per calendar year. Limit of one (1) dental prophylaxis service (88111, 88114 or 88115) per day.	**98.20**
88115	**Removal of calculus – subsequent visit** This item describes procedures in item 88114 when, because of the extent or degree of calculus, an additional visit(s) is required to remove deposits from the teeth. **Applicable restrictions** Limit of two (2) per 12 month period. Limit of one (1) dental prophylaxis service (88111, 88114 or 88115) per day.	**63.85**

Item	Service – Remineralising Agents	Benefit ($)
88121	**Topical application of remineralisation and/or cariostatic agents, one treatment** Application of remineralisation and/or cariostatic agents to the surfaces of the teeth. This may include activation of the agent. Not to be used as an intrinsic part of the restoration. **Applicable restrictions** Limit of one (1) per 5 month period. Limit of two (2) per calendar year.	**37.85**

Item	Service – Other Preventive Services	Benefit ($)
88161	**Fissure and/or tooth surface sealing – per tooth (first four services on a day)** Sealing of non-carious pits, fissures, smooth surfaces or cracks in a tooth with an adhesive material. Any preparation prior to application of the sealant is included in this item number. **Applicable restrictions** Limit of four (4) per day. For additional fissure sealing on the same day use item 88162. A benefit does not apply if a benefit has been paid for a restoration service (items 88511- 88535) on the same tooth on the same day.	**50.45**
88162	**Fissure and/or tooth surface sealing – per tooth (subsequent services)** Sealing of non-carious pits, fissures, smooth surfaces or cracks in a tooth with an adhesive material. Any preparation prior to application of the sealant is included in this item number. **Applicable restrictions** A benefit does not apply if a benefit has been paid for a restoration service (items 88511- 88535) on the same tooth on the same day.	**25.25**

Periodontics

88213 Treatment of acute periodontal infection – per visit

88221 Clinical periodontal analysis and recording

Item	Service	Benefit ($)
88213	**Treatment of acute periodontal infection – per visit** This item describes the treatment of acute periodontal infection(s). It may include establishing drainage and the removal of calculus from the affected tooth (teeth). Inclusive of the insertion of sutures, normal post-operative care and suture removal. **Applicable restrictions** Limit of two (2) per 12 month period. A benefit does not apply if a benefit has been paid for item 88415 on the same tooth on the same day.	**76.30**
88221	**Clinical periodontal analysis and recording** This is a special examination performed as part of the diagnosis and management of periodontal disease. The procedure consists of assessing and recording a patient's periodontal condition. All teeth and six sites per tooth must be recorded. Written documentation of these measurements must be retained. **Applicable restrictions** Limit of one (1) per 24 month period.	**58**

Oral Surgery

88311 Removal of a tooth or part(s) thereof – first tooth extracted on a day

88314 Sectional removal of a tooth or part(s) thereof – first tooth extracted on a day

88316 Additional extraction requiring removal of a tooth or part(s) thereof, or sectional removal of a tooth

88322 Surgical removal of a tooth or tooth fragment not requiring removal of bone or tooth division – first tooth extracted on a day

88323 Surgical removal of a tooth or tooth fragment requiring removal of bone – first tooth extracted on a day

88324 Surgical removal of a tooth or tooth fragment requiring both removal of bone and tooth division – first tooth extracted on a day

88326 Additional extraction requiring surgical removal of a tooth or tooth fragment

88351 Repair of skin and subcutaneous tissue or mucous membrane

88384 Repositioning of displaced tooth/teeth – per tooth

88386 Splinting of displaced tooth/teeth – per tooth

88387 Replantation and splinting of a tooth

88392 Drainage of abscess

Item	Service – Extractions	Benefit ($)
88311	**Removal of a tooth or part(s) thereof – first tooth extracted on a day** A procedure consisting of the removal of a tooth or part(s) thereof. Inclusive of the insertion of sutures, normal post-operative care and suture removal. **Applicable restrictions** Limit of one (1) per day. For additional extractions on the same day, use item 88316. A benefit does not apply if a benefit has been paid for item 88314 on the same day. A benefit does not apply if a benefit has been paid for an extraction service on the same tooth. **Provider claiming restrictions** This item may only be claimed by a dentist, dental therapist, or oral health therapist.	**143.75**

Item	Service – Extractions	Benefit ($)
88314	**Sectional removal of a tooth or part(s) thereof – first tooth extracted on a day** The removal of a tooth or part(s) thereof in sections. Bone removal may be necessary. Inclusive of the insertion of sutures, normal post-operative care and suture removal. **Applicable restrictions** Limit of one (1) per day. For additional extractions on the same day, use item 88316. A benefit does not apply if a benefit has been paid for an extraction service on the same tooth. **Provider claiming restrictions** This item may only be claimed by a dentist.	**183.75**
88316	**Additional extraction requiring removal of a tooth or part(s) thereof, or sectional removal of a tooth** Additional extraction provided on the same day as a service described in item 88311 or 88314 is provided to the patient. **Applicable restrictions** A benefit does not apply if a benefit has been paid for an extraction service on the same tooth. **Provider claiming restrictions** This item may only be claimed by a dentist, dental therapist, or oral health therapist.	**90.60**

Item	Service – Surgical Extractions	Benefit ($)
88322	**Surgical removal of a tooth or tooth fragment not requiring removal of bone or tooth division – first tooth extracted on a day** Removal of a tooth or tooth fragment where an incision and the raising of a mucoperiosteal flap is required, but where removal of bone or sectioning of the tooth is not necessary to remove the tooth. Inclusive of the insertion of sutures, normal post-operative care and suture removal. **Applicable restrictions** Limit of one (1) per day. For additional extractions on the same day, use item 88326. A benefit does not apply if a benefit has been paid for item 88323 or 88324 on the same day. A benefit does not apply if a benefit has been paid for an extraction service on the same tooth. **Provider claiming restrictions** This item may only be claimed by a dentist.	**233.30**

Item	Service – Surgical Extractions	Benefit ($)
88323	**Surgical removal of a tooth or tooth fragment requiring removal of bone – first tooth extracted on a day** Removal of a tooth or tooth fragment where removal of bone is required after an incision and a mucoperiosteal flap raised. Inclusive of the insertion of sutures, normal post-operative care and suture removal. **Applicable restrictions** Limit of one (1) per day. For additional extractions on the same day, use item 88326. A benefit does not apply if a benefit has been paid for item 88324 on the same day. A benefit does not apply if a benefit has been paid for an extraction service on the same tooth. **Provider claiming restrictions** This item may only be claimed by a dentist.	**266.45**
88324	**Surgical removal of a tooth or tooth fragment requiring both removal of bone and tooth division – first tooth extracted on a day** Removal of a tooth or tooth fragment where both removal of bone and sectioning of the tooth are required after an incision and a mucoperiosteal flap raised. The tooth will be removed in portions. Inclusive of the insertion of sutures, normal post-operative care and suture removal. **Applicable restrictions** Limit of one (1) per day. For additional extractions on the same day, use item 88326. A benefit only applies if performed on multi-rooted teeth. A benefit does not apply if a benefit has been paid for an extraction service on the same tooth. **Provider claiming restrictions** This item may only be claimed by a dentist.	**358.40**
88326	**Additional extraction requiring surgical removal of a tooth or tooth fragment** Additional surgical extraction provided on the same day as a service described in item 88322, 88323 or 88324 is provided to the patient. **Applicable restrictions** A benefit does not apply if a benefit has been paid for an extraction service on the same tooth. **Provider claiming restrictions** This item may only be claimed by a dentist.	**190.85**

Item	Service – Treatment of Maxillo-facial injuries	Benefit ($)
88351	**Repair of skin and subcutaneous tissue or mucous membrane** The surgical cleaning and repair of a facial skin wound in the region of the mouth or jaws, or the repair of oral mucous membrane, where the	**175.15**

Item	Service – Treatment of Maxillo-facial injuries	Benefit ($)
	wounds involve the subcutaneous tissues. Inclusive of the insertion of sutures, normal post-operative care and suture removal. **Applicable restrictions** A benefit only applies if the service is provided on the same day of a service under item 88384, 88386 or 88387. **Provider claiming restrictions** This item may only be claimed by a dentist.	

Item	Service – Other Surgical Procedures	Benefit ($)
88384	**Repositioning of displaced tooth/teeth – per tooth** A procedure following trauma where the position of the displaced tooth/teeth is corrected by manipulation. Stabilising procedures are itemised separately. Inclusive of the insertion of sutures, normal post-operative care and suture removal. **Applicable restrictions** A benefit does not apply if a benefit has been paid for an extraction service on the same tooth. **Provider claiming restrictions** This item may only be claimed by a dentist, dental therapist, or oral health therapist.	**209**

Item	Service – Other Surgical Procedures	Benefit ($)
88386	**Splinting of displaced tooth/teeth – per tooth** A procedure following trauma where the position of the displaced tooth/teeth may be stabilized by splinting. Inclusive of the insertion of sutures, normal post-operative care and suture removal. **Applicable restrictions** A benefit does not apply if a benefit has been paid for an extraction service on the same tooth. **Provider claiming restrictions** This item may only be claimed by a dentist, dental therapist, or oral health therapist.	**215.60**
88387	**Replantation and splinting of a tooth** Replantation of a tooth which has been avulsed or intentionally removed. It may be held in the correct position by splinting. Inclusive of the insertion of sutures, normal post-operative care and suture removal. **Applicable restrictions** A benefit does not apply if a benefit has been paid for an extraction service on the same tooth.	**422.20**

Item	Service – Other Surgical Procedures	Benefit ($)
	Provider claiming restrictions This item may only be claimed by a dentist, dental therapist, or oral health therapist.	
88392	**Drainage of abscess** Drainage and/or irrigation of an abscess other than through a root canal or at the time of extraction. The drainage may be through an incision or inserted tube. Inclusive of the insertion of sutures, normal post-operative care and suture removal. **Applicable restrictions** A benefit does not apply if a benefit has been paid for an extraction service on the same tooth. **Provider claiming restrictions** This item may only be claimed by a dentist.	**106.10**

Endodontics

88411 Direct pulp capping

88412 Incomplete endodontic therapy (tooth not suitable for further treatment)

88414 Pulpotomy

88415 Complete chemo-mechanical preparation of root canal – one canal

88416 Complete chemo-mechanical preparation of root canal – each additional canal

88417 Root canal obturation – one canal

88418 Root canal obturation – each additional canal

88419 Extirpation of pulp or debridement of root canal(s) – emergency or palliative

88421 Resorbable root canal filling – primary tooth

88455 Additional visit for irrigation and/or dressing of the root canal system – per tooth

88458 Interim therapeutic root filling – per tooth

Item	Service – Pulp and Root Canal Treatments	Benefit ($)
88411	**Direct pulp capping** A procedure where an exposed pulp is directly covered with a protective dressing or cement. **Applicable restrictions** A benefit does not apply if the service is provided within 3 months of a service under item 88458. A benefit does not apply if a benefit has been paid under item 88412 on the same tooth. **Provider claiming restrictions** This item may only be claimed by a dentist, dental therapist, or oral health therapist.	**38.15**
88412	**Incomplete endodontic therapy (tooth not suitable for further treatment)** A procedure where in assessing the suitability of a tooth for endodontic treatment a decision is made that the tooth is not suitable for restoration. **Applicable restrictions** Limit of one (1) per tooth. **Provider claiming restrictions** This item may only be claimed by a dentist.	**130.70**
88414	**Pulpotomy** Amputation within the pulp chamber of part of the vital pulp of a tooth. The pulp remaining in the canal(s) is then covered with a protective dressing or cement. **Applicable restrictions** A benefit does not apply if a benefit has been paid for item 88421 on the same tooth on the same day.	**83.30**

Item	Service – Pulp and Root Canal Treatments	Benefit ($)
	A benefit does not apply if the service is provided within 3 months of a service under item 88458. A benefit does not apply if a benefit has been paid under item 88412 on the same tooth. **Provider claiming restrictions** This item may only be claimed by a dentist, dental therapist, or oral health therapist.	
88415	**Complete chemo-mechanical preparation of root canal – one canal** Complete chemo-mechanical preparation including removal of pulp or necrotic debris from a canal. **Applicable restrictions** Limit of one (1) per tooth per day. A benefit does not apply if the service is provided within 3 months of a service under item 88458 unless on same day. A benefit does not apply if a benefit has been paid under item 88412 on the same tooth. **Provider claiming restrictions** This item may only be claimed by a dentist.	**234.50**
88416	**Complete chemo-mechanical preparation of root canal – each additional canal** Complete chemo-mechanical preparation including removal of pulp or necrotic debris from each additional canal of a tooth with multiple canals. **Applicable restrictions** Limit of two (2) per tooth per day. A benefit does not apply if the service is provided within 3 months of a service under item 88458 unless on same day. A benefit does not apply if a benefit has been paid under item 88412 on the same tooth. **Provider claiming restrictions** This item may only be claimed by a dentist.	**111.70**
88417	**Root canal obturation – one canal** The filling of a root canal, following chemo-mechanical preparation. **Applicable restrictions** Limit of one (1) per tooth per day. A benefit does not apply if the service is provided within 3 months of a service under item 88458. A benefit does not apply if a benefit has been paid under item 88412 on the same tooth. **Provider claiming restrictions** This item may only be claimed by a dentist.	**228.40**
88418	**Root canal obturation – each additional canal** The filling, following chemo-mechanical preparation, of each additional canal in a tooth with multiple canals.	**106.80**

Item	Service – Pulp and Root Canal Treatments	Benefit ($)
	Applicable restrictions Limit of two (2) per tooth per day. A benefit does not apply if a benefit has been paid for item 88419 on the same tooth on the same day. A benefit does not apply if the service is provided within 3 months of a service under item 88458. A benefit does not apply if a benefit has been paid under item 88412 on the same tooth. **Provider claiming restrictions** This item may only be claimed by a dentist.	
88419	**Extirpation of pulp or debridement of root canal(s) – emergency or palliative** 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. **Applicable restrictions** A benefit does not apply if a benefit has been paid for an extraction, metallic or adhesive restoration service or items 88411, 88415, 88416, 88417, 88421, 88455, 88458, on the same tooth on the same day. A benefit does not apply if the service is provided within 3 months of a service under item 88458. A benefit does not apply if a benefit has been paid under item 88412 on the same tooth. **Provider claiming restrictions** This item may only be claimed by a dentist.	**151**
88421	**Resorbable root canal filling – primary tooth** The placement of resorbable root canal filling material in a primary tooth. **Applicable restrictions** Limit of one (1) per tooth. A benefit does not apply if a benefit has been paid for item 88414 on the same tooth on the same day. A benefit does not apply if the service is provided within 3 months of a service under item 88458. A benefit does not apply if a benefit has been paid under item 88412 on the same tooth. **Provider claiming restrictions** This item may only be claimed by a dentist.	**130.70**

Item	Service – Other Endodontic Services	Benefit ($)
88455	**Additional visit for irrigation and/or dressing of the root canal system – per tooth** 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.	**115.70**

Item	Service – Other Endodontic Services	Benefit ($)
	Applicable restrictions A benefit does not apply if a benefit has been paid for item 88414, 88415, 88416, 88417, 88418 or 88421 on the same tooth on the same day. A benefit only applies if the service is provided within 3 months of a service under item 88415 or 88416. A benefit does not apply if a benefit has been paid under item 88412 on the same tooth. **Provider claiming restrictions** This item may only be claimed by a dentist.	
88458	**Interim therapeutic root filling – per tooth** A procedure consisting of the insertion of a long-term provisional (temporary) root canal filling with therapeutic properties which facilitates healing/development of the root and periradicular tissues over an extended time. **Applicable restrictions** Limit of three (3) per 12 month period. A benefit does not apply if a benefit has been paid under item 88412 on the same tooth. **Provider claiming restrictions** This item may only be claimed by a dentist.	**154.35**

Restorative Services

88511 Metallic restoration – one surface – direct

88512 Metallic restoration – two surfaces – direct

88513 Metallic restoration – three surfaces – direct

88514 Metallic restoration – four surfaces – direct

88515 Metallic restoration – five surfaces – direct

88521 Adhesive restoration – one surface – anterior tooth – direct

88522 Adhesive restoration – two surfaces – anterior tooth – direct

88523 Adhesive restoration – three surfaces – anterior tooth – direct

88524 Adhesive restoration – four surfaces – anterior tooth – direct

88525 Adhesive restoration – five surfaces – anterior tooth – direct

88531 Adhesive restoration – one surface – posterior tooth – direct

88532 Adhesive restoration – two surfaces – posterior tooth – direct

88533 Adhesive restoration – three surfaces – posterior tooth – direct

88534 Adhesive restoration – four surfaces – posterior tooth – direct

88535 Adhesive restoration – five surfaces – posterior tooth – direct

88572 Provisional (intermediate/temporary) restoration – per tooth

88574 Metal band

88575 Pin retention – per pin

88579 Bonding of tooth fragment

88586 Crown – metallic – with tooth preparation - preformed

88587 Crown – metallic – minimal tooth preparation – preformed

88597 Post – direct

Item	Service – Metallic Restorations – Direct	Benefit ($)
88511	**Metallic restoration – one surface – direct** Direct metallic restoration involving one surface of a tooth. Inclusive of the preparation of the tooth, placement of a lining, contouring of the adjacent and opposing teeth, placement of the restoration and normal post-operative care. **Applicable restrictions** Limit of one (1) service under 88511-88535 per tooth per day. **Provider claiming restrictions** This item may only be claimed by a dentist, dental therapist, or oral health therapist.	**114.10**
88512	**Metallic restoration – two surfaces – direct** Direct metallic restoration involving two surfaces of a tooth. Inclusive of the preparation of the tooth, placement of a lining, contouring of the adjacent and opposing teeth, placement of the restoration and normal post-operative care.	**139.95**

Item	Service – Metallic Restorations – Direct	Benefit ($)
	Applicable restrictions Limit of one (1) service under 88511-88535 per tooth per day. **Provider claiming restrictions** This item may only be claimed by a dentist, dental therapist, or oral health therapist.	
88513	**Metallic restoration – three surfaces – direct** Direct metallic restoration involving three surfaces of a tooth. Inclusive of the preparation of the tooth, placement of a lining, contouring of the adjacent and opposing teeth, placement of the restoration and normal post-operative care. **Applicable restrictions** Limit of one (1) service under 88511-88535 per tooth per day. **Provider claiming restrictions** This item may only be claimed by a dentist, dental therapist, or oral health therapist.	**167**
88514	**Metallic restoration – four surfaces – direct** Direct metallic restoration involving four surfaces of a tooth. Inclusive of the preparation of the tooth, placement of a lining, contouring of the adjacent and opposing teeth, placement of the restoration and normal post-operative care. **Applicable restrictions** Limit of one (1) service under 88511-88535 per tooth per day. **Provider claiming restrictions** This item may only be claimed by a dentist, dental therapist, or oral health therapist.	**190.35**
88515	**Metallic restoration – five surfaces – direct** Direct metallic restoration involving five surfaces of a tooth. Inclusive of the preparation of the tooth, placement of a lining, contouring of the adjacent and opposing teeth, placement of the restoration and normal post-operative care. **Applicable restrictions** Limit of one (1) service under 88511-88535 per tooth per day. **Provider claiming restrictions** This item may only be claimed by a dentist, dental therapist, or oral health therapist.	**217.30**

Item	Service – Adhesive Restorations – Anterior Teeth – Direct	Benefit ($)
88521	**Adhesive restoration – one surface – anterior tooth – direct** Direct restoration, using an adhesive technique and a tooth-coloured material, involving one surface of an anterior tooth. Inclusive of the preparation of the tooth, placement of a lining, contouring of the adjacent and opposing teeth, placement of the restoration and normal post-operative care.	**126.40**

Item	Service – Adhesive Restorations – Anterior Teeth – Direct	Benefit ($)
	Applicable restrictions Limit of one (1) service under 88511-88535 per tooth per day. Limit of five (5) single-surface adhesive restorations (88521 or 88531) per day. **Provider claiming restrictions** This item may only be claimed by a dentist, dental therapist, or oral health therapist.	
88522	**Adhesive restoration – two surfaces – anterior tooth – direct** Direct restoration, using an adhesive technique and a tooth-coloured material, involving two surfaces of an anterior tooth. Inclusive of the preparation of the tooth, placement of a lining, contouring of the adjacent and opposing teeth, placement of the restoration and normal post-operative care. **Applicable restrictions** Limit of one (1) service under 88511-88535 per tooth per day. **Provider claiming restrictions** This item may only be claimed by a dentist, dental therapist, or oral health therapist.	**153.45**
88523	**Adhesive restoration – three surfaces – anterior tooth – direct** Direct restoration, using an adhesive technique and a tooth-coloured material, involving three surfaces of an anterior tooth. Inclusive of the preparation of the tooth, placement of a lining, contouring of the adjacent and opposing teeth, placement of the restoration and normal post-operative care. **Applicable restrictions** Limit of one (1) service under 88511-88535 per tooth per day. Provider claiming restrictions This item may only be claimed by a dentist, dental therapist, or oral health therapist.	**181.75**
88524	**Adhesive restoration – four surfaces – anterior tooth – direct** Direct restoration, using an adhesive technique and a tooth-coloured material, involving four surfaces of an anterior tooth. Inclusive of the preparation of the tooth, placement of a lining, contouring of the adjacent and opposing teeth, placement of the restoration and normal post-operative care. **Applicable restrictions** Limit of one (1) service under 88511-88535 per tooth per day. **Provider claiming restrictions** This item may only be claimed by a dentist, dental therapist, or oral health therapist.	**210.05**

Item	Service – Adhesive Restorations – Anterior Teeth – Direct	Benefit ($)
88525	**Adhesive restoration – five surfaces – anterior tooth – direct** Direct restoration, using an adhesive technique and a tooth-coloured material, involving five surfaces of an anterior tooth. Inclusive of the	**246.85**

	preparation of the tooth, placement of a lining, contouring of the adjacent and opposing teeth, placement of the restoration and normal post-operative care. **Applicable restrictions** Limit of one (1) service under 88511-88535 per tooth per day. **Provider claiming restrictions** This item may only be claimed by a dentist, dental therapist, or oral health therapist.	

Item	Service – Adhesive Restorations – Posterior Teeth – Direct	Benefit ($)
88531	**Adhesive restoration – one surface – posterior tooth – direct** Direct restoration, using an adhesive technique and a tooth-coloured material, involving one surface of a posterior tooth. Inclusive of the preparation of the tooth, placement of a lining, contouring of the adjacent and opposing teeth, placement of the restoration and normal post-operative care. **Applicable restrictions** Limit of one (1) service under 88511-88535 per tooth per day. Limit of five (5) single-surface adhesive restorations (88521 or 88531) per day. **Provider claiming restrictions** This item may only be claimed by a dentist, dental therapist, or oral health therapist.	**134.95**
88532	**Adhesive restoration – two surfaces – posterior tooth – direct** Direct restoration, using an adhesive technique and a tooth-coloured material, involving two surfaces of a posterior tooth. Inclusive of the preparation of the tooth, placement of a lining, contouring of the adjacent and opposing teeth, placement of the restoration and normal post-operative care. **Applicable restrictions** Limit of one (1) service under 88511-88535 per tooth per day. **Provider claiming restrictions** This item may only be claimed by a dentist, dental therapist, or oral health therapist.	**169.45**
88533	**Adhesive restoration – three surfaces – posterior tooth – direct** Direct restoration, using an adhesive technique and a tooth-coloured material, involving three surfaces of a posterior tooth. Inclusive of the preparation of the tooth, placement of a lining, contouring of the adjacent and opposing teeth, placement of the restoration and normal post-operative care. **Applicable restrictions** Limit of one (1) service under 88511-88535 per tooth per day. **Provider claiming restrictions** This item may only be claimed by a dentist, dental therapist, or oral health therapist.	**203.70**

88534	**Adhesive restoration – four surfaces – posterior tooth – direct** Direct restoration, using an adhesive technique and a tooth-coloured material, involving four surfaces of a posterior tooth. Inclusive of the preparation of the tooth, placement of a lining, contouring of the adjacent and opposing teeth, placement of the restoration and normal post-operative care. **Applicable restrictions** Limit of one (1) service under 88511-88535 per tooth per day. **Provider claiming restrictions** This item may only be claimed by a dentist, dental therapist, or oral health therapist.	**229.65**
88535	**Adhesive restoration – five surfaces – posterior tooth – direct** Direct restoration, using an adhesive technique and a tooth-coloured material, involving five surfaces of a posterior tooth. Inclusive of the preparation of the tooth, placement of a lining, contouring of the adjacent and opposing teeth, placement of the restoration and normal post-operative care. **Applicable restrictions** Limit of one (1) service under 88511-88535 per tooth per day. **Provider claiming restrictions** This item may only be claimed by a dentist, dental therapist, or oral health therapist.	**265.20**

Item	Service – Other Restorative Services	Benefit ($)
88572	**Provisional (intermediate/temporary) restoration – per tooth** The provisional (intermediate) restoration of a tooth designed to last until the definitive restoration can be constructed or the tooth is removed. This item should only be used where the provisional (intermediate) restoration is not an intrinsic part of treatment. It does not include provisional (temporary) sealing of the access cavity during endodontic treatment or during construction of indirect restorations. **Applicable restrictions** Limit of three (3) per 3 month period. A benefit does not apply if a benefit has been paid for item 88411, 88414, 88415, 88416, 88417, 88418, 88421, 88455 or 88458 on the same day.	**53.40**

Item	Service – Other Restorative Services	Benefit ($)
88574	Metal band The cementation of a metal band for diagnostic, protective purposes or for the placement of a provisional (intermediate) restoration. **Provider claiming restrictions** This item may only be claimed by a dentist, dental therapist, or oral health therapist.	**44.95**

88575	**Pin retention – per pin** Use of a pin to aid the retention and support of direct or indirect restorations in a tooth. **Applicable restrictions** Limit of two (2) per tooth per day. Limit of four (4) per day. A benefit only applies if the service is provided on the same tooth on the same day of a service under item 88511-88535. **Provider claiming restrictions** This item may only be claimed by a dentist, dental therapist, or oral health therapist.	**30.65**
88579	**Bonding of tooth fragment** The direct bonding of a tooth fragment as an alternative to placing a restoration. **Provider claiming restrictions** This item may only be claimed by a dentist, dental therapist, or oral health therapist.	**106.10**
88586	**Crown – metallic - with tooth preparation – preformed** Placing a preformed metallic crown as a coronal restoration for a tooth. **Applicable restrictions** Limit of one (1) metallic crown service (88586 or 88587) per tooth per day. **Provider claiming restrictions** This item may only be claimed by a dentist, dental therapist, or oral health therapist.	**281.50**
88587	**Crown – metallic – minimal tooth preparation – preformed** Placing a preformed metallic crown as a coronal restoration for a tooth and where minimal or no restoration of the tooth is required. Commonly referred to as a 'Hall' crown. **Applicable restrictions** Limit of one (1) metallic crown service (88586 or 88587) per tooth per day. **Provider claiming restrictions** This item may only be claimed by a dentist, dental therapist, or oral health therapist.	**167**
88597	**Post – direct** Insertion of a post into a prepared root canal to provide an anchor for an artificial crown or other restoration. **Applicable restrictions** Limit of two (2) per tooth per day. A benefit only applies if the service is provided on the same tooth on the same day of a service under item 88511-88535. **Provider claiming restrictions** This item may only be claimed by a dentist.	**96.50**

Prosthodontics

88721 Partial maxillary denture – resin, base only

88722 Partial mandibular denture – resin, base only

88723 Provisional partial maxillary denture

88724 Provisional partial mandibular denture

88731 Retainer – per tooth

88733 Tooth/teeth (partial denture)

88736 Immediate tooth replacement – per tooth

88741 Adjustment of a denture

88761 Reattaching pre-existing clasp to denture

88762 Replacing/adding clasp to denture – per clasp

88764 Repairing broken base of a partial denture

88765 Replacing/adding new tooth on denture – per tooth

88766 Reattaching existing tooth on denture – per tooth

88768 Adding tooth to partial denture to replace an extracted or decoronated tooth – per tooth

88776 Impression - dental appliance repair/modification

Item	Service – Dentures and Denture Components	Benefit ($)
88721	**Partial maxillary denture – resin, base only** Provision of a resin base for a removable dental prosthesis for the maxilla where some natural teeth remain. **Applicable restrictions** Limit of one (1) per 24 month period. A benefit does not apply if the service is provided within 6 months of a service under item 88723. **Provider claiming restrictions** This item may only be claimed by a dentist.	**478.10**
88722	**Partial mandibular denture – resin, base only** Provision of a resin base for a removable dental prosthesis for the mandible where some natural teeth remain. **Applicable restrictions** Limit of one (1) per 24 month period. A benefit does not apply if the service is provided within 6 months of a service under item 88724. **Provider claiming restrictions** This item may only be claimed by a dentist.	**478.10**
88723	**Provisional partial maxillary denture** Provision of a patient removable partial dental prosthesis replacing the natural teeth and adjacent tissues in the maxilla which is designed to last until the definitive prosthesis can be constructed. This item should	**358.50**

Item	Service – Dentures and Denture Components	Benefit ($)
	only be used where a provisional denture is not an intrinsic part of item 88721. **Applicable restrictions** Limit of one (1) per patient. **Provider claiming restrictions** This item may only be claimed by a dentist.	
88724	**Provisional partial mandibular denture** Provision of a patient removable partial dental prosthesis replacing the natural teeth and adjacent tissues in the mandible which is designed to last until the definitive prosthesis can be constructed. This item should only be used where a provisional denture is not an intrinsic part of item 88722. **Applicable restrictions** Limit of one (1) per patient. **Provider claiming restrictions** This item may only be claimed by a dentist.	**358.50**
88731	**Retainer – per tooth** A retainer or attachment fitted to a tooth to aid retention of a partial denture. The number of retainers should be indicated. **Applicable restrictions** Limit of four (4) per denture base (88721-88724). **Provider claiming restrictions** This item may only be claimed by a dentist.	**48.25**
88733	**Tooth/teeth (partial denture)** An item to describe each tooth added to the base of a new partial denture. The number of teeth should be indicated. **Applicable restrictions** Limited to anterior teeth. Limit of four (4) per denture base (88721-88724). **Provider claiming restrictions** This item may only be claimed by a dentist.	**39.60**
88736	**Immediate tooth replacement – per tooth** Provision within a denture to allow immediate replacement of an extracted tooth. The number of teeth so replaced should be indicated. **Applicable restrictions** Limit of four (4) per denture base (88721-88724). **Provider claiming restrictions** This item may only be claimed by a dentist.	**9.95**

Item	Service – Denture Maintenance	Benefit ($)
88741	**Adjustment of a denture** Adjustment of a denture to improve comfort, function or aesthetics. This item does not apply to routine adjustments following the insertion of a new denture or the maintenance or repair of an existing denture. **Applicable restrictions** A benefit does not apply if the service is provided within 12 months of a service under items 88721-88724 by the same provider. **Provider claiming restrictions** This item may only be claimed by a dentist.	**57.50**

Item	Service – Denture Repairs	Benefit ($)
88761	**Reattaching pre-existing clasp to denture** Repair, insertion and adjustment of a denture involving re-attachment of a pre-existing clasp. **Provider claiming restrictions** This item may only be claimed by a dentist.	**157.85**
88762	**Replacing/adding clasp to denture – per clasp** Repair, insertion and adjustment of a denture involving replacement or addition of a new clasp or clasps. **Provider claiming restrictions** This item may only be claimed by a dentist.	**164.95**
88764	**Repairing broken base of a partial denture** Repair, insertion and adjustment of a broken resin partial denture base. **Provider claiming restrictions** This item may only be claimed by a dentist.	**157.85**
88765	**Replacing/adding new tooth on denture – per tooth** Repair, insertion and adjustment of a denture involving replacement with or addition of a new tooth or teeth to a previously existing denture. **Provider claiming restrictions** This item may only be claimed by a dentist.	**164.95**
88766	**Reattaching existing tooth on denture – per tooth** Repair, insertion and adjustment of a denture involving reattachment of a pre-existing denture tooth or teeth. **Provider claiming restrictions** This item may only be claimed by a dentist.	**157.85**
88768	**Adding tooth to partial denture to replace an extracted or decoronated tooth – per tooth** Modification, insertion and adjustment of a partial denture involving an addition to accommodate the loss of a natural tooth or its coronal section.	**167**

Item	Service – Denture Repairs	Benefit ($)
	Applicable restrictions Limit of eight (8) per 24 month period. **Provider claiming restrictions** This item may only be claimed by a dentist.	

Item	Service - Other Prosthodontic Services	Benefit ($)
88776	**Impression – dental appliance repair/modification** An item to describe taking an impression where required for the repair or modification of a dental appliance.	**50.45**

General Services

88911 Palliative care

88942 Sedation – intravenous

88943 Sedation – inhalation

Item	Service – Emergencies	Benefit ($)
88911	**Palliative care** An item to describe interim care to relieve pain, infection, bleeding or other problems not associated with other treatment. **Applicable restrictions** A benefit does not apply if the service is provided on the same day as any other service by the same provider.	**74.85**

Item	Service – Sedation	Benefit ($)
88942	**Sedation – intravenous** Sedative drug(s) administered intravenously, usually in increments. The incremental administration may continue while dental treatment is being provided. **Applicable restrictions** Limit of one (1) per 12 month period. **Provider claiming restrictions** This item may only be claimed by a dentist.	**146.75**
88943	**Sedation – inhalation** Nitrous oxide gas mixed with oxygen is inhaled by the patient while dental treatment is being provided. **Provider claiming restrictions** This item may only be claimed by a dentist.	**73.35**

Attachment B: Example of Informed Financial Consent - Non-Bulk Billing Patient Consent Form

The link to this form is available from the Services Australia website at: (CDBS for health professionals - dental practitioner requirements - Services Australia)

Australian Government
Department of Health

CHILD DENTAL BENEFITS SCHEDULE
NON-BULK BILLING PATIENT CONSENT FORM

I, the patient / legal guardian, certify that I have been informed of:

- the treatment that has been or will be provided on this day under the Child Dental Benefits Schedule;
- the likely cost of this treatment, including any out-of-pocket costs; and
- the billing and payment arrangements for the services.

I understand that I / the patient will only have access to dental benefits of up to the benefit cap.

I understand that benefits for some services may have restrictions and that the Child Dental Benefits Schedule covers a limited range of services. I understand I will need to personally meet the costs of any services not covered by the Child Dental Benefits Schedule.

In addition to the out-of-pocket costs discussed, I understand that the cost of services will reduce the available benefit cap and that I will need to personally meet the costs of any additional services once benefits are exhausted.

Patient's Medicare number

Patient / legal guardian signature

Patient's full name

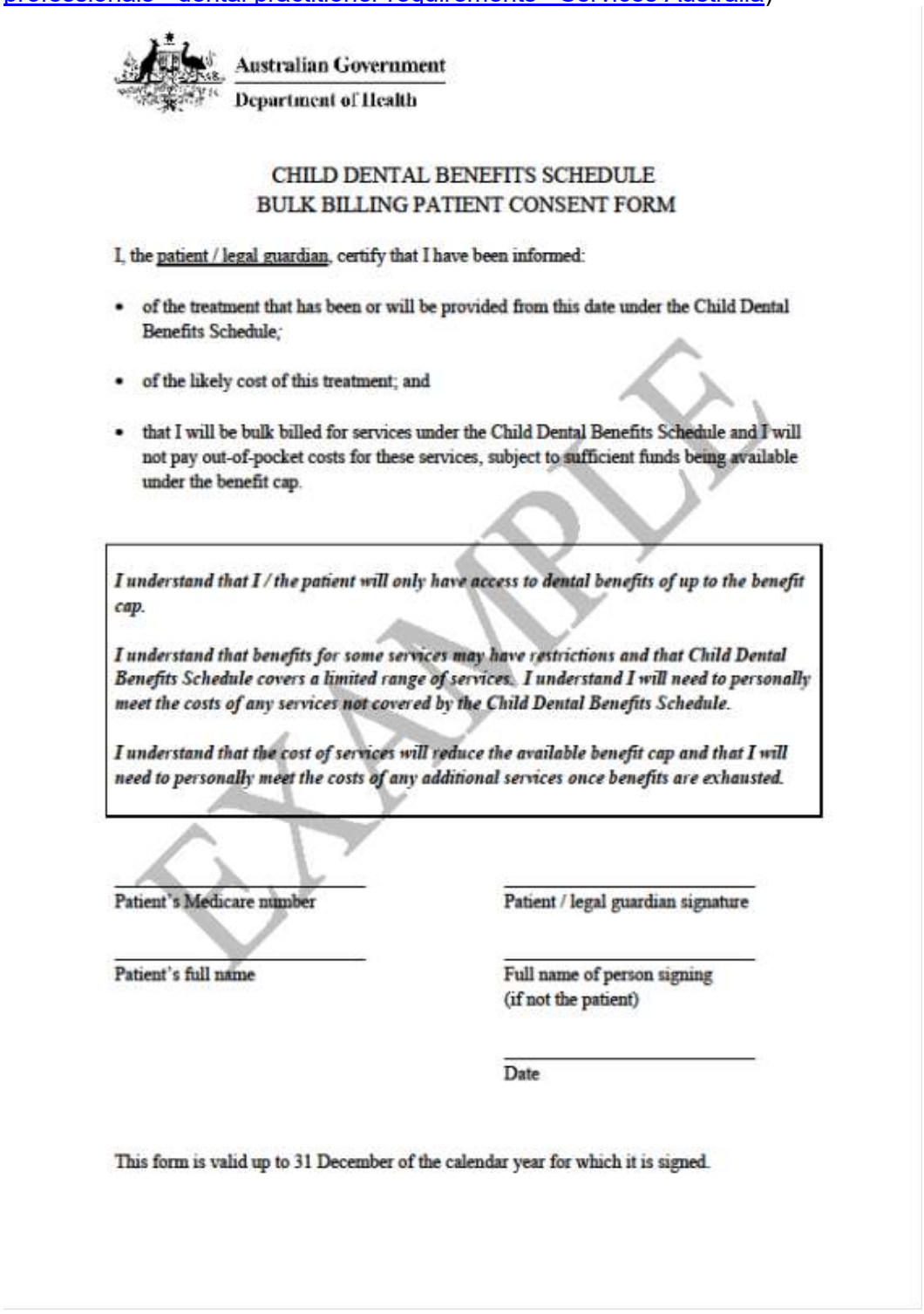
Full name of person signing (if not the patient)

Date

This form must be completed on each day of service provision under the Child Dental Benefits Schedule.

Attachment C: Example of Informed Financial Consent - Bulk Billing Patient Consent Form

The link to this form is available from the Services Australia website at: (CDBS for health professionals - dental practitioner requirements - Services Australia)



Australian Government
Department of Health

CHILD DENTAL BENEFITS SCHEDULE
BULK BILLING PATIENT CONSENT FORM

I, the patient / legal guardian, certify that I have been informed:

- of the treatment that has been or will be provided from this date under the Child Dental Benefits Schedule;
- of the likely cost of this treatment; and
- that I will be bulk billed for services under the Child Dental Benefits Schedule and I will not pay out-of-pocket costs for these services, subject to sufficient funds being available under the benefit cap.

I understand that I / the patient will only have access to dental benefits of up to the benefit cap.

I understand that benefits for some services may have restrictions and that Child Dental Benefits Schedule covers a limited range of services. I understand I will need to personally meet the costs of any services not covered by the Child Dental Benefits Schedule.

I understand that the cost of services will reduce the available benefit cap and that I will need to personally meet the costs of any additional services once benefits are exhausted.

Patient's Medicare number

Patient / legal guardian signature

Patient's full name

Full name of person signing (if not the patient)

Date

This form is valid up to 31 December of the calendar year for which it is signed.

EXAMPLE

Health.gov.au

All information in this publication is correct as at 1 January 2024