Operational Guidelines

For the Combined Dental Agreement (CDA)

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Te Whatu Ora
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Document Control Summary

Amendment to the Operational Guidelines for the Combined Dental Agreement (CDA) will be numbered consecutively and dated by the issuer.

Please ensure that all amendments are inserted and complete the record below.

Version	Date Issued	Sections Re-issued	Initials
0	January 2006	New Document	MoH
1	July 2007		
2			
3	July 2008		21 DHBs
4	March 2011	New Document	20 DHBs
5	June 2014	New Document	20 DHBs
6	July 2015	New Document	20 DHBs
7	July 2016	New Document	20 DHBs
8	July 2017	Variation	20 DHBs
9	July 2018	Variation	20 DHBs
10	July 2019	New Document	20 DHBs
11	July 2020	Variation	20 DHBs
12	July 2021	Variation	20 DHBs
13	July 2022	New Document	20 Districts

Summary of Changes to Operational Guidelines effective from 1 July 2022

The Operational Guidelines have been amended to include guidelines specific to mobile dental services. These guidelines can be found in Sections 2.1 and 2.7.

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Contents

1. Introduction

These guidelines have been developed to assist oral health providers in providing oral health services to adolescents and special dental services for children and adolescents, including those provided through mobile dental clinics.

These guidelines cover a range of issues including

- definitions of treatments
- information and reporting requirements
- payment processes
- audit protocols.

These guidelines should be read in conjunction with your CDA and any subsequent amendments or variations. These guidelines may be updated from time to time in consultation with Te Whatu Ora Health New Zealand (**Te Whatu Ora**) and the New Zealand Dental Association.

Please retain these guidelines to assist your provision of oral health services to adolescents and children under the Agreement.

For further assistance in interpreting these Guidelines at a regional level, please contact the ADO who approves treatment for your district.

2. General guidelines

2.1 General definitions

The following is a list of general definitions relating to the provision of oral health services for adolescents and special dental services for children and adolescents. Dentists, dental therapists, oral health therapists and dental hygienists may contract to provide both oral health services for adolescents and special dental services for children and adolescents or either only oral health services for adolescents or special dental services for children and adolescents.

2.1.1 Oral health services for children and adolescents

A term describing oral health services for

- adolescents from Year 9 at school until the day before their 18th birthday and
- children, year 8 and under at school, or pre-schoolers under five years of age, who have been referred or officially released early from the Community Oral Health Service as not being able to be treated by them due to medical or management reasons.

The term includes oral health services for adolescents provided through mobile dental clinics.

2.1.2 Fee for service

A method for funding services where a fee is paid for each item of treatment provided.

2.1.3 Standard (capitated) package of oral health services for adolescents

A method of funding services where a price is paid per annum for a prescribed list of treatment (see section E5.1 of the CDA) for each enrolled patient. The price covers a range of services from which a provider can choose the combination that best meets individual patient's needs. This includes diagnostic services, operative and preventive treatment.

The capitation model enables the provider to meet individual patient needs, noting these will vary between patients. The capitated funding model allows for those patients that require preventive care and/or occasional restorative work to be offered a package of dental care appropriate to their needs while ensuring providers are remunerated adequately. Through capitation funding a satisfactory average level of remuneration is achieved from providing services to a group of patients with a mix of oral health needs.

The CDA's Oral Health Services for Adolescents (OHSA) provides a capitated package of services that includes an annual examination and where required:

- An annual examination and all other necessary consultations within the 12-month period (excluding emergency consultations outside of normal practice hours).
- Bite wing and periapical radiographs
- Prophylaxis, including removal of supragingival calculus
- Fissure sealants
- Single surface restorations (FIL1)
- Preventive treatment, including oral health education and topical fluoride applications.

Any further necessary consultations throughout the year should be coded as a CON2. Whilst there is no fee payable it is important for data collection that this information is recorded.

A provider who provides oral health services for adolescents through a mobile dental clinic (**Mobile Provider**) must comply with all of the obligations in the CDA. This involves ensuring that adolescents can easily obtain the full range of services and treatments from the Mobile Provider within the expected timeframes after examination, including any treatments that are outside the scope of practice of a Dental Therapist or Oral Health Therapist, and that are required to be completed by a Dentist. Where a Dentist is required to complete an adolescent's treatment, the preferred option is that completion takes place onsite at the mobile dental clinic.

The alternatives are that treatment is completed at the provider's own fixed site or, in limited situations, by another CDA provider subcontracted by the Mobile Provider as described further below. In both cases, the required travel to a fixed site or another provider for the completion of treatment must not a barrier for the completion of treatment. Additionally, adolescents must not be left requiring the services of another dental provider because of incomplete work, resulting in additional costs to Te Whatu Ora.

In the following limited situations, the Mobile Provider may be unable to complete services or treatments required by an enrolled adolescent within expected timeframes:

- the services or treatments required are complex and/or outside of the Mobile Provider's practitioners' scope of practice
- in emergencies when follow-up care is urgently required during normal hours, but the Mobile Provider's mobile unit is no longer at the adolescent's school.

For those limited situations, the Mobile Provider can enter into a subcontracting arrangement with another CDA provider for it to provide the services and treatments required. The Mobile Provider must ensure that completion of the capitated standard package of services by another CDA provider will not result in additional costs (eg, CON1, COM1, COM2, and COM3) to Te Whatu Ora beyond the CDA annual capitation fee. The Mobile Provider must:

- have a written subcontract with any CDA provider it subcontracts to provides part of the capitated standard package services for an adolescent; and
- pay that provider/subcontractor for any capitated standard package of services treatments in association with the provision of ongoing treatment (for example, FIL1 restorations out of the CDA annual capitation fee that the Mobile Provider claims via a CON1).

2.1.4 Additional oral health services for adolescents not requiring prior approval

These are services described in clause E5.3 of the CDA that are outside the Standard Package of Services and may be provided without the approval of a designated ADO of the district.

2.1.5 Additional oral health services for adolescents requiring prior approval

These are services described in clause E5.4 of the CDA that are outside the Standard Package of Services and require the approval of a designated ADO of the district before a claim will be paid.

For Mobile Providers, a prior agreement can be discussed with the ADO regarding approval for certain treatments outside the standard fee schedule, in order to ensure timely completion of care.

2.1.6 Special dental services for children and adolescents

This term describes a set of oral health services available to children and adolescents.

These services cover:

- all children from birth until the end of school Year 8 enrolled with the Community Oral Health Service; and who otherwise would not have reasonable access to their regular oral health services provider. Access to these services is not for a routine examination. A referral is required from the regular oral health service provider except in an emergency.
- adolescents, from and including school year 9 up to their 18th birthday, who otherwise would not have access to their regular oral health services provider.

2.1.7 Special dental services for children and adolescents not requiring prior approval

These are services described in Clause E5.4 of the CDA that will be purchased on a fee-for-service basis and may be provided without the approval of a designated ADO of the district.

2.1.8 Special dental services for children and adolescents requiring prior approval

These are services described in Clause E5.5 of the CDA that may be provided with the prior approval of a designated ADO of the district.

2.2 Where prior approval is required

Prior approval is required for *all* treatment items listed in Clauses E5.5 and E5.7 of the CDA. This applies to all enrolled patients. Obviously, in some urgent or emergency situations, prior approval for the service may not be practicable. In this circumstance approval should be sought as soon as possible after the treatment is provided. The Dentist, Dental Therapist, Oral Health Therapist or Dental Hygienist providing the treatment must sign the prior approval application form.

Please Note: If prior approval has not been sought and is subsequently declined, then the patient is not obliged to pay for the treatment provided.

2.3 High caries treatment planning

Where an adolescent presents with high caries needs, these services may be purchased on a fee-for-service basis.

It is expected that High Caries Treatment Planning will arise in one of four ways:

1. The enrolling adolescent is in Year 9 and has left the Community Oral Health Service with extensive unmet treatment need (the Principal Dental Officer or Clinical Director of the relevant Community Oral Health Service should be made aware, if not already so, of such individuals leaving the service); OR
2. The adolescent has not attended the Community Oral Health Service or any other health provider for an extended period of time, resulting in a large amount of unmet treatment need; OR

3. The adolescent has recently entered New Zealand from overseas and, being an eligible person, presents to the oral health service provider with a large amount of unmet treatment need; OR

4. The adolescent's caries risk has changed dramatically.

Consideration will be given by the ADO of the district for access to High Caries Treatment Plan funding where the adolescent can be shown to be in need of one surface restorations (FIL1) in four or more posterior teeth, in addition to any other treatment need. Please note that carious lesions requiring single surface restorations (FIL1) are expected to involve dentinal tooth structure. High Caries Treatment Plan funding is not confined to the first 12 months after enrolment. It can be applied for in any 12 month period where the patient demonstrates a need for the treatment.

The ADO is not obliged to approve High Caries Treatment Plan funding just because an adolescent is deemed to have four or more teeth requiring single surface restorations (FIL1), without further evidence of high caries and an explanation of the reasons as to why this has occurred (as described above). **For example, the provision of four or more small single surface restorations for an adolescent who has received regular care and is not showing other evidence of high caries activity, would not be considered in need of High Caries Treatment Plan funding.**

Please Note: If a claim is made under High Caries Treatment Plan funding, a further capitation package claim can be made in 6 months.

Approving Process

1. The Provider will submit an application for approval to provide treatment not covered by the standard package or the fee schedule (HP5958), outlining the treatment required and including radiographs and / or clinical photographs. From 2017, the ADOs have developed a high caries treatment planning form (in addition to the prior approval form). This form (HP6656) should be used in order to avoid delays in processing the applications. This may be accompanied by a letter or computer-generated treatment plan. The treatment plan submitted should include <u>all</u> dental treatment required. **An explanation as to why the adolescent is in need of High Caries Treatment Plan funding must be provided.**

2. If the ADO approves the application, the ADO will assign an approval number and sign and return the form to the provider.

3. The Provider must attach the approved and signed form to the appropriate claim form. For high caries treatment this is form HP5955 High Caries Treatment Planning (Adolescents) Treatment Report/Claim Summary Form.

4. A single surface restoration (FIL1) and a fissure sealant (FIS1) may not be claimed on the same tooth at the same appointment. It is expected that while any one surface restoration is provided that any other at risk surfaces are sealed at the same time.

Please Note

- Many cases with high treatment need are already covered under Sections F2.1 and F2.2 of the CDA – Schedules for Additional Oral Health Services for Adolescents.

2.4 Services not provided under this agreement

The CDA excludes services sedation services and other services that are not within the scope of practice of a general dentist, dental therapist, dental hygienist or oral health therapist. If you propose to provide a service not covered under this agreement you are required to have the patient's informed consent and agreement to the payment of any fees.

This situation may occur where the proposed services are not included in the agreement (for example, extractions for orthodontic purposes, sedation).

Patients who are eligible for treatment through Accident Compensation Commission (ACC) are not funded through the CDA. If a patient's required treatment is due to an accident, then the patient must register the accident with the ACC. Treatment under this agreement is only available when ACC declines the claim. Written evidence is required.

2.5 Queries

If you have any queries regarding the Agreement with us please contact the person named on the front of your CDA contract.

2.6 Providers required to provide treatment

In general, you are required to provide all the services to which you have contracted in this Agreement to enrolled adolescents and/or children and adolescents. Private fees are not permitted for any treatment for which an item exists under the CDA (e.g. periodontal treatment or hygiene visits). Co-payments are not permitted in any form.

However, you may sub-contract the provision of services as outlined in Clause A14 of the CDA as long as these services are undertaken under the CDA. If two different providers are required to complete one course of treatment, only a single CON1 can be claimed. A second provider must not claim a CON1 or a CON3. Only the treatment completed maybe claimed.

2.7 Mobile Providers required to arrange ongoing treatment for adolescents

Mobile Providers must ensure that their enrolled adolescents can easily obtain the full range of services and treatments that the Mobile Provider is required to provide under the CDA from the Mobile Provider, within the expected timeframes after examination. If the services or treatments required are complex and/or outside of the Mobile Provider's practitioners' scope of practice, or in emergencies when follow-up care is urgently required during normal hours, but the Mobile Provider's mobile unit is no longer at the adolescent's school, the Mobile Provider must arrange for their enrolled adolescents requiring additional consultations, treatment or emergency care to be seen at:

(a) a fixed practice within the same company ownership as the Mobile Provider and within reasonable travelling distance for the patient;
(b) a mobile clinic owned by the Mobile Provider based at another school within reasonable travelling distance for the patient; or
(c) another CDA provider (**Second Provider**) with which it has a written subcontract, at a practice that is within reasonable travelling distance for the patient.

The Mobile Provider is required to have a written subcontract with a Second Provider that provides:

(a) the Second Provider has agreed to provide follow up consultations, treatments and emergency services for adolescents enrolled with the Mobile Provider;
(b) only one CDA annual capitation fee (via a CON1) will be claimed per adolescent annually and, therefore, the Second Provider will not claim a CON3 or an annual capitation fee (eg, via a CON1, COM1, COM2, or COM3) for an adolescent enrolled with a Mobile Provider with which they have the subcontract;
(c) the Mobile Provider will pay the Second Provider a fee for a consultation in association with provision of on-going treatment, including emergency consultations in normal hours. The fee will be paid by the Mobile Provider to the Second Provider out of the CDA annual capitation fee that the Mobile Provider claims for the enrolled adolescent;
(d) the Mobile Provider will pay the Second Provider a fee for any capitated standard package of services treatments in association with provision of on-going treatment, for example FIL1 restorations. Any fees will be paid by the Mobile Provider to the Second Provider out of the CDA annual capitation fee that the Mobile Provider claims for the enrolled adolescent;
(e) any non-capitated treatment fees (eg, for High Caries Treatments of Additional Oral Health Services for Adolescents) can be claimed in the usual way by the Second Provider under its CDA, and must not be claimed by the Mobile Provider; and
(f) the Mobile Provider will share dental radiographs with the Second Provider, wherever possible, and in a secure and timely manner.

A template subcontract between a Mobile Provider and Second Provider that includes provisions that reflect the above requirements is available on Te Whatu Ora's website, for Mobile Providers and Second Providers to use if they wish to do so.

To ensure timely access to emergency dental care throughout the year, the Mobile Provider will inform adolescents enrolled with the Mobile Provider about how and where to access emergency care, and ensure that this information is also readily available on the Mobile Provider's website and phone messaging service. This information will be provided in using methods acceptable to the adolescent or their caregiver e.g. text messaging.

3. Audit Guidelines

Audits can be initiated by either Te Whatu Ora, or by the Audit & Compliance Unit or other entity which monitors information and payments to ensure they are justified. Since health services are funded by taxpayers' money, they are closely monitored to provide accountability. Audits and investigations are conducted in accordance with the terms of the CDA.

3.1 Audit

The audit process involves the following:

- Comparison of the provider's reporting levels and trends with national, regional and district data.
- Desktop analysis of the provider's reporting over a recent 12-month period.
- A visit to the practice where a selection of reports are checked against the patients' records.
- A survey of a selection of patients to check that the services reported were provided.
- A clinical audit of patients.

3.2 Investigation

Formal investigation systems have been developed to detect and deal with the rare cases where fraudulent and inappropriate reporting and service provision is encountered. In these cases, the audit may become an investigation with police involvement. Our aim is to be professional, objective and fair. Please refer to Part A, Standard Terms and Conditions in the CDA.

4. Information Guidelines

4.1 Computer claiming

Computer claiming is acceptable provided the computer-generated printout contains all the information required and has the same layout as the forms supplied. Providers should ensure that all software used for reporting complies with the reporting criteria and standards required under the CDA.

Please ensure that computer-generated forms include all information to demonstrate the full sequence of treatment items.

The Ministry of Health website contains the full range of forms for enrolling patients and claiming under the CDA. These can be completed electronically, printed and signed before sending to Sector Operations (http://www.health.govt.nz/new-zealand-health-system/claims-provider-payments-and-entitlements/dental-claim-and-enrolment-forms)

Items of treatment which fall within the standard capitated package must be reported separately even though there is no individual fee for the item. This is vital to ensuring accurate oral health records.

4.2 Agreement number

Your CDA will have your agreement number written on the front page. The number must be on all information reporting approval applications and correspondence you submit to Te Whatu Ora. New agreement numbers are only issued when a new provider enters into an agreement.

The name and Dental Council (DCNZ) registration number of the treating clinician is required on forms HP5952 (adolescent claim summary form), HP5955 (high caries form), HP5958 (application for prior approval), and HP5957 (special dental claim summary form), and on prescriptions. Clinicians without a DCNZ registration number should use their DCNZ Person ID number.

4.3 Assigning or ending your agreement

The CDA contains specific clauses regarding ending or assigning your contract. You may transfer your rights and obligations to another provider after seeking written approval from Te Whatu Ora. Te Whatu Ora will not unreasonably withhold approval. The following guidelines are suggested to allow Te Whatu Ora and/or other party time to complete their due diligence processes:

- Less than 1000 enrolled patients: six weeks
- Greater than 1000 enrolled patients: 13 weeks

Clause A34 of the CDA lists specific notice periods required when ending your contract.

4.4 Identification of patients and providers

The agreement number is to be used for the purpose of identification of providers.

The first name, last name, date of birth and NHI number are to be used for identification of patients.

4.5 National Health Index (NHI) number

The unique number allocated to every user of health and disability services in New Zealand. An NHI number alone does not guarantee eligibility (see section 5.5).

5. Payment Guidelines

5.1 Goods and Services Tax (GST)

All fees contained in the Oral Health Services for Adolescents and Special Dental Services for Children and Adolescents Agreement are GST exclusive.

5.2 Identification of payments

Each Claim Summary form should have a unique Reference Number, that is, the number YOU have given that particular form. This number will be shown on any Remittance Advice and identifies the group of services for which the payment is being made.

If your records are in order and we notify you of any changes to your payments, you will have all the information required.

Records you need to keep to enable you to identify payments are:

- copies of all claims sent to Sector Operations
- records of the date that these claims were sent
- copies of approvals from the ADO of your district.

5.3 Seeking approval for additional oral health services for adolescents requiring prior approval

Approval for these items should be sought by sending all three copies of the approval form to the designated ADO appointed by your district. This enables the two copies to be returned to the provider, and the third copy to be retained by the ADO. For computer generated requests, three copies must be sent to the ADO.

The ADO will issue you with an approval number which must be included when you submit any claims requiring prior approval. Do not claim for these services until you have the approval of the ADO of the district as payment will not be made for these services without of the approval form and an approval number.

5.4 When can you expect payments?

On receipt of a valid claim Sector Operations will make payment by direct credit to your bank account within 20 working days.

Please keep all correspondence from Sector Operations to check against the remittance advice and copies of information reported.

5.5 General eligibility guidelines

The eligibility criteria are set out below and in clause E4 of the CDA. Eligibility for services provided under the CDA is also subject to the Health and Disability Services Eligibility Direction, which is available on the Ministry of Health's website by searching under 'Eligibility Direction'.

An Eligible Person for Oral Health Services for Adolescents comprises:

- Adolescents from the start of school year 9 up to the day before their 18th birthday (including adolescents who are home schooled or placed in alternative education, or who have left school).
- Children, year 8 at school and under, who have been referred or officially released early from the Community Oral Health Service due to the Service not being able to treated them due to medical or management reasons and whose transfer has been approved by the ADO. On the top of the child's dental enrolment form it must be clearly written that this is an approved early release from the Community Oral Health Service (this is to inform Sector Operations that the transfer is accepted by Te Whatu Ora). In addition, the name of the school the child currently attends should be noted on the enrolment form.
- Providers will not exclude from enrolment Eligible Persons based on their presentation at enrolment with a high level of treatment need or their likelihood to have a high prevalence of oral disease.
- Having an NHI number does not guarantee eligibility.

An Eligible Person for Special Dental Services comprises:

- All children from birth until the end of school year 8 enrolled with the Community Oral Health Service, and who otherwise would not have reasonable access to their regular oral health services provider.
- Adolescents, from and including school year 9 up to their 18th birthday, who otherwise would not have access to their regular oral health services provider.
- Eligible Persons for Special Dental Services include children and adolescents meeting the above criteria who are home schooled or placed in alternative education, or who have left school.

In all cases eligibility is also subject to the general eligibility criteria for publicly funded health services in New Zealand specified in the Health and Disability Services Eligibility Direction, which can be found on the Ministry of Health's website: http://www.health.govt.nz/new-zealand-health-system/eligibility-publicly-funded-health-services.

The 'Eligibility Check List' is particularly useful to dental practitioners and their practice managers. Those eligible include persons under 18 years of age who meet the following criteria, or persons under 18 years of age who are under the care and protection of a parent or guardian who meets these criteria:

- New Zealand citizens (including those from the Cook Islands, Niue or Tokelau).
- New Zealand permanent residents
- An Australian citizen or permanent resident who has lived, or intends to live, in New Zealand for two years or more.
- New Zealand Aid Programme student receiving Official Development Assistance funding.
- Commonwealth scholarship students.
- Refugees and protected persons, applicants and appellants for refugee and protection status, and victims of people trafficking offences.
- Holders of work visas for a period that equals or exceeds two years.

6. Treatment Guidelines

The Treatment Guidelines should be read in conjunction with the CDA and subsequent amendments. They are intended to assist contracting oral health practitioners to interpret the Agreement.

6.1 Standard oral health services

6.1.1 Consultations – oral health services for adolescents (covered in capitated funding)

Consultations include examination and diagnosis, prophylaxis, advice on dental care and any special tests along with bitewing and periapical radiographs considered necessary. This includes both regular consultations as necessary and any necessary emergency consultations in normal hours.

All patients will receive at least one annual consultation per calendar year (1 January to 31 December). It is expected that such consultations will be at approximately 12 monthly intervals except in the year when the patient reaches their 18th birthday. At this time a consultation may be claimed prior to the birthday, providing there is an interval of nine months or more since the previous consultation. This is at the provider's discretion.

All treatments should be scheduled within two months of the initial consultation date. All patients should have their treatment plans designed to meet their level of need and caries risk.

A consultation fee may be claimed once each calendar year for each patient. Where a patient is at risk, it is expected that such consultations will meet the needs of the patient at no further consultation cost.

The CDA's capitation package has three payment bands. These are based on the Ministry of Education decile of the school the patient attends – with payments being higher for adolescents attending low-decile schools. The majority of patients are expected to be in good oral health, requiring only preventive care such as fluoride varnish application and/or fissure sealants, and relatively little restorative care. Some adolescents may require multiple services such as fissure sealants, preventive resin restorations, and/or occlusal restorations within a particular treatment episode. The capitated fee remains the same (excluding fee adjustments) for each year that an adolescent is seen under the contract (provided they do not move from one 'decile band' to another). Providers who treat adolescents who have left school or attend a school without a decile rating (some independent and charter schools) should claim the 'middle' decile band (COM2) as described in F2 of the CDA.

The purchase unit (services within the package) for Oral Health Services for Adolescents contains the following: Consultation, including examination and diagnosis, advice on dental care and any special tests and bitewing radiographs considered necessary. This includes all consultations with the exception of emergency consultations outside normal practice hours. Where a patient is at increased risk (for example, high caries rate or evidence of periodontal disease), it is expected that any additional consultations required will be provided to meet the needs of the patient at no further consultation cost.

1. Prophylaxis as required. Most adolescents will require no more than the removal of supragingival calculus. Prophylaxis is considered the removal of all coronal calculus with or without a polish. For those requiring treatment of periodontal disease prior approval will need to be sought for PDT1.

2. Fissure sealants where required. It is expected that all teeth considered at risk will be fissure sealed to reduce the chance of decay. This is aimed at improving the dental health of the patients and reducing the number of patients who require treatment for the remaining years of the capitated package of care.
3. Other preventive treatments (for example, topical fluoride applications) where required.
4. Chair side education on oral health care. Prevention provided early in the capitated package benefits both the patient and dental provider.
5. Single surface restorations (FIL1) (when more than three teeth require treatment, High Caries Treatment Plan funding may be applied for.) These restorations are expected to involve dentinal tooth structure.

It is important that all fissure sealants, topical fluoride applications and single surface restorations (FIL1) are recorded as being completed. Even though an extra fee is not usually able to be paid, this data is essential for ongoing analysis of the capitation model.

6.1.2 Consultations – special dental service (CON3)

There is a consultation fee covering referrals from the Community Oral Health Service or adolescents enrolled with another provider in an emergency or referral situation

CON3 may be claimed when a patient:

1. Is a child or an adolescent and has been referred from the Community Oral Health Service or another provider for a service they are unable to provide, or
2. Presents for emergency care and is in school year 8 or below OR if in year 9 or above either enrolled with another provider or not enrolled with any provider

It is expected that the patient will return to their usual provider as soon as practical

CON3 is **not** to be used for any patient enrolled in your own practice.

6.1.3 Posterior restorations – single surface (FIL1)

All posterior single surface restorations (FIL1) are included in the standard capitated package for adolescent patients. Please refer to section 2.3 High Caries Treatment Plan funding where the adolescent can be shown to be in need of single surface restorations in four or more posterior teeth. A fee is claimable for single surface restorations for SDS patients.

The fee for any single surface occlusal restoration includes any carious pit on that surface filled at that treatment episode. This includes both the anterior and posterior occlusal pits of molars if carious. The fee also includes any carious buccal, lingual, or palatal fissure which is an extension of the occlusal lesion. If the buccal, lingual, or palatal carious lesion requires a separate restoration it may be claimed as such.

6.1.4 Preventive services - Fissure sealants, fluoride applications, oral health education

Fissure sealants as well as spot and general applications of fluoride are included and funded as part of the standard (capitated) oral health services for adolescents' package unless High Caries Treatment Planning has been approved. Fissure sealants are outside the scope of Special Dental Services because

they are provided by the Community Oral Health Service. Fissure sealants may not be claimed as a single surface restoration.

6.2 Additional oral health services not requiring prior approval

6.2.1 Posterior restorations two-and three surface restorations (FIL2 and FIL3)

- Separate MO and DO fillings placed in the same tooth at the same course of treatment may be claimed separately as individual two surface restorations (FIL2).
- The two surface (FIL2) code is for mesio-occlusal, or disto-occlussal restorations**, including** buccal / palatal / lingual extensions.
- The three surface (FIL3) code is for mesio-occlusal-distal restorations, **including** any buccal / palatal / lingual extensions.

6.2.2 Posterior complex restorations (FIL4)

The fee for a complex restoration is payable only in cases where a cusp is being restored. The fee for a complex restoration includes the concurrent restoration of any other surface of the same tooth.

6.2.3 Anterior restorations – one-surface non- metallic (FIL5)

These may be claimed for any surface of an anterior tooth or buccal surface of a premolar tooth. Mesiopalatal and distopalatal restorations in anterior teeth are classed as 'one-surface' restorations. If the palatal surface was involved only to gain access to the proximal then this is a one-surface restoration. If decay was so extensive that it involved the palatal and the proximal surfaces then it would be a two-surface restoration. Two or more single-surface restorations on the one anterior tooth may be claimed for.

6.2.4 Anterior restorations – multiple-surface (MI, DI, MID) non- metallic (FIL6)

It is anticipated that most anterior teeth requiring multiple surface non-metallic fillings will have been damaged as the result of an accident. In such circumstances, claims must be made from the ACC.

However, if there are multiple surface anterior restorations required due to caries then these restorations can be claimed separately and are no longer claimed per tooth, even if done at the same appointment.

Separate single-surface restorations may be claimed in addition to a multiple surface restoration where they are filled concurrently in the same tooth.

6.2.5 Routine extractions (non-surgical)

Deciduous teeth

A specific fee (EXT1) can be claimed for the extraction of a deciduous tooth, or multiple deciduous teeth in the same quadrant. If additional deciduous teeth in a different quadrant are extracted at the same appointment, then a further fee can be claimed at a lower rate (EXT2) as shown in the Fee Schedule.

Permanent teeth

A specific fee (EXT1) can be claimed for the extraction of a single permanent tooth (EXT1). If additional permanent teeth are extracted at the same appointment, then a further fee can be claimed at a lower rate (EXT2) as shown in the Fee Schedule.

If there are more than four permanent teeth to be extracted, then a fee may be negotiated with an ADO.

Orthodontic extractions are not claimable under the Agreement.

6.2.6 Emergency consultation outside normal hours

A fee is provided for an emergency consultation outside the practice's normal practice opening hours. This fee is intended to compensate a practitioner for having to make a special visit to the surgery. The time and date of the consultation should be recorded in the patient's surgery records and on the claim form.

6.2.7 Emergency dressings

This service is applicable only in those circumstances where a patient attends as an emergency patient and where the placement of a dressing is the only treatment that can be provided in the time available. It covers only dressings that are placed within teeth and not medicaments placed on soft tissues or teeth. The fee does not cover temporary fillings in teeth that are being root filled or temporary fillings placed during definitive permanent restoration, as all such dressings are included as part of the treatment fee.

6.2.8 Preformed metal crowns

Stainless steel crowns may be placed on deciduous or permanent teeth with extensive caries or developmental deformities or after pulp therapy.

6.2.9 Recementation

Recementation of inlays or crowns may be included as items not requiring prior approval.

6.2.10 Panoramic radiograph

These should be taken only in special circumstances, for example, in lieu of taking multiple periapical radiographs or where a larger view is required. To assist you in deciding the appropriateness of seeking approval, please consider the following:

- An OPG (panoramic) x-ray film is an aid to oral diagnosis that is available in some dental practices and at Hospital Dental Departments.
- Under the CDA, radiographs will most commonly be PBW films (especially for caries diagnosis) and PA films. In most cases, a well-placed and well-processed PBW or PA film will provide superior information to that given by an OPG. This is especially the case with caries diagnosis for which an OPG is generally not indicated, since definition of enamel and dentine radiolucencies is inferior to that given by the PBW film.
- Routine patient screening with OPGs is not justifiable.
- The clinical indications for the use of an OPG film under dental benefits in general practice could include:

- Family history or other evidence that suggests increased probability of missing or extra teeth.
- Assessment of the dentition in planning treatment when multiple grossly hypo-mineralised or grossly carious permanent teeth are present, if extraction of such teeth is being considered (but please note that approval for a claim is not available for an OPG taken to assist in orthodontic treatment or for the routine extraction of third molars).
- Evidence of bony fracture.
- When a client cannot tolerate intra-oral films, for instance because of facial swelling, gagging reflex, limited opening, or some degree of handicap. This is probably the sole indication for using an OPG to aid in caries diagnosis.
- Evidence of extensive pathology.
- Those rare occasions where symptoms exist in more than one area of the mouth.
- Routine OPG radiographs are not approved for wisdom teeth unless there is a specific reason to do so, for example, pain, pericoronitis, extreme pressure.

6.2.11 Pulp and root canal treatment

Best clinical practice for irreversible pulpally-involved permanent teeth suggests that management by root canal therapy and not by pulpotomy is the preferred option. A pulpotomy should only be used in unusual cases. For example, a hypo-mineralised first permanent molar may require extraction but we may want to delay extraction to coincide with appropriate development of the second permanent molar. A pulpotomy is defined as the complete removal of tissue within the pulp chamber. It is certainly not intended as a routine procedure. Pulp capping or dressings are NOT pulpotomies.

Root canal fees are based on the number of root canals filled. For example, for teeth with two canals the fee is twice the schedule fee. After performing any root canal treatment, a post-operative radiograph must be taken and placed with the patient's records.

It is a clinician's responsibility to appropriately assess and discuss not only the difficulties and risk of the root canal, but also the restorative success of the tooth. A root canal should not be attempted unless the tooth can be successfully restored following the root canal.

Where additional visits are required (e.g. to manage difficult acute problems) contact your Approving Dental Officer who may be able to approve additional fees.

Usually, posterior teeth (premolars and molars) should have cuspal protection. Usually this can be provided with direct restorations. On occasions this may be better achieved with a crown and these may be applied for, with prior approval, after a period of six months (with interim cuspal protection) so the success of the root canal treatment can be assessed.

The long term success of any molar root canal is usually reliant on the success of the restoration following root canal treatment. It is expected that interim restorations and future restorations, as well as other options (apart from root canal therapy) are discussed in the prior approval, as part of the treatment planning for any patient.

With deciduous teeth there is a maximum fee for treatment regardless of the number of canals, where root canals are filled in addition to the pulp chamber. Pulpectomy, in deciduous teeth should only be

considered for primary teeth that have intact roots. Severe infections associated with primary teeth do not respond well to pulpectomy.

There are occasions, although rare, where a pulpectomy is required on a deciduous second molar, in order to keep this tooth long term.

6.3 Additional oral health services requiring prior approval

6.3.1 Minor oral surgery (including surgical extraction)

Fees may be approved for minor oral surgery.

Minor oral surgery is defined as surgery normally considered to be within the practice of general dentistry, for example surgical removal of impacted teeth, roots, cysts, gingivectomy. Fees are on a time basis. Adequate clinical information and, where appropriate the inclusion of radiographs, should be supplied with the approval application to the ADO. Radiographs will assist the ADO in making a decision. If a fee for minor oral surgery is approved, then an extraction under local anesthetic cannot be claimed as well for the same tooth or teeth.

Approval is not given for the routine extraction of wisdom teeth. There must be a demonstrable need to extract the wisdom teeth, for example, pain or infection.

Root resection (apicectomy) is claimed as a minor surgical operation.

The prescribing of antibiotics and the simple lancing of an abscess to control infection is considered to be included within the treatment fee. However, should further intervention be required to control the infection then prior approval can be granted on a limited time base on request, for example tubal drainage.

***NB**: The fee claimed should be for the total time taken for the surgical procedures including post-operative services such as the removal of sutures. The time taken must be shown on the approval form.*

6.3.2 Bleaching

Bleaching of permanent teeth may be claimed on a time basis at a fee equivalent to that for a minor surgical operation. Bleaching is limited to discoloured non-vital teeth and intrinsic staining.

6.3.3 Splints (other than as a result of an accident)

In most cases the splints are provided as emergency treatment for accident cases and therefore should be claimed from ACC.

These splints are to support teeth which are mobile due to periodontal condition. Approval may be given on a time basis. This would include cost of splint materials.

Also see 7.3.12 – Bite Splints.

6.3.4 Periodontal treatment

Removal of supragingival calculus is expected to be completed under the standard package of care, accepting that some individuals will require longer treatment times than others, and occasionally more than once a year. However, there will be times when more extensive treatment is required.

For patients who have sub-gingival calculus and bleeding on probing, or have pocket depths greater than 3.5mm with bleeding on probing (with or without attachment loss), it would be considered appropriate to offer further treatment and a PDT1 fee may be applied for. This will allow for further appointments to be undertaken. It is not expected that this is undertaken at the time of examination and may be undertaken by a dentist, dental hygienist or oral health therapist. This allows for all periodontal care to be completed by means of CON1 (coronal scaling within the standard package of care) or PDT1. The only exception to providing care within the CDA would be severe periodontal disease, which would require treatment by a specialist. At present this is not covered by the CDA.

For prior approval, evidence of sub-gingival calculus, charting of bleeding pockets of greater than 3.5mm and/or bone loss is expected. Additional information will be required for the approval for PDT1 for use in periodontal treatment and must include a diagnosis of the periodontal disease state and a treatment plan. At a minimum this will include:

- CPITN/BPE charting with bleeding on probing.
- Diagnostic radiographs.
- Proposed treatment schedule (number and length of visits).

The treatment plan may also include photographs where these support the request for approval.

When more than one appointment is proposed more than one PDT1 can be applied for at a time. However, the provider must provide justification for the number of visits.

6.3.5 Prosthetic appliances – partial dentures

Acrylic partial dentures may be approved at the scheduled fee.

Repairs and additions to dentures may be approved and claimed at laboratory costs plus the provider's time. An invoice for the laboratory costs should be available to the ADO on request.

Precision cast metal partial dentures may be approved for patients over 15 years of age.

Replacement of metal partial dentures is unlikely to be approved.

To discuss the provision of other partial denture materials such as "Valplast", please contact your ADO.

6.3.6 Prosthetic appliances – full dentures

These are rarely required but may be approved in appropriate circumstances. Fees for relining of immediate dentures may also be approved.

6.3.7 Crowns

The CDA allows for crowns to be constructed, usually in composite, ceramic, ceramic bonded to metal or full gold materials. In general, approval is limited to cases where restoration is required as the result of tooth tissue loss or absence that adversely affects function, or where malformation or discolouration is sufficiently severe to affect the patient's wellbeing. The application must be supported with appropriate periapical and bitewing radiographs.

The patient should be 15 years of age or older. Providers should be aware that if a ceramic, ceramic bonded to metal crown or a full gold crown requires replacement before the adolescent's 18th birthday it is unlikely to be approved for payment.

In all cases parents and/or patients should give consent only after being fully informed regarding removal of tooth tissue, the likelihood of the need for replacement and their responsibility for the cost of replacement.

The prior approval application should include clinical information*:*

- Periapical radiograph of the tooth/teeth.
- If root canal filled, a film usually six months or more after completion of root canal treatment.
- Posterior bitewing radiographs.
- A statement indicating that the dentition is well cared for and free from periodontal disease and significant levels of active dental caries.
- A statement showing why a direct restoration would not be satisfactory.
- Photographs where appropriate.

A complex composite restoration, (with its own price) includes a full coverage composite crown. 'Full coverage' includes at least half of each of the mesial, distal, labial and palatal/lingual surfaces.

For any crown to be approved it is expected that the same criterion be used, as in any other patient, that the caries risk has been assessed and considered to be low. Oral hygiene must be good. Crowns will not be approved if a patient is caries active.

- **Hypo-mineralised teeth.**

A variety of treatment regimes can be approved on a case-by-case basis.

- **Posts**

Both cast and preformed posts may be approved. The higher price in the agreement is for a post and core cast in precious metal and includes the cost of the metal. Other non-precious metal posts attract a lower fee, for example plain stainless steel or others such as para or flexi posts.

- **A temporary crown**

While a permanent crown is being constructed, the temporary crown is not funded under the Agreement as a separate item as it is considered to be part of the overall price of the permanent crown.

6.3.8 Anterior veneers

Approval will be limited to teeth which have severe intrinsic discolouration, hypo-mineralised incisors, Turners teeth, teeth with congenital abnormalities and those that have been extensively restored. Single-surface repair is no longer possible.

Composite veneers means full labial surface coverage and are the first choice on children up to the age of 17 years.

Porcelain veneers may be approved in children over the age of 15 years. However, approval is at the discretion of the ADO as it is good clinical practice to delay the placement of porcelain veneers as long as possible.

Requests for approval for all veneers should include periapical radiographs and clinical photographs.

6.3.9 Inlays

Inlays are not provided for under this Agreement.

6.3.10 Periapical radiograph

Generally this is considered a part of the capitation package and is included in the Annual Consultation fee. On rare occasions, a fee may be justified after approval from the ADO, for example in lieu of a panoramic radiograph.

6.3.11 Apexification/root filling teeth with an open apex

Approval may be given for a fee to cover the placement of a calcium hydroxide dressing or other appropriate materials in a root canal to promote the apexification of an immature tooth. The treatment requires prior approval. The fee may be paid on more than one occasion but there should be radiographic evidence of change before replacement of the calcium hydroxide dressing or other material. This should be submitted with the approval form.

6.3.12 Bite splints

Occlusal splints (bite splints) have been proposed to manage temporomandibular disorders and parafunctional activity. Temporomandibular disorders are rare in adolescents (and usually temporary) and requests for occlusal splints are most likely to be as a result of bruxism. Generally, it is accepted that tooth wear, in adolescents, is from attrition, erosion or a combination. Diagnosing and treating the underlying disease is a prerequisite in the management of tooth wear.

Bite splints, for bruxism, should only be considered for severe cases with **significant** tooth wear, where the cause is attrition as opposed to erosion. Bite splints will only be considered for the permanent dentition. Hard acrylic materials are preferred for the majority of splints as there is some evidence that soft splints may exacerbate bruxism. Soft splints are only advocated for short term use and are not covered within the CDA.

Splints funded from the CDA are expected to be a full coverage laboratory processed heat-cured acrylic product (with or without a soft lining).

The ADOs will monitor the clinical circumstances being submitted for prior approval. Applications should provide the following information:

- The degree of attrition noted and the differential diagnosis between attrition and erosion.
- Any mobility of the teeth affected.
- Any sensitivity of the teeth.
- Comments on the TMJ: pain, clicking, deviation on opening.
- Did the patient complain of the problem or was it the clinician's observation?

It is expected that either models, or photographs of models, will be sent to an ADO, to assess the degree of wear. Please note significant wear is required for a bite splint to be approved. It is also important that the type of splint (full coverage laboratory processed heat-cured acrylic product (with or without a soft lining) is written on the application to avoid any confusion.

7.0 General

7.1 Pulp capping

This is considered as part of the routine treatment so there is no additional fee.

***NB**: This treatment may not be claimed as a pulpotomy.*

7.2 Pins

There is no payment for pins as this is included within the price for the particular treatment provided.

7.3 Orthodontic treatment and extractions for orthodontic purposes

Orthodontic treatment, including space maintainers, and extractions of either deciduous or permanent teeth for an orthodontic purpose are outside the scope of the CDA. The issue of congenital absence of a permanent tooth can be discussed with the ADO.

7.4 Implants

This treatment is outside the scope of the CDA.

7.5 Bridges

Adhesive bridges (of the Maryland type) are permitted subject to prior approval. Other forms of bridges are outside the scope of this Agreement.

7.6 Glass Ionomer cement or composite fillings in primary teeth

Glass Ionomer cement or composite may be used as a filling material in primary molars where appropriate. The maximum fee is that for the equivalent amalgam filling.

7.7 Sensibility test

This is normally included within the consultation fee. If an exceptional case was to arise this could be negotiated with the ADO. It is expected that in most cases this would be an ACC charge.

7.8 ACC

Treatment as the result of an accident is not covered under this Agreement and should be referred to ACC for payment.

7.9 Prescription of subsidised prescriptions

As a prescriber you are responsible for coding any patient's prescription for subsidised medicines.

When you are providing a service under a Te Whatu Ora contract (for example the Combined Dental Agreement) you are considered to be an approved provider for the maximum $5 co-payment on prescriptions for subsidised medicines (including ACC) and the following codes should be used:

- For children aged 14-17 years you should code a prescription J4 and a maximum co-payment of $5 applies

- For younger children (13 years and under) you should code prescriptions Y4 and there's no co-payment on prescriptions

Providers/prescribers providing a service that is privately funded and do NOT have a contract with Te Whatu Ora, are not approved to code prescriptions for subsidised medicines J4 or Y4 and the following codes should be used:

- For children aged 14- 17 years you should code a prescription J3 and a $10 co-payment applies
- For younger children (13 years and under) you should code a prescription Y3 and there is no co-payment.

Please refer to https://www.health.govt.nz/our-work/primary-health-care/primary-health-care-subsidies-and-services/pharmaceutical-co-payments"

8.0 Children's Act, 2014

8.1.0 Registered dental health professionals and dental assistants working under the CDA are children's workers

Registered dental health professionals and dental assistants providing services to children under the CDA are publicly funded by Te Whatu Ora to deliver children's services, as defined in section 15 of the Children's Act 2014 (the Act), and meet the definition of children's workers under the Act.

8.1.1 Child Protection Policies

In accordance with section 16 of the Act, service providers (including CDA contract holders) are required to:

- adopt, as soon as practicable, a child protection policy (in respect of the provision of children's services) that complies with section 19 of the Act
- review that policy a minimum of every three years
- in accordance with best practice, post a copy of the child protection policy on their internet site. If a provider does not have a website, then they are to ensure a hard copy of the policy is available in the practice.

8.1.2 Children's workers' safety checks

Core and non-core workers

All children's workers employed or funded directly or indirectly by state services (including Te Whatu Ora) for the provision of services that involve regular contact with children are required to be safety checked in accordance with the requirements of the Children's Act 2014, and the Children's (Requirements for Safety Checks of Children's Workers) Regulations 2015, which are together referred to as the 'Children's Legislation'.

The Act has created two categories of children's workers, core and non-core children's workers.

Core children's workers are those who regularly work with children unsupervised or have primary responsibility for children. Dental health professionals providing services under the CDA meet the definition of core children's workers.

Non-core workers are those who have regular but limited child contact. Dental assistants who have contact with children while supporting the provision of services under the CDA meet the definition of non-core children's workers.

Administrative and reception staff in the setting of a dental practice are generally not considered to be children's workers.

Timeline for safety checks

The requirements for safety checks to be completed differ in timing according to whether a children's worker is a core worker or a non-core worker, and whether they are existing or new employees working or to be working with children.

Timing requirements of checks are as follows:

- New core workers from 1 July 2015
- New non-core workers from 1 July 2016
- Existing core workers by 1 July 2018
- Existing non-core workers by 1 July 2019
- Periodic re-checks are required for all workers every three years.

Existing and new children's workers

For the purposes of a safety check, dental health professionals who hold a current CDA or have previously held an agreement are considered to be existing children's workers. Their existing staff who meet the definition of children's workers are also considered to be existing children's workers.

Any dental health professional who intends to enter into a CDA for the first time will need to ensure that a safety check that meets the requirements of the Children's Legislation is completed before an agreement is executed.

Staff newly employed by a CDA contract holder as a dental health professional, or as a dental assistant who will be supporting the delivery of CDA services, must be safety checked and the documentation sent to Te Whatu Ora before they provide services under the CDA.

What is a safety check?

Workforce safety checks involve gathering a range of key information about the person and evaluating this information to assess whether the person to be employed as children's worker poses any risk in working with children. All children's workers must be safety checked by their employer or an external agency.

Police vetting is only part of the requirement for a safety check. A Police vet under the Children's Legislation opens up the Criminal Records (Clean Slate) Act 2004 for certain offences and includes an assessment which is specific to vulnerable children. This is different to a pre-employment Police check.

How to get a safety check

There are two main ways of being safety checked:

If the dental health professional is self-employed:

Because children's workers cannot undertake safety checks for themselves, self-employed sole practitioners need to be externally safety checked. The CV Check service has been selected by the Ministry of Health and gazetted as the provider of Children's Worker Safety Checks for children's workers in the health sector (see https://gazette.govt.nz/notice/id/2017-go730). Information on how to arrange safety checking through CV Check is available on the CV Check website: https://cvcheck.com/nz .

The CV Check service is an online service and there is a cost to be safety checked. If you wish to discuss the safety checking process with CV Check or need support to navigate their website, please ring the CV Check helpline (0800 282 432).

If the dental health professional or dental assistant is employed by a CDA-holder:

Employers can also use the CV Check service to safety check their staff. Alternatively, employers can safety check their own staff, provided the safety check meets the requirements of the Children's Legislation. Employers need to ensure that a Police vet specific to the Children's Legislation is completed for each staff member being safety checked.

Children's workers' safety checks transferable

Safety checks that meet the requirements of the Children's Legislation, whether carried out by CV Check or by an employer, are transferable to another employer provided the safety check was completed within the preceding three years.

Safety checks for new and existing children's workers are different

The safety checking requirements for a new children's worker are more extensive than for existing workers.

Checks for a **new children's worker** are:

- ID verification
- Police vetting
- Employment or personal references

- Employment history
- Interviews with the applicant
- Professional registration check (registration and annual practising certificate – if applicable, i.e. for dental health professionals)
- Final assessment

Checks for an **existing children's worker** are:

- ID verification
- Police vetting
- Professional registration check (registration and annual practising certificate – if applicable, i.e. for dental health professionals)
- Final assessment

Further information

More information about the Children's Act and children's worker safety checking is available on the Ministry of Heath's website by searching under 'Children's Act'.

9.0 Guideline for the Use of Fluoride and Minimal Intervention Strategies

Water fluoridation is considered the safest, most effective and socially equitable population approach to the prevention of dental decay (WHO, 1994). In areas of low, or an absence of, fluoride in community water supplies, fluoride toothpastes appear to have made the greatest impact on reducing dental decay (Thylstrup & Bruun, 1992).

The document Guidelines for the use of fluorides from the NZ Guidelines Group is available on the following link:

http://www.health.govt.nz/system/files/documents/publications/guidelines-for-the-use-of-fluoride-nov09.pdf

Minimal intervention dentistry has been increasingly incorporated into public dental health programmes as the evidence-base for newer materials and techniques has evolved. The principles underpinning minimal intervention dentistry include

- Remineralisation of early dental caries lesions
- Reduction in cariogenic bacteria, in order to eliminate the risk of further demineralisation and cavitation
- Repair rather than replacement of defective restorations
- Disease control.

(Tyas et al, 2000)

The advent of new generations of adhesive materials makes fissure sealants especially important adjuncts to practical prevention. However, certain techniques still lack a suitable level of evidence, reproducibility or predictive value to permit them being endorsed as public health interventions (and thus suitable for incorporation into the Agreement) at this time.

10.0 References

Thylstrup A and Bruun,C (1992). The use of dentifrices in the treatment of dental caries. In: Embery G and Rolla G (eds) Clinical and biological aspects of dentifrices. Oxford: Oxford University Press, pp 131-144.

Tyas MJ, Anusavice KJ, Frencken JE and Mount GJ (2000). Minimal intervention dentistry – A review. International Dental Journal 50:1-12.

World Health Organisation (1994). Technical Report Series 846. Fluorides and health. Geneva: WHO.

11.0 Claiming guidelines

These guidelines outline the correct procedure when providers are submitting dental claims. A list of all codes is provided at the end of these Guidelines.

11.1 The forms

Under the CDA there are six forms.

11.1.1 Enrolment form for adolescent oral health services

An enrolment form must be completed for all patients in order for you to provide treatment and claim under the Adolescent Oral Health Services contract. This form is completed when the adolescent enrols with you after leaving the Community Oral Health Service or when they change to you from another provider. The Agreement Holder must complete all details in the top section of the form. The lower half of this form must be completed by the patient or their legal guardian.

The completed forms are to be sent to: Ministry of Health, Private Bag 3015, Whanganui Mail Centre, Whanganui.

11.1.2 Oral health services for adolescents and special dental services claim summary forms

The Claim Summary Forms are used to summarise the total of the individual claim forms attached. Each claim must contain only those forms which relate to the services identified in the title. A Claim Summary Form must have one or more Treatment Reports attached. Please complete this form in full or your claim may be returned to you for further information.

Please Note: A High Caries Treatment Planning Report does **not** require a Claim Summary form.

11.1.3 The oral health services for adolescents individual treatment report

This form is used to document the treatment and services provided as part of the standard (capitated) package of care. It includes six monthly and emergency consultations (except where a High Caries Treatment Planning Report is used – see below for details). Only 1 patient can be entered on each form. All restorative and other work included in the Standard Capitated Package (even though it does not attract a separate fee) must be reported.

Please Note: If the claim includes treatment requiring prior approval you need to ensure that the Approval number is provided.

11.1.4 Oral health services in high caries treatment planning (adolescents) treatment report/claim summary form

This form is used when there is a high number of caries to treat. All treatments and costs must be listed. Approval must have been obtained from the ADO of your district prior to commencing treatment, and the Approval number must be included on the form. Each claim form provides the details of one patient only.

Please Note: An Individual Treatment Report Form is **not** required when submitting this form.

11.1.5 Special dental services individual treatment form

This form is used for patients enrolled with the Community Oral Health Service requiring treatment outside the scope of the oral health therapist or dental therapist, or for adolescents who are unable

to access their usual provider. If the claim is for treatment requiring prior approval you need to ensure that the prior approval number is provided. The top portion of this form is to be completed by either the patient or the legal guardian of the patient. The bottom portion is completed by the provider.

11.1.6 Application for approval to provide treatment not covered by standard fee schedule

This form HP5958 (Application for Approval to Provide Treatment Not Covered by Standard Fee Schedule) is to be used prior to providing any treatment (OHSA, SDS or H/Caries) requiring prior approval. The form, preferably with radiographs and/or clinical photographs supporting the application and the patient's proposed treatment plan, must be sent to the ADO of the district.

Please ensure that all required information is provided and that the application is signed and dated by the treatment provider. After consideration of the application and if the proposed treatment is approved, the ADO will assign an approval number and sign and return the form to the provider. The provider must attach the approved and signed form HP5958 to the claim form. A copy is retained by the provider.

11.2 Steps for making a claim –Oral Health Services for Adolescents

Step 1

Complete the Individual Treatment Report (**or** a High Caries Treatment Planning Report /Summary for a patient whose care falls into the High Caries Treatment Planning area – see section 11.3, below)

Please Note: A patient must be entered on only **one** of these forms.

Step 2

Oral Health Services for Adolescents – Individual Treatment Report form

Enter the following information on this form:

- The patient's first name, middle initial (if known) and surname.
- The patient's date of birth, gender and NHI number.
- The patient's school's decile score.
- The school name and School ID number of the school the patient attends.

Note: School decile scores and school ID numbers can be found on the Ministry of Education's website: https://www.educationcounts.govt.nz/data-services/directories/list-of-nz-schools

There are three claiming sections on this form and specific information is required in each where appropriate. **For the standard package of care:**

The appropriate Completion or Non-Completion codes based on the decile of the school the patient attends: (COM1, COM2, COM3, NCO1, NCO2 or NCO3)

The appropriate treatment codes provided under the standard package, where relevant noting the tooth number and whether the treatment was completed:

CON1	Annual consultation	PBW1	Bitewing radiography
CON2	Other scheduled consultation (e.g. 6 monthly)	SCL1	Removal of supragingival calculus
CON3	Initial oral consultation for Community Oral Health Service patients or adolescents who are not able to access their regular oral health provider in an emergency during normal practice hours.	FIL1	Single surface restorations in a posterior tooth
CON4	Emergency consultation outside normal practice hours	FIS1	Fissure sealant
TOP1	Topical fluoride treatment	OPT1	Other preventative treatment
RAD1	Periapical radiography		

CON3	A patient for whom your practice has already claimed the annual capitation fee via a CON 1 should not attract a separate fee for a CON3. i.e. there should be no CON3 fee claimed for an oral health practitioner's own patients. These should be recorded as a non-chargeable CON3 for emergency consultations or as a non-chargeable CON2 for other scheduled consultations e.g. 6 monthly. The CON3 should only be claimed when seeing: • A child referred from the Community Oral Health Services. • An adolescent from another practice seen as an emergency (but not from a Mobile Provider with whom your practice has a subcontract). • An adolescent on referral from another provider for a service they are unable to provide (but not from a Mobile Provider with whom your practice has a subcontract nor from a Mobile Provider within the same company ownership as your practice). In the case of a Second Provider with a subcontract with a Mobile provider, or within the same company ownership as the mobile provider, it is expected that the Mobile Provider will pay the Second Provider a fee for a CON3 examination in association with provision of on-going treatment, or for a CON3 emergency consultation. The fee will be paid by the Mobile Provider to the Second Provider out of the CDA annual capitation fee that the mobile provider claims for the patient.

Please note: If the patient no longer attends secondary school or the school they attend does not have a decile rating they will be allocated the middle (4-6) decile band.

For additional services not requiring prior approval:

Refer to F2.1 of the CDA for fees claimed in this section.

In this section enter all other treatment that does not require prior approval.

Enter the following information for each treatment provided:

- The date of treatment.
- The appropriate code (see list at end of this document or on the writing shield on the Claim Summary form pad).
- Any relevant comments.
- Under Quantity enter the number of treatments being claimed on this line.
- Under the heading Tooth enter the number(s) of the tooth/teeth on which the treatment was performed.
- Under Value $ enter the total of fees being claimed for each code multiplied by the number of teeth treated on this line.

For additional services requiring prior approval:

Refer to F2.2 of the CDA for fees claimed in this section.

In this section enter all treatment that requires prior approval.

Enter the following information for each treatment provided:

- The Prior Approval number.
- The date of treatment.
- The appropriate code (see list at end of this document or on the writing shield on the Claim Summary form pad).
- Any relevant comments.
- Under Quantity enter the number of treatments being claimed on this line.
- Under the heading Tooth enter the number(s) of the tooth/teeth on which the treatment was performed.
- Under Value $ enter the total of the fees being claimed for each code multiplied by the number of teeth treated on this line.

Please Note: The claim will not be paid if the prior approval number is not entered.

Add all fees on the Treatment Report together and enter in Total Claimed (note that the total is **GST exclusive).**

Step 3

Claim Summary Form

When all Individual Treatment Reports have been completed, the information from them is brought together and summarised on an Oral Health Services for Adolescents **Claim Summary Form**.

Enter the following information on this form:

- The Claim Reference number.
- The Payee Number.
- The Agreement Number.
- The Agreement Holder's Name.
- The name and Dental Council (DCNZ) registration number (or the DCNZ Person ID for clinicians without a DCNZ registration number) of the clinician who provided the most treatment to each patient on the attached Individual Treatment Reports.
- The number of Individual Treatment Reports attached to the form.
- The value of the attached treatment reports (GST exclusive)
- The GST amount, and the total (GST inclusive).

Ensure the Provider (i.e. the Agreement Holder) signs and dates the form at the bottom of the page below the certification.

Please Note: Failure to provide any of the above information may result in the claim being returned to you unpaid.

Step 4

When forms are completed, attach all Individual Treatment Reports to the back of the Claim Summary form and submit to Sector Operations, PO Box 1026, Wellington for the process of checking and payment.

11.3 Steps for making a claim - High Caries Treatment Planning

Step 1

Claims for treatment for patients who fall into the category of High Caries Treatment Planning are made on the High Caries Treatment Planning (Adolescents) Treatment Report / Claim Summary Form. Each patient requires a separate form.

Please Note: All claims for High Caries Treatment Planning must have prior approval.

Enter the following information on this form:

- The Claim Reference Number, Payee number and Agreement number.
- The Agreement Holder's name.
- The name and Dental Council (DCNZ) registration number of the treating clinician (or the DCNZ Person ID for clinicians without a DCNZ registration number).

- The patient's surname and first name (in BLOCK LETTERS).
- The patient's date of birth and gender.
- The patient's school name and School ID number and the school's decile score (if applicable)
- The Prior Approval Number.

For each treatment provided enter:

- Treatment date.
- The appropriate code (see list of Codes at end of this document).
- Any relevant comments.
- Under Quantity enter the number of treatments being claimed for on this line.
- Under the heading Tooth enter the number(s) of the tooth/teeth on which the treatment was provided
- Under Value $ enter the total of the fees being claimed for on this line.
- Add all fees together and enter in Total Claimed (GST exclusive).
- Calculate the GST if you are registered for GST.
- Enter the GST inclusive total.
- Ensure the Agreement Holder signs and dates the certification at the bottom of the page.

Please Note: Failure to provide any of the above information may result in the claim being returned to you unpaid.

Step 2

Attach the approved treatment plan and submit claim to Sector Operations, P O Box 1026, Wellington, for the process of checking and payment.

11.4 Steps for making a claim - Special Dental Services

Step 1

Special Dental Services – Individual Treatment Report

This form is to be used either for children who have been referred by the Community Oral Health Service or for children or adolescents who have been treated as an emergency patient when unable to access the Community Oral Health Service or their usual oral health practitioner. Use one report per patient.

Ensure that the patient or their legal guardian has completed the top portion of the form on entering your practice and prior to receiving treatment. All boxes must be completed as applicable.

Step 2

Tick the box appropriate for the treatment provided and the category of the patient.

Please Note: The claim will be denied if a box is not ticked.

Step 3

In the appropriate section in the bottom portion of the form, (either standard services or services requiring prior approval), enter the following information:

- Date of treatment.
- Treatment code (see the list of codes at the end of this document or on the reverse of the Individual Treatment Report form).
- Any relevant comments.
- Community Oral Health Service referral number and ADO approval number (where applicable).
- Under Quantity enter the number of treatments being claimed on this line.
- Under the heading Tooth enter the number(s) of the tooth/teeth on which the treatment was provided.
- Under value $ enter the total of the fees being claimed on this line.
- Add all fees together and enter in Total Claimed (GST exclusive).

Step 4

Claim Summary Form

When all the Individual Treatment Reports have been completed, the information from them is brought together and summarised on a Special Dental Services **Claim Summary Form**.

Enter the following information on this form:

- The Claim Reference number.
- The Payee Number.
- The Agreement Number.
- The Agreement Holder's Name.

The name and Dental Council (DCNZ) registration number (or the DCNZ Person ID for clinicians without a DCNZ registration number) of the clinician who provided the most treatment to each patient on the attached Individual Treatment Reports.

- The number of patient reports attached to the form.
- The value of the attached treatment reports (GST exclusive).
- The GST amount, and the total (GST inclusive).
- Ensure the Provider signs and dates the form at the bottom of the page below the certification.

Please Note: Failure to provide any of the above information may result in the claim being returned to you unpaid.

Step 5

When forms are completed, attach all Special Dental Service Agreement Individual Treatment Reports to the back of the Claim Summary form and submit to Sector Operations, P O Box 1026, Wellington for the process of checking and payment.

11.5 Processing system

Once claims are received at Sector Operations, they are date-stamped and checked to ensure accuracy of data provided. If the claim has been completed correctly it is entered on the computer payment programme and payment is lodged in the provider's bank account within the time allowance noted in the Agreement.

If required information is not provided the claim is returned to the provider for correction.

For inquiries regarding claims, call: Sector Operations Helpline – 0800 855 066.

12.0 Codes and Descriptions

Code	Description	Code	Description
COM1	Completion - Decile 1-3	**EMD1**	Emergency dressing
COM2	Completion – Decile 4-6	**PDT1**	Treatment of Periodontal Disease
COM3	Completion – Decile 7-10	**RAD1**	Periapical radiograph
NCO1	Non-completion – Decile 1-3	**RAD2**	Panoramic radiograph
NCO2	Non-completion – Decile 4-6	**RAD3**	Occlusal radiograph
NCO3	Non-completion –Decile 7-10	**MSO1**	Minor surgical operation or time based treatment– 1st half hour
CON1	Annual consultation	**MSO2**	Minor surgical operation or time based treatment – each additional ¼ hour
CON2	Other scheduled consultation (e.g. 6 monthly)	**CRN1**	Preformed metal crown
CON3	Emergency consultation within normal practice hours	**CRN2**	Ceramic to metal crown
CON4	Emergency consultation outside normal practice hours	**CRN3**	All ceramic crown (partial or full coverage)
CON5	High Caries Treatment Planning 12 monthly consultation	**CRN4**	Gold crown (partial or full coverage)
PBW1	Bitewing radiograph	**CRN5**	Full coverage composite crown
FIS1	Fissure sealant	**RCM1**	Re-cement inlay or crown
SCL1	Removal of supragingival calculus	**PST1**	Cast post and core
RAD1	Periapical radiography	**PST2**	Preformed post (para, flexi etc) and core
TOP1	Topical fluoride application	**VEN1**	Porcelain veneers
OPT1	Other preventative treatment	**VEN2**	Labial composite veneers
FIL1	Posterior tooth restoration of Occlusal or Buccal / Palatal / Lingual surfaces	**DEN1**	Precision-cast metal partial denture
FIL2	Approximo-occusal (mesio-occlusal / disto-occlusal) restoration	**DEN2**	Precision-cast metal partial denture – each extra tooth
FIL3	Mesio-occusal-distal restoration	**DEN3**	Acrylic partial denture
FIL4	Complex coronal reconstructions in (including restoration of one or more cusps)	**DEN4**	Acrylic partial denture – each extra tooth

FIL5	Simple restoration in anterior tooth or buccal surface of premolar tooth	**DEN5**	Acrylic partial denture – each clasp
FIL6	More than one surface fillings in an anterior tooth	**DEN6**	Single full denture (upper or lower)
RCT1	Root canal treatment and root fillings in permanent anterior teeth (per canal treated) including all necessary radiographs performed during treatment and a mandatory post-operative radiograph for the patient's records	**DEN7**	Pair of full dentures
RCT2	Pulp removal and root filling in a deciduous tooth (maximum per tooth)	**ABMT**	Adhesive Bridges- Maryland type
RCT3	Pulpotomy in deciduous tooth	**APX1**	Apexification/root filling teeth with an open apex
RCT4	Pulpotomy in permanent tooth	**SPLT**	Bite splints
RCT5	Root canal treatment and root fillings in permanent posterior teeth (per canal treated) including all necessary radiographs performed during treatment and a mandatory post-operative radiograph for the patient's records		
EXT1	First extraction with local anaesthetic		
EXT2	Subsequent extraction with local or general anaesthetic		
EXT3	First extraction with general anaesthetic		

13.0 Conflicts of Interest

Contracted dentists, dental therapists, oral health therapists and dental hygienists are required to declare potential conflict of interest with any parties to their Te Whatu Ora portfolio manager. A process to check conflicts of interest should be completed by Te Whatu Ora at the time of signing a provider onto the CDA and contracted providers are responsible for declaring any conflicts of interest that may arise while they are contracted to provide services.

Dentists contracted to provide adolescent oral health services may also be appointed as an ADO. However, an ADO who is also a contracted dentist and making applications for approval to perform treatment (in accordance with these guidelines) must refer their applications to another ADO.