Victorian privately contracted dental schemes

Provider Handbook

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dental health services victoria

oral health for better health

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This handbook provides information for private providers regarding the Victorian Privately Contracted Dental Schemes. The information supplied is a guide only. More specific information can be obtained by contacting local community dental agencies or Dental Health Services Victoria.

1. OVERVIEW

On behalf of the Victorian Government, Dental Health Services Victoria (DHSV) purchases dental treatment from Community Dental Agencies (agencies) for eligible Victorians. Much of this treatment is provided by public dental providers, with a proportion also provided by private providers.

There are three privately delivered dental schemes operating for public dental patients in Victoria. All schemes aim to improve access to affordable dental care for eligible patients, are administered through agencies, and are funded by the Victorian Government.

The Victorian Emergency Dental Scheme (VEDS) is designed to assist agencies to cope with peaks in demand for emergency care. The Victorian General Dental Scheme (VGDS) may be offered to patients on public General waiting lists, particularly where agencies do not have the capacity to provide in-house care, or where additional funding is available. The Victorian Denture Scheme (VDS) is designed to facilitate greater numbers of patients receiving dentures.

The provision of emergency, general, and denture services by the private sector, will assist agencies to cope with demand for such services.

The VEDS, VGDS and the VDS have a defined schedule of services, defined by the ADA Inc. Australian Schedule of Dental Services and Glossary, 12th edition. Remuneration for services provided by participating providers is based on the Department of Health and Human Services State Rate Fees for Dental Services.

It is not necessary for a private dental provider to sign a formal contract in order to participate in privately delivered schemes. Treating a patient (issued with a voucher) and subsequently submitting a claim for payment is taken as agreement to adhere to scheme guidelines. Providers may participate in privately delivered schemes on a case-by-case basis.

1.1 ELIGIBILITY FOR TREATMENT WITH VOUCHERS

The following groups, being eligible for public dental services, may have their treatment provided via vouchers:

- People aged 18 years and over, who are health care or pensioner concession card holders or dependants of concession card holders
- All Refugees and Asylum Seekers, (whose vouchers need to be issued as copayment exempt)

Ordinarily, children and young people up to 18 years of age will have treatment funded by the Medicare Child Dental Benefits Schedule if care is provided at private providers.

Note: *Holders of the Commonwealth Seniors Health Cards are* ***not eligible*** *for publicly funded dental services.*

Emergency Care

- Usually, patients collect their vouchers from an authorising agency. However, in some special circumstances, a small number of patients may be given 'Telephone Vouchers'. In these cases, the private providers will need to confirm patient eligibility.

Denture Care

- VDS vouchers will usually be issued following a dental examination and provision of any required general treatment. This is to ensure that the oral environment is in an optimal state of health prior to denture construction.
- In some instances, agencies may issue vouchers to patients who have not been examined; those agencies will indicate in an appropriate letter to private providers what additional processes are required.

Telephone Vouchers

If there are special circumstances, such as excessive distances to travel in rural areas, a telephone voucher may be given by the referring agency. In this case, the patient will: • Inform the provider of the name of the agency authorising treatment

- Confirm their eligibility to the private provider upon seeking treatment, and
- Pay the provider the appropriate patient copayments (unless exempt).

The provider will be required to:

- Contact the agency and confirm that a voucher has been given to the patient, *prior to commencement of treatment*
- Obtain a voucher number from the agency, and • Confirm the patient's eligibility to the agency.

The authorising agency will fax, mail or email the voucher to the provider.

Confirming Patient Eligibility

Should a private provider be required to check eligibility, the patient's concession card should be sighted, with a valid date as at the date of issuing the voucher; it is suitable to complete treatment where a patient's concession card is not being renewed by Centrelink, but was valid as at the issue date of the voucher.

Note: *Where a patient presents with a voucher and eligibility cannot be confirmed, treatment should not be provided until confirmation of eligibility is received; contact should be made with the authorising agency for advice.*

1.2 PROVIDER PARTICIPATION

Any private provider, registered with the Dental Board of Australia, may participate in any of the schemes applicable to their profession. Patients will have the option of accessing the participating provider of their choice.

Consideration should be given to the fact that public dental services are delivered within a finite budget. While care delivered should be of the highest quality, private providers are requested to take public oral health principles into account when treatment-planning for public patients. Essentially, this dictates that the highest quality of care for the largest possible number of patients should be considered. As an example, careful consideration should be given to treatment-planning endodontic care when the particular tooth has either a questionable prognosis, will be difficult to restore, or is not of fundamental occlusal significance. Treatment-planning should prioritise the more significant dental problems of the patient and deal with the most urgent work first, rather than simpler treatment items that could be left until later in the treatment plan, within the limited funds available under a voucher.

DHSV publishes clinical guidelines to ensure publicly-provided oral health services allow for consistency to occur across large patient cohorts with a variety of oral health clinicians. The Treatment Planning for Multiple Tooth Replacement Clinical Guideline

(Appendix A) details the procedure that should be followed to ensure uniform assessment of all patients in which treatment planning for partial dentures is to be provided.

Voucher issuing fluctuates according to available funding by agencies and resources available. It is not possible to release voucher funds at a consistent rate throughout the whole financial year. A patient should not expect a voucher to be issued by the agency, rather it is the decision of the agency to either treat the patient in-house or authorise treatment via a voucher.

Patients who present to their private provider should not expect the practice to contact an agency to obtain a voucher. In these circumstances, it is recommend that private practices refer the patient to their nearest agency to determine eligibility and care access, and then re-present to a private practice, if suitable.

A list of agencies, with contact details, is located on the DHSV website at http://www.dhsv.org.au/clinic-locations/community-dental-clinics/.

A patient must always have a voucher from an authorising agency to receive care. A voucher will not be issued after treatment has been provided. Payment will not normally be provided for care provided in the absence of a voucher.

1.3 PATIENT COPAYMENTS WITH TREATMENT VIA VOUCHERS

Copayments for public dental services apply to:

- People aged 18 years and over, who are health care or pensioner concession card holders or dependants of concession card holders, unless copayment exempt

Where patient copayments apply, this will be indicated on the voucher presented by the patient and payable directly to the private provider at the time of treatment: • VEDS single copayment per voucher

- VGDS single copayment per visit; the number of visits and copayment per visit to charge will be indicated on the voucher • VDS single copayment per denture

Some patients are exempt from paying copayments for public dental services (https://www2.health.vic.gov.au/primary-and-community-health/dental-health). Should a patient not be required to pay any copayment to the private provider, this will be clearly indicated by the agency on the voucher or authorised attachment.

Note: The private provider's total remuneration for treatment provided will be less any patient copayments due to be collected by the provider.

Any patient copayments payable by patients cannot be claimed against private health insurance.

1.4 VALIDITY

Vouchers are only valid for the period from date of issue indicated:

	Voucher expiry from date of issue	
	To first appointment	**To voucher redemption**
VEDS	1 month	2 months
VGDS	3 months	6 months
VDS	3 months	6 months

The date of issue is indicated in the upper right hand corner of the voucher. Care must be commenced within the period indicated.

Private providers should not accept vouchers that have expired; to do so will risk payment for services being declined by the authorising agency.

Patients presenting with expired vouchers should be redirected back to the authorising agency for a replacement voucher or extension. In almost all circumstances, replacement of any expired vouchers will be granted, except when funding is no longer available.

1.5 SCHEDULE OF TREATMENT ITEMS AND FEES

The Schedule of Treatment Items and Fees for each of the private schemes is available at https://www2.health.vic.gov.au/primary-and-community-health/dental-health/accesspublic-dental-services

The applicable provider fee and patient copayment is as at the date of the issue of the voucher, no matter how long the course of care takes to complete.

Only the items set out in the schedule are able to be claimed.

Remuneration to private providers is based on the applicable Department of Health and Human Services State Rate Fees for Dental Services.

1.6 MAXIMUM ENTITLEMENTS (VOUCHER CAPS)

Under a single voucher, eligible patients will be entitled to care with a maximum claim available under the voucher cap. **This voucher cap is inclusive of both the agency payment to the private provider and the patient copayments (if applicable).**

Emergency Care
An emergency course of care is not necessarily limited to one visit. For example, a follow up appointment for normal post-operative care and suture removal might be required following an extraction. However, the maximum available to be claimed *remains* limited to the voucher cap per patient.

The intent of the VEDS voucher is to treat the presenting symptom only. For any further dental needs, the patient should be referred back to the authorising agency.

If the care required is beyond the available item numbers or the voucher cap, the participating private provider must contact the authorising agency for advice, who will arrange for further care to be provided. This is not expected to be a common occurrence.

General Care
Given the capped limit for each voucher, private providers are encouraged to provide all or as much of the most urgent dental care required for each patient within the scope of this limit. Additional voucher(s) may be made available for completion of care, or more complex care may be provided at the agency. Private providers should contact the authorising agency for advice.

Denture Care
A VDS voucher from the referring agency will stipulate denture treatment that has been authorised, and therefore the voucher cap. If there is concern or disagreement with the treatment stipulated, it is necessary for the provider to contact the agency to discuss, prior to providing any treatment.

Voucher caps may change from time to time. Current voucher caps are available at https://www2.health.vic.gov.au/primary-and-community-health/dental-health/accesspublic-dental-services.

1.7 PROCEDURES

Patients who have been given approval to receive care through the private schemes will be provided with a voucher for treatment (Flow chart 1).

The patient, on receiving a voucher and, where necessary, an Item and Fee Schedule for dental care from an authorising agency, should:

- Locate a participating private dental provider of their choice, and arrange an appointment
- Unless copayment exempt, discuss payment options with the provider at the time of arranging the appointment. The required patient copayments are described on the voucher.
- On arrival, present the voucher to the provider
- Receive the required dental care and pay the required patient copayments (unless exempt).

The participating private provider should:

- Fully complete the Practitioner Details section of the voucher
- Provide the necessary treatment within the schedule of treatment items
- Have the patient sign the declaration, on a date no earlier than the date of the last visit, that treatment has been provided; this signature assigns the patient's benefits to the private provider and prevents GST from being incurred on the transaction.
- Collect the appropriate patient copayments (unless exempt)
- Complete the voucher
- Return the voucher to the agency by fax/mail for processing
- Commit to addressing any problems that arise as a direct consequence of the care provided. The VDS payment and patient copayment covers any adjustment made to the dentures during the first 12 months following insertion. Any concerns about treatment becoming complex should be discussed with the authorising agency.

Submission of items not contained within the schedule or beyond the voucher cap will not normally be reimbursed.

Vouchers may not be paid when returned more than 6 months after the date of issue.

Incomplete Courses of General Care

For items of care required that exceed the VGDS voucher cap, or for treatment beyond the scope of the scheme, including the construction of dentures, the patient should be referred back to the authorising agency where the patient may receive the remainder of their general care. Referral back to the agency can be undertaken by indicating the appropriate box on the voucher and/or providing a short summary of further treatment required.

Additional voucher(s) may be made available for completion of care, or more complex care may be provided at the agency by being provided with the next available appointment. For denture needs, patients will be placed on the agency's Denture waiting list and receive assessment and treatment, where clinically appropriate, in due course.

Additional Care beyond VGDS Scope

The patient and provider are free to negotiate continuation of care for items outside the scope of the VGDS. This is a private arrangement, no government subsidies apply, and payment cannot be sought from the authorising agency. However, patients should be also provided with the option to return to the authorising agency.

1.8 ADDITIONAL CHARGES

Emergency Care
Apart from the patient copayments, the scheme does not permit additional payments to be made by the patient for an authorised course of emergency care.

General Care
Apart from the patient copayments, the scheme does not permit additional payments to be made by the patient for the services provided within an authorised course of general care. The maximum patient copayment to be collected under a single course of care through the VGDS is capped and should not be exceeded.

Denture Care
Apart from the patient copayments, the scheme does not permit additional payments to be made by the patient for items of care already included in the scheme (such as provision of "better teeth"). However, patients may elect to receive and pay for additional denture services, such as soft liners, metal frameworks, or gold inlays. The cost for these additional denture services is to be met by the patient, with the fee negotiated between the practitioner and the patient. The patient assessment for clinical appropriateness of a cast metal framework should be undertaken in accordance with Appendix A.

Whilst a range of prosthetic services may be available to any patient, private providers should be aware that the VDS is designed to provide patients with satisfactory dentures to restore the patient's occlusion, without resorting to complex denture components. Should any specific patient concerns be noted, it is necessary for the provider to contact the agency to discuss, prior to providing any treatment.

1.9 PAYMENT OF CLAIMS

Claims for reimbursement for treatment provided are to be submitted on the voucher supplied by the agency. Any vouchers returned without the patient declaration will **not** be paid. *All vouchers are to be sent to the authorising agency identified on the voucher*.

Payment of claims will be made within 45 days of the voucher being received by the agency. All queries regarding reimbursement of claims should be directed to the agency identified on the voucher.

1.10 PROVIDER LISTS

To assist patients to locate providers willing to provide care, agencies may have *Participating Provider Lists* which they update from time-to-time and provide to patients when issuing vouchers. Private providers who wish to be placed on the list(s) at any agency(ies) are encouraged to contact the relevant agency to organise this. A full list of agencies is located on the DHSV website at http://www.dhsv.org.au/clinic-locations/community-dental-clinics/.

2. GENERAL INFORMATION

2.1 COMPLAINT RESOLUTION

In the event of a dispute arising between the patient and the participating provider regarding any aspect of service provision under the VEDS, VGDS, or VDS, the two parties should attempt to resolve the issue. If a satisfactory resolution cannot be reached, the authorising agency may be contacted for assistance. It is anticipated that most concerns will be successfully resolved between the patient and the private provider (Flow chart 2).

Disputes between the agency and a participating provider should also be resolved by the two parties involved. DHSV may be contacted if the dispute cannot be resolved (Flow chart 3).

Patients may contact the authorising agency regarding dissatisfaction with the care received. In this instance, assistance may be requested from the provider concerned to facilitate dispute resolution.

2.2 QUALITY ASSURANCE

DHSV has a strong commitment to the provision of high quality care for public patients. It is expected that participating private providers will adhere to the highest standards of care, including adherence to the various codes and guidelines of the Dental Board of Australia.

DHSV has a requirement to be accountable for the use of public funds, and maintains a right to undertake an audit program of services provided in public facilities. Patients issued with vouchers for treatment remain the responsibility of the authorising agency, so audits may be extended to services provided through the private sector for public patients. Acceptance of a voucher and provision of care under any of the privately delivered schemes constitutes agreement to participate, if selected, in an audit of such schemes. Upon identification of aberrant data, DHSV or the authorising agency will communicate findings to the private provider, inviting the provider and a member of their professional association to discuss the findings.

For the VGDS and VEDS schemes, providers are requested to, in addition to providing relevant tooth numbers, also include relevant tooth surfaces treated, if applicable (i.e. not if claiming tooth- or mouth-wide treatments, e.g. 114 Removal of calculus, or 222 Root planning and subgingival curettage). This is primarily to maintain completeness of the patient clinical record on the electronic patient management system at agencies. It also provides valuable data for evaluation purposes.

2.3 INQUIRIES

All specific inquiries regarding the privately delivered schemes should be directed to the agency which has issued a voucher. General inquiries regarding these schemes can be made at any agency.

3. ITEM AND FEE SCHEDULES

3.1 VEDS

ITEM CODE	SERVICE DESCRIPTION
013	Oral Examination - limited
022	Intraoral periapical or bitewing radiograph - per exposure
024	Intraoral PA or B/W radiograph - each subs. exposure (same day)
061	Pulp testing (part of examination) - per visit
165	Desensitising procedure - per visit
213	Treatment of acute periodontal infection - per visit
311	Removal of a tooth or part(s) thereof
314	Sectional removal of a tooth or part(s) thereof
316	Removal of additional tooth or part(s) thereof - same quadrant per day
322	Surgical removal of tooth or tooth fragment not requiring removal of bone or tooth division
411	Direct pulp capping
419	Extirpation of pulp or debridement of root canal(s) - emergency or palliative
511	Metallic restoration - one surface - direct
512	Metallic restoration - two surfaces - direct
513	Metallic restoration - three surfaces - direct
514	Metallic restoration - four surfaces - direct
515	Metallic restoration - five surfaces - direct
521	Adhesive restoration - one surface - anterior tooth - direct
522	Adhesive restoration - two surface - anterior tooth - direct
523	Adhesive restoration - three surfaces - anterior tooth - direct
524	Adhesive restoration - four surfaces - anterior tooth - direct
525	Adhesive restoration - five surfaces - anterior tooth - direct
531	Adhesive restoration - one surface - posterior tooth - direct
532	Adhesive restoration - two surface - posterior tooth - direct
533	Adhesive restoration - three surfaces - posterior tooth - direct
534	Adhesive restoration - four surfaces - posterior tooth - direct
535	Adhesive restoration - five surfaces - posterior tooth - direct
572	Provisional (intermediate/temporary) restoration - per tooth
575	Pin retention - per pin
577	Cusp capping - per cusp
651	Recementing crown or veneer

652	Recementing bridge or splint - per abutment
741	Adjustment of pre-existing denture

3.2 VGDS

ITEM CODE	SERVICE DESCRIPTION
011	Comprehensive oral examination
022	Intraoral periapical or bitewing radiograph - per exposure
024	Intraoral PA or B/W radiograph - each subs. exposure (same day)
114	Removal of calculus - first visit
115	Removal of calculus - subsequent visit
121	Topical application of remineralizing and/or cariostatic agents, one treatment
165	Desensitising procedure - per visit
222	Periodontal debridement - per tooth
311	Removal of a tooth or part(s) thereof
314	Sectional removal of a tooth or part(s) thereof
316	Removal of additional tooth or part(s) thereof - same quadrant per day
322	Surgical removal of tooth or tooth fragment not requiring removal of bone or tooth division
411	Direct pulp capping
415	Complete chemo-mechanical preparation of root canal - one canal
416	Complete chemo-mechanical preparation of root canal - each additional canal
417	Root canal obturation - one canal
418	Root canal obturation - each additional canal
455	Additional visit for irrigation and/or dressing of root canal system - per tooth
511	Metallic restoration - one surface - direct
512	Metallic restoration - two surfaces - direct
513	Metallic restoration - three surfaces - direct
514	Metallic restoration - four surfaces - direct
515	Metallic restoration - five surfaces - direct
521	Adhesive restoration - one surface - anterior tooth - direct
522	Adhesive restoration - two surface - anterior tooth - direct
523	Adhesive restoration - three surfaces - anterior tooth - direct
524	Adhesive restoration - four surfaces - anterior tooth - direct
525	Adhesive restoration - five surfaces - anterior tooth - direct
531	Adhesive restoration - one surface - posterior tooth - direct
532	Adhesive restoration - two surface - posterior tooth - direct
533	Adhesive restoration - three surfaces - posterior tooth - direct
534	Adhesive restoration - four surfaces - posterior tooth - direct
535	Adhesive restoration - five surfaces - posterior tooth - direct

575	Pin retention - per pin
577	Cusp capping - per cusp
597	Post - direct

3.3 VDS

ITEM CODE	SERVICE DESCRIPTION
711	Complete maxillary denture
712	Complete mandibular denture
719	Complete maxillary and mandibular dentures
721	Partial maxillary denture - resin base
722	Partial mandibular denture - resin base
731	Retainer - per tooth
732	Occlusal rest - per rest
733	Tooth/teeth (partial denture) – per tooth
743	Relining - complete denture - processed
744	Relining - partial denture - processed

4. APPENDIX A

Treatment Planning for Multiple Tooth Replacement

Clinical Guidelines (CPG's) are systematic developed statements intended to support clinicians in providing high quality, best practice evidence-based care. They are not intended to be wholly prescriptive or a legal directive for clinical decisions. While their application is an acceptable ground for client care, clinicians should carefully consider the individual circumstances and the specifics of their work environment in conjunction with these guidelines. Selection of alternative treatment modalities, based on clinical judgement and/or specialist advice, may be justified in certain clinical scenarios. In such cases, justification for the chosen treatment must be clearly documented in the client records.

Purpose

This clinical guideline aims to standardise the way in which clients are assessed and establish a sequence to assist in treatment planning for the replacement of multiple missing teeth.

Clinical Considerations

The loss of teeth may be a consequence of the outcome of advanced disease processes, trauma, complications associated with treatment, by client's request or other pathology or conditions.

The replacement of multiple missing teeth is based on the following principles:

- Is part of an established care pathway, all primary dental care is completed, that is:
  - Acute Phase including management of pain
  - Disease Stabilisation Phase including establishing good self-management
  - Definitive Care Phase including simple restorative care.
  - Supportive Phase including check-ins by an oral health educator/coach established.
- Prognosis (fair to good) of the remaining dentition [1]
- Aesthetics to provide dignity and confidence (anterior teeth replaced)
- Function – speech, mastication and swallowing (consider a shortened dental arch).

These principles are applied following a comprehensive examination and an understanding of the client's needs.

Considerations	Factors
Needs and Capability	Age Needs and expectations Medical and Special needs Manual dexterity Oral hygiene status and level of self-management Health Literacy
Oral Health / Disease	Carious lesions Restorative status of remaining teeth Periodontal condition Status of the oral mucosa Saliva – flow and consistency Parafunction
Prosthetic and Occlusal	Number and location of remaining dentition Form and contour of denture bearing areas – inc. tori Occlusion – static/dynamic – inc. vertical dimension Existing prosthesis

These key elements assist the clinician in the treatment planning for the replacement of teeth:

- diagnosis and management of primary disease
- establish the prognosis (periodontal, restorative, endodontic) of remaining teeth prosthodontics requirements/constraints (clinician and client based).

Following the completion of the comprehensive assessment, the clinical options will be proposed to the client and/or their carer, using a shared decision making process to come to a common understanding. The discussion regarding the low value of the unnecessary replacement of teeth should be clearly articulated especially if there is no improvement in function, comfort and aesthetics (quality of life). Clients should be aware that all options have some limitations and that no artificial tooth replacement can be equal to the function, comfort and appearance of healthy, undamaged teeth.

The consideration of options should be based on:

- Whether teeth should be replaced
- Method of tooth replacement
- Predictability of the prosthetic outcome
- Long-term stability of oral comfort, function and health.

There are some clients facing the potential loss of all their remaining teeth due to hopeless prognosis. Three treatment options become available:

- All remaining teeth extracted and following 6-8 weeks healing a conventional complete denture fabricated [22] [26]. The client is rendered edentulous not only during the healing period, but also during the time required for fabrication of dentures.
- The conversion of an existing removable partial denture into a transitional immediate complete denture [26] [27].
- Immediate complete denture [22] where a denture is made for immediate insertion following a phased extraction of all posterior teeth first while retaining anterior teeth;

completing denture stages around these teeth then anterior extractions and immediate insertion of full denture [5] [6].

The Shortened Dental Arch [SDA)

The shortened dental arch (SDA) concept is a problem-oriented strategy, based on individual clients' needs, in order to reduce unnecessary complex and costly prosthodontic treatment in posterior areas [2]. The literature indicates that dental arches comprising the anterior and premolar regions meet the requirements of a functional dentition [3-6] [8] [9].

However, masticatory ability is impaired when there are fewer than 10 pairs of occluding teeth [3]. The World Health Organization (WHO) Public Health Policy [9] [10] recommends 'the retention throughout life, of a functional, aesthetic natural dentition of not less than 20 teeth and that not requiring recourse to prostheses should be the treatment goal for oral health' [13].

In this context, SDA concept can be considered a minimum interventional strategy. A review of the literature regarding the SDA has evaluated client outcomes such as:

Oral Functionality

- Impaired masticatory ability and changes in food selection only occur when there is <10 pairs of occluding teeth [16]. In this case, malnourishment becomes a risk with potential adverse consequence on overall health.
- With intact premolars plus at least one pair of occluding molars, SDA maintains masticatory efficiency [15] and oral functionality was not improved when provided with a distal extension removable partial denture (RPD) [14].

Client Comfort/Satisfaction

- People with SDA reported no significant difference in pain/distress compared to those with a distal extension RPD or complete dentition - only 8% of clients with SDA reported impaired masticatory ability [19].
- 20% of clients with SDA and RPD were dissatisfied with their dentures [19].
- Free ends saddles have poor retention and may do further damage to remaining teeth if poorly designed or maintained.

Prosthodontic Considerations

The impact of SDA on occlusal stability (the stable spatial relationship in occluding arches), vertical dimension and the health of soft tissues, hard tissues and temporomandibular joints [9].

- SDA (anterior and premolar teeth) satisfy oral functional demands and show similar vertical overlap and occlusal tooth wear patterns to those with a complete dentition [17].
- No evidence that SDA causes overloading of the TMJ or teeth, suggests the neuromuscular regulatory systems are control the forces under various occlusal conditions [18].

Shortened Dental Arch Summary and Recommendations

Clients' needs and demands will vary and should be individually assessed [3] [20]. The SDA offers oral functionality, improved oral hygiene, comfort and potentially reduced treatment costs [3]. RPD are associated with increased risk of caries and periodontal disease in clients with poor self management [21].

When developing a treatment plan for clients, clinicians should aim to:

- Preserve all incisors/canines/premolars + 1 set of molars
- Support self-management (healthy behaviour and practice)
- Select clients most suitable for SDA based on their age, oral health and oral disease risk assessment

(See Appendix 1 – for additional evidence.)

Treatment Planning Options

Treatment Option	Indications
Replacement of teeth is not clinically indicated or required	• Client asymptomatic and content with appearance and function • Existing tooth migration/over eruption is minimal • Small edentulous areas distal of second pre-molar
Replacement of teeth with Removable Partial Denture [RPD) ***Note**: When considering a RPD discuss the limitations of RPDs and impact on speech, eating, comfort; on oral hard and soft tissues and influence on oral hygiene.*	***Interim RPD*** Indicated where the client's age, health or lack of time precludes definitive treatment such as for the: • Inadvertent loss of an anterior tooth usually through trauma • Young people - trauma, disease or genetic condition (hypodontia) □ Older people where health, age or mobility are of concern. Interim RPD's are predominantly acrylic resin.
	Treatment RPD Typically acrylic and used as a vehicle to provide a temporary course of treatment, such as: • Tissue treatment material where traumatised tissues are present • Restoration of or to increase vertical dimensions [5] Splinting following immediate extraction or surgical corrections.
	Transitional RPD

Treatment Option	Indications
	Indicated where the client requires a functional prosthesis during a transition to definitive care eg during the removal of other teeth. Made of acrylic resin to allow the addition of teeth during this phase. Factors which may indicate a transitional RPD are: • Poor oral hygiene • Teeth/dentition with poor prognosis - periodontally involved or with advanced carious lesions • Limited oral health literacy and awareness **Note**: A RPD can be converted to a complete denture as a transitional prosthesis, if it is assessed to remain functional for a realistic length of time following immediate addition [24]. This presents advantages especially for older people as a RPD can be relined, with changes to OVD or occlusion if required, prior to transitioning to an immediate denture [25]. This supports phased extraction, reduces potential trauma to the client and the immediate addition to a RPD is simple. Stress and anxiety are significant barriers for successful treatment, particularly for older people, a transitional denture can help overcome these.

	Definitive RPD Indicated where the client requires treatment to restore the occlusion to function or for aesthetics when there is a stable dentition, good oral health and good oral health awareness. The definitive RDP typically incorporates a cast metal framework however, it is recognised that in the public oral health setting it is more likely designed with an acrylic base. This RDP generally is more stable, provides greater longevity and is less detrimental to the overall oral health. Factors which indicate a definitive RPD are : • Good oral hygiene and periodontal health • Suitable abutment teeth to support RPD • Presence of tori (and an acrylic denture not possible) • Insufficient space in the edentulous area for acrylic dentures Occlusal parafunctional habits
Immediate Denture	The immediate denture is a suitable treatment option in public oral health services and should be based on a clinician assessment of the individual client needs and when it is desirable to minimise functional and aesthetic changes. It may also help the client overcome problems associated with the impending loss of their teeth. The placement of an immediate denture should satisfy the following requirements: • Be comfortable and physiologically accepted in the oral environment • Restore adequate masticatory function • Maintain harmony with functions of speech, respiration and swallowing • Acceptable aesthetics • Preservation of remaining hard and soft tissues [22] [23] Associated risks of procedures must be thoroughly explained during the client consultation (dentist and prosthetist) to obtain informed consent. It is recommended that under typical circumstances a phased extraction plan is scheduled. Most or all of the posterior quadrants are extracted first to allow healing of posterior ridges to provide firm support for
Treatment Option	**Indications**
	placement of an immediate denture and improve the clinical outcome. Following a healing period of 6-8 weeks, the anterior teeth are extracted, and the immediate denture is placed. (see Appendix 2)
Replacement of teeth with a Fixed Prosthesis	As a result of the clinical assessment it may be evident that the outcomes of treatment may be best achieved through the replacement of the missing teeth with a fixed prosthesis. In appropriate circumstances this treatment can be provided through specialist referral to the Prosthodontic Unit RDHM. Prior to such a referral it is important for the clinician to consider the clinical principles, scope and requirements for treatment and referral criteria as set out in the referral form for the Prosthodontic Unit. **Note:** Inform the client that they are being referred for an assessment of replacement options rather than promising a specific type of specialist treatment.

Follow-up

- In all cases where treatment involves the replacement of teeth with RPD, immediate full denture or fixed prosthesis clients should be provided with instructions regarding care of the prosthesis and modification in oral hygiene (as required).
- In the case of RPD and immediate denture, clients should be informed that adjustments may be required if the client experiences problems with fit, function or comfort. Dentures generally require a level of maintenance that exceeds that of fixed restorations. A definitive RPD supported by edentulous ridges and immediate dentures will require relining or rebasing over time.
- Clients with a definitive RPD should ideally have regular check-ins with an oral health educator/coach and depending on risk status present for an annual oral health examination.
- Clients provided with an Interim, Treatment or Transitional RPD will be followed up in line with the treatment plan.

Costs

This guideline has been developed to enable and support clinicians to provide evidence informed care when treatment planning for multiple teeth replacement.

Clients receiving prosthetic care in the public oral health services are required to contribute a co- payment to their care. It is important that this is clearly established and agreed to during the treatment planning and options stage.

Current business rules are there is no requirement to collect a second copayment for the reline when constructing an immediate denture.

Specialist care at RDHM is more expensive and will depend on the service provide and explained during the consultation with a prosthodontist.

Appendix 1

1. Oral Functionality

SDA configurations	Mastication ability	Prevalence of complaints
Intact premolar regions & 1 pair of occluding molars	Good	3-5%
Asymmetric arches & unevenly distributed teeth	Fair	33-54%
0-2 pairs of occluding premolars	Difficult/Limited	95-98%

2. Client Comfort

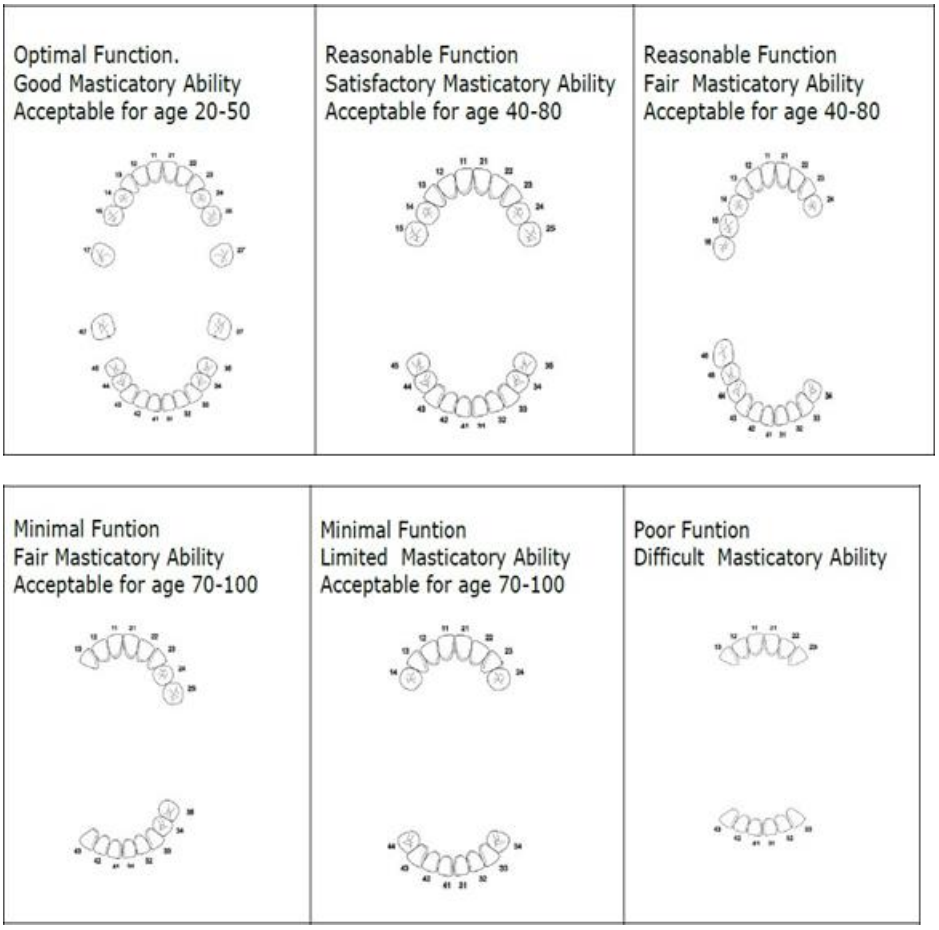
Kayser AF 1989

Relation between age and needed oral functional level, expressed in minimum number of occluding pairs of teeth (arch length)

Age	Functional Level	Occluding pairs
20-50	Optimal	12

40-80	Reasonable	10 (SDA)
70-100	Minimal	8 (extreme SDA)

3. Clinical Presentation



Appendix 2

Immediate Dentures

A typical prosthetic treatment plan

Stage 1 Multidisciplinary case discussion and treatment planning

- Dentist, prosthetist, oral health educators etc.
- Consider RDHM specialist referral in complicated cases.

Stage 2 – Extraction of posterior teeth

- Healing and stable posterior edentulous area established.

Stage 3 – Construct immediate denture

- Visit 1. Review referral from dentist, comprehensive oral exam, treatment planning, informed consent, primary impression taking, bite registration and shade taking if applicable.
- Visit 2. Secondary impression taking, bite registration/try in
- Visit 3. Issue immediate denture to patient, provide oral and denture hygiene instructions, complete a handover to dentist.

Stage 4 - Extraction of remaining anterior teeth/insert denture

- The prosthetist cannot insert the denture, due to the presence of open sockets and therefore out of scope.
- Post-operative instructions: Keep denture in at least the first 24 hours, and then review for adjustments in 1-3 days with dentist

Stage 5 - Post Insertion

- Visit 1. Post-operative review with dentist within 1 week (Dentist)
- Visit 2. Denture review within 2-3 weeks (Prosthetist)
- Visit 3. Routine denture review within 3 months (Prosthetist)

Stage 6 - Reline

Transitional or Interim Dentures

A removable partial denture may be converted to a complete denture as an interim prosthesis, if assessed to be in reasonable conditions i.e. the denture will remain functional for a realistic length of time following immediate addition . There are certain advantages to this such as:

- For older people as their RPD can be relined, and, if required, changes to OVD or occlusion can be assessed prior to transitioning to an immediate denture
- Allows a phased extraction plan to occur, reducing potential trauma to the client Immediate addition to the removable partial denture is a simple technique.

Visit 1. - Review referral from dentist, limited oral exam, treatment planning, informed consented, primary impression taking with denture in situ, bite registration and shade taking

Visit 2. - Dentist for extractions and insert denture.

Following a period of healing, commence prosthetic treatment for the definitive prosthesis

Note: Additions to an existing denture after a single or multiple tooth extraction, could be immediate, after a few days or weeks.

Approved by	Date approved	Document owner	Revision date
Oral Health Clinical Council	2/9/2020	Chief Oral Health Officer	03/09/2023

This document supersedes: **Treatment Planning for Multiple Teeth Replacement CG-02202**

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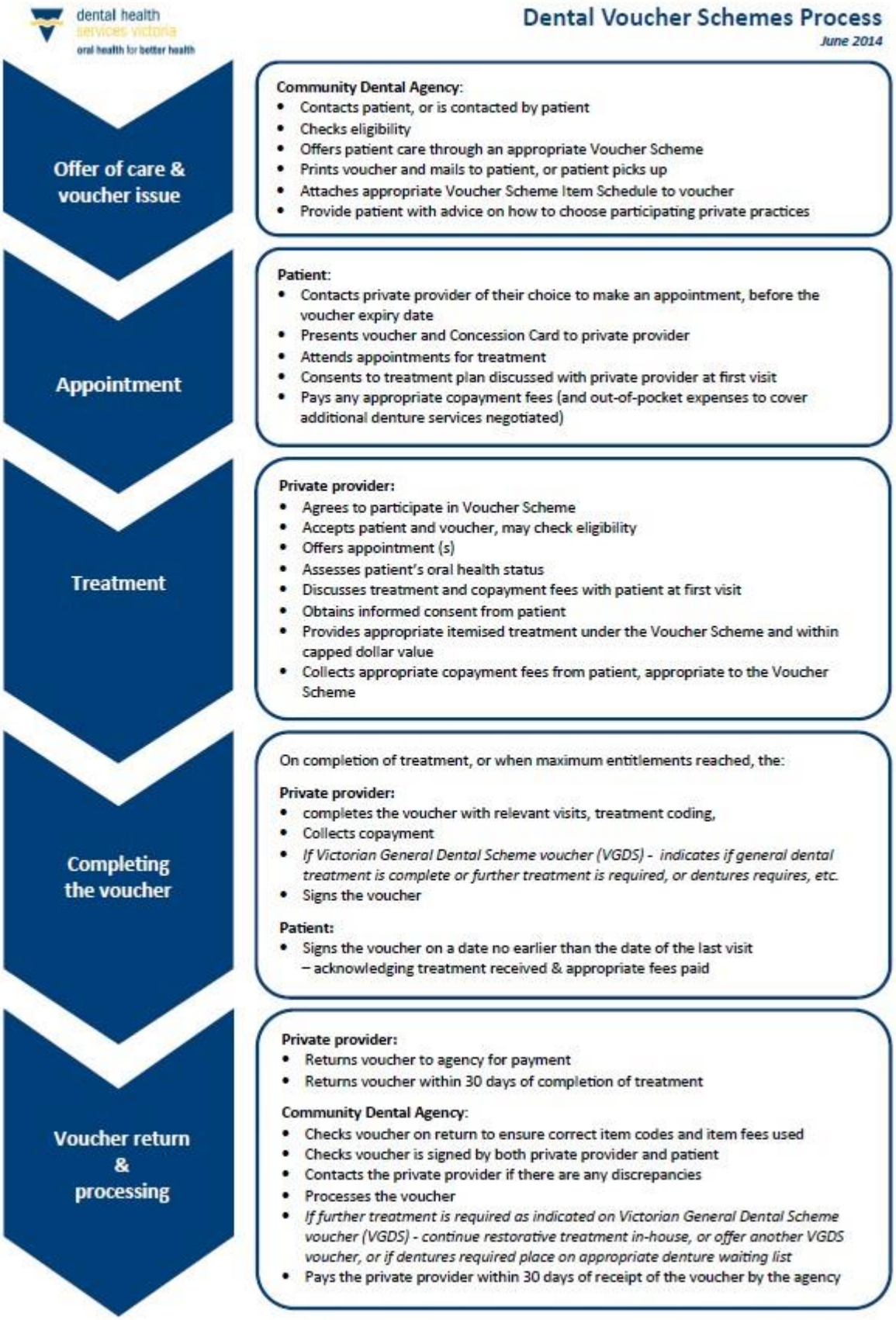
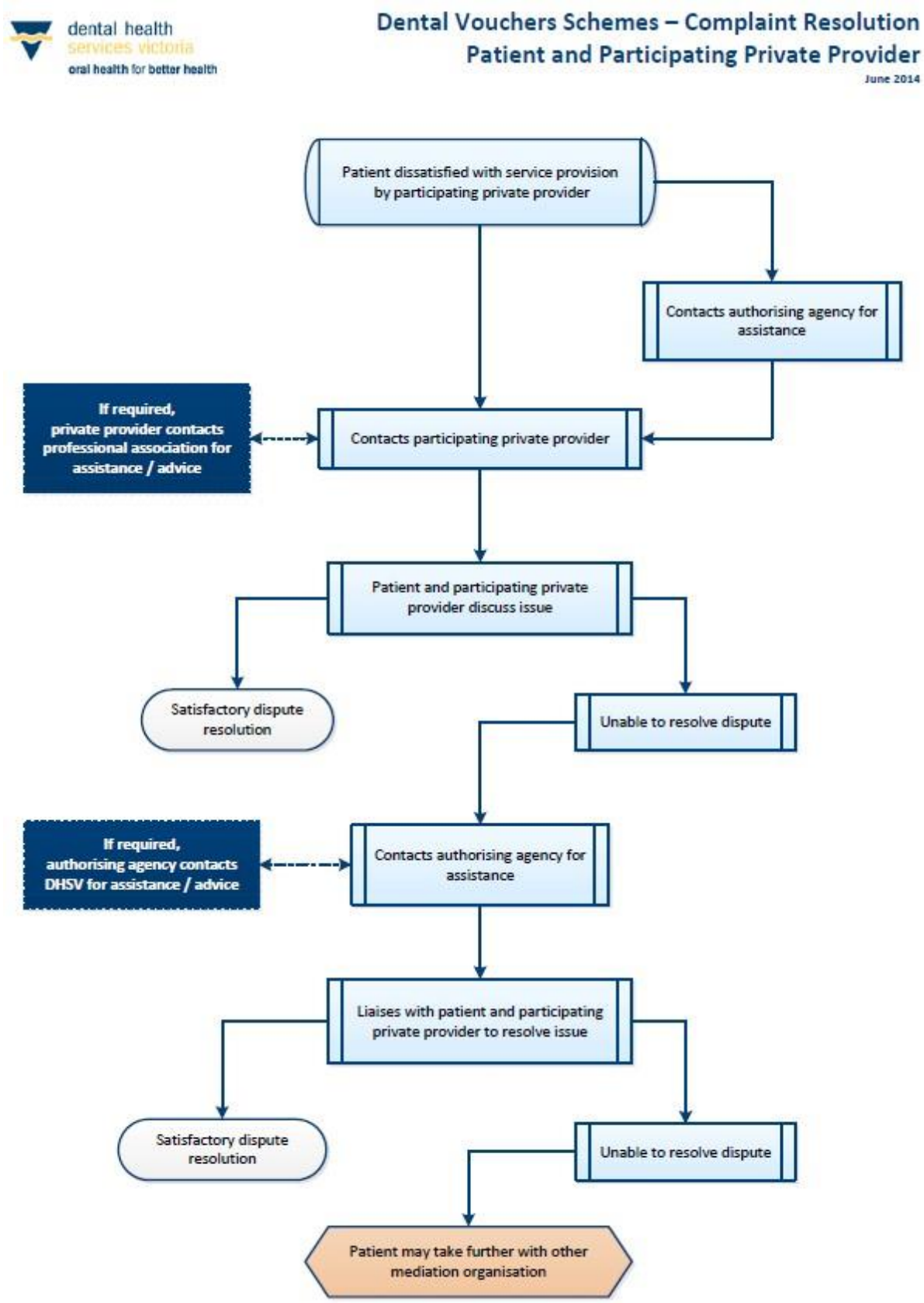
5. FLOW CHART 1



6. FLOW CHART 2



7. FLOW CHART 3

dental health services victoria
oral health for better health

Dental Vouchers Schemes - Complaint Resolution
Participating Private Provider and Authorising Agency
June 2014