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:

<table>
<thead>
<tr>
<th>Provider</th>
<th>Voucher expiry from date of issue</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>To first appointment</td>
</tr>
<tr>
<td>VEDS</td>
<td>1 month</td>
</tr>
<tr>
<td>VGDS</td>
<td>3 months</td>
</tr>
<tr>
<td>VDS</td>
<td>3 months</td>
</tr>
</tbody>
</table>

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 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.

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

<table>
<thead>
<tr>
<th>ITEM CODE</th>
<th>SERVICE DESCRIPTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>013</td>
<td>Oral Examination - limited</td>
</tr>
<tr>
<td>022</td>
<td>Intraoral periapical or bitewing radiograph - per exposure</td>
</tr>
<tr>
<td>024</td>
<td>Intraoral PA or B/W radiograph - each subs. exposure (same day)</td>
</tr>
<tr>
<td>061</td>
<td>Pulp testing (part of examination) - per visit</td>
</tr>
<tr>
<td>165</td>
<td>Desensitising procedure - per visit</td>
</tr>
<tr>
<td>213</td>
<td>Treatment of acute periodontal infection - per visit</td>
</tr>
<tr>
<td>311</td>
<td>Removal of a tooth or part(s) thereof</td>
</tr>
<tr>
<td>314</td>
<td>Sectional removal of a tooth or part(s) thereof</td>
</tr>
<tr>
<td>316</td>
<td>Removal of additional tooth or part(s) thereof - same quadrant per day</td>
</tr>
<tr>
<td>322</td>
<td>Surgical removal of tooth or tooth fragment not requiring removal of bone or tooth division</td>
</tr>
<tr>
<td>411</td>
<td>Direct pulp capping</td>
</tr>
<tr>
<td>419</td>
<td>Extirpation of pulp or debridement of root canal(s) - emergency or palliative</td>
</tr>
<tr>
<td>511</td>
<td>Metallic restoration - one surface - direct</td>
</tr>
<tr>
<td>512</td>
<td>Metallic restoration - two surfaces - direct</td>
</tr>
<tr>
<td>513</td>
<td>Metallic restoration - three surfaces - direct</td>
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<td>514</td>
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<td>515</td>
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<td>521</td>
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<tr>
<td>535</td>
<td>Adhesive restoration - five surfaces - posterior tooth - direct</td>
</tr>
<tr>
<td>572</td>
<td>Provisional (intermediate/temporary) restoration - per tooth</td>
</tr>
<tr>
<td>575</td>
<td>Pin retention - per pin</td>
</tr>
<tr>
<td>577</td>
<td>Cusp capping - per cusp</td>
</tr>
<tr>
<td>651</td>
<td>Recementing crown or veneer</td>
</tr>
<tr>
<td>652</td>
<td>Recementing bridge or splint - per abutment</td>
</tr>
<tr>
<td>741</td>
<td>Adjustment of pre-existing denture</td>
</tr>
</tbody>
</table>
### 3.2 VGDS

<table>
<thead>
<tr>
<th>ITEM CODE</th>
<th>SERVICE DESCRIPTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>011</td>
<td>Comprehensive oral examination</td>
</tr>
<tr>
<td>022</td>
<td>Intraoral periapical or bitewing radiograph - per exposure</td>
</tr>
<tr>
<td>024</td>
<td>Intraoral PA or B/W radiograph - each subs. exposure (same day)</td>
</tr>
<tr>
<td>114</td>
<td>Removal of calculus - first visit</td>
</tr>
<tr>
<td>115</td>
<td>Removal of calculus - subsequent visit</td>
</tr>
<tr>
<td>121</td>
<td>Topical application of remineralizing and/or cariostatic agents, one treatment</td>
</tr>
<tr>
<td>165</td>
<td>Desensitising procedure - per visit</td>
</tr>
<tr>
<td>222</td>
<td>Periodontal debridement - per tooth</td>
</tr>
<tr>
<td>311</td>
<td>Removal of a tooth or part(s) thereof</td>
</tr>
<tr>
<td>314</td>
<td>Sectional removal of a tooth or part(s) thereof</td>
</tr>
<tr>
<td>316</td>
<td>Removal of additional tooth or part(s) thereof - same quadrant per day</td>
</tr>
<tr>
<td>322</td>
<td>Surgical removal of tooth or tooth fragment not requiring removal of bone or tooth division</td>
</tr>
<tr>
<td>411</td>
<td>Direct pulp capping</td>
</tr>
<tr>
<td>415</td>
<td>Complete chemo-mechanical preparation of root canal - one canal</td>
</tr>
<tr>
<td>416</td>
<td>Complete chemo-mechanical preparation of root canal - each additional canal</td>
</tr>
<tr>
<td>417</td>
<td>Root canal obturation - one canal</td>
</tr>
<tr>
<td>418</td>
<td>Root canal obturation - each additional canal</td>
</tr>
<tr>
<td>455</td>
<td>Additional visit for irrigation and/or dressing of root canal system - per tooth</td>
</tr>
<tr>
<td>511</td>
<td>Metallic restoration - one surface - direct</td>
</tr>
<tr>
<td>512</td>
<td>Metallic restoration - two surfaces - direct</td>
</tr>
<tr>
<td>513</td>
<td>Metallic restoration - three surfaces - direct</td>
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<td>Adhesive restoration - five surfaces - posterior tooth - direct</td>
</tr>
<tr>
<td>575</td>
<td>Pin retention - per pin</td>
</tr>
<tr>
<td>577</td>
<td>Cusp capping - per cusp</td>
</tr>
<tr>
<td>-----</td>
<td>------------------------</td>
</tr>
<tr>
<td>597</td>
<td>Post - direct</td>
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</tbody>
</table>
### 3.3 VDS

<table>
<thead>
<tr>
<th>ITEM CODE</th>
<th>SERVICE DESCRIPTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>711</td>
<td>Complete maxillary denture</td>
</tr>
<tr>
<td>712</td>
<td>Complete mandibular denture</td>
</tr>
<tr>
<td>719</td>
<td>Complete maxillary and mandibular dentures</td>
</tr>
<tr>
<td>721</td>
<td>Partial maxillary denture - resin base</td>
</tr>
<tr>
<td>722</td>
<td>Partial mandibular denture - resin base</td>
</tr>
<tr>
<td>731</td>
<td>Retainer - per tooth</td>
</tr>
<tr>
<td>732</td>
<td>Occlusal rest - per rest</td>
</tr>
<tr>
<td>733</td>
<td>Tooth/teeth (partial denture) - per tooth</td>
</tr>
<tr>
<td>743</td>
<td>Relining - complete denture - processed</td>
</tr>
<tr>
<td>744</td>
<td>Relining - partial denture - processed</td>
</tr>
</tbody>
</table>
Treatment Planning for Multiple Tooth Replacement

**Purpose**

Clinical Practice 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 patient 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 patient records.

This Clinical Guideline aims to:
- Standardise the way in which patients are assessed and establish a standardised sequence to assist in treatment planning for the replacement of multiple missing teeth.

**Guideline**

**Clinical Considerations**

The loss of teeth may be a consequence of the outcome of advanced disease process (dental caries or periodontal disease), trauma, complications associated with treatment, a patient’s request, or other pathology or conditions.

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

1. All primary dental care is completed, including – Acute Phase (management of pain), and Disease Control Phase (namely dental caries and periodontal disease)
2. Current stability and maintenance of oral health
3. Fair to good prognosis of the remaining dentition
4. Dental aesthetics to provide dignity and confidence for patients (anterior teeth replaced)
5. Sufficient number of teeth to provide function – speech, mastication and swallowing (consideration of a shortened dental arch - SDA).

These principles are applied following a comprehensive examination and an understanding of the patient’s needs and expectations as well as the clinical constraints in formulating a treatment plan in replacing multiple missing teeth.
Key elements of the examination should assess:

| Needs and Capability Considerations | • Age  
| • Special Needs  
| • Manual Dexterity  
| • Oral Hygiene Status  
| • Needs and Expectations  |
| Oral Health/Disease Considerations | • Carious Lesions  
| • Restorative status of remaining teeth  
| • Periodontal Condition  
| • Status of the Oral Mucosa  
| • Saliva – flow and consistency  |
| Prosthetic and Occlusal Considerations | • 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 should assist the clinician in the diagnosis and management of primary disease, establish the prognosis (Periodontal, Restorative and Endodontic) of the remaining dentition, and consider the prosthodontics requirements and constraints (clinician- and patient-based) in the treatment planning for the replacement of teeth.

Following the completion of a comprehensive assessment, the clinical options will be proposed and discussed with the patient taking into consideration the most appropriate treatment to fulfil the agreed requirements for function, comfort and aesthetics.

The consideration of options may be on the basis of whether teeth should be replaced, the method of tooth replacement employed, the predictability of the prosthetic outcome, and the long-term stability of oral comfort, function and health.

Patients 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 Shortened Dental Arch (SDA)**

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

Masticatory ability is impaired when there are fewer than 20 uniformly distributed teeth in the mouth (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 approach to reduce the burden of oral disease.
A review of the literature regarding the Shortened Dental Arch has evaluated patient outcomes such as functionality, comfort and satisfaction as well as prosthodontics considerations:

**Oral Functionality**

- Impaired masticatory ability and associated changes in food selection occur only when there are less than 10 pairs of occluding teeth (16). This can result in malnourishment with adverse consequence on the individual's overall health.
- If the premolar regions are intact and at least one pair of occluding molars, the SDA does not impair masticatory efficiency (15).
- In such cases oral functionality was not improved when provided with a distal extension RPD (14).

**Patient Comfort/Satisfaction**

- Patients with a SDA reported no significant difference in pain or distress when compared to subjects with a distal extension RPD or those with a complete dentition; only 8% of patients with SDA reported impaired masticatory ability (19).
- 20% of patients with SDA and removable partial denture were dissatisfied with their dentures (19).

**Prosthodontic Considerations**

These include: occlusal stability (stable spatial relationship in the occluding arches) establishing correct vertical dimension and preserving the health of the soft and hard tissues and the temporomandibular joint (9).

- SDA comprising anterior and premolar teeth satisfy oral functional demands and show similar vertical overlap and occlusal tooth wear patterns to those with complete dentition (17).
- There is no evidence that SDA causes overloading of the TMJ or the teeth, suggesting the neuromuscular regulatory systems are efficient in controlling the maximum clenching force under various occlusal conditions (18).

**Summary**

Patients' needs and demands may vary and should be individually assessed (3, 20). However, the SDA offers oral functionality, improved oral hygiene, comfort and possibly reduced costs (3). RPD are associated with increased risk of caries and periodontal disease in patients with poor oral health maintenance (21).

**Recommendations**

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

- Preserve all incisors/canines/premolars + 1 set of molars
- Ensure optimum oral health
- Encourage healthy behaviour and practice
- Select patients most suitable for SDA based on their age, oral health and oral disease risk assessment

(See below for additional evidence)
Treatment Planning Options

1. **No replacement of tooth/teeth is clinically indicated or required.**
   - Patient content with appearance and function
   - Existing tooth migration/over eruption is minimal over a sustained period
   - Small edentulous areas distal of second pre-molar when asymptomatic

2. **Replacement of teeth with Removable Partial Denture (RPD)**
   In the consideration of a RPD, the clinician should discuss the limitations in design and the impact on speech, eating and comfort. Also the clinician should discuss the impact of the RPD on oral hard and soft tissues and influence on oral hygiene.
   A RPD may be considered in one of the following contexts:
   a. **Provision of an Interim RPD treatment** - indicated where the patient’s age, health or lack of time precludes definitive treatment. Interim RPD’s are predominantly produced from acrylic resin unless the interim treatment is required for an extended period of time.
      Indications:
      - Inadvertent loss of an anterior tooth (Trauma)
      - Young patients where teeth are missing due to trauma, disease or genetic condition (hypodontia)
      - Elderly patients where health, age or mobility are of concern
   b. **Provision of a Transitional RPD** - indicated where the patient requires a functional prosthesis as treatment continues in transition – lose of remaining symptomatic teeth. Transitional RPDs are constructed from acrylic resin to allow the addition of teeth during this transition. A transitional RPD is used during transition to the definitive treatment.
      Indications:
      - Poor oral hygiene
      - Periodontally involved dentition with poor prognosis
      - Advanced carious lesions
      - Dental health awareness of patient is limited
   c. **Provision of Definitive RPD** - indicated where the patient requires treatment to restore the occlusion or aesthetics and presents with a stable remaining dentition, good oral health status and good oral health awareness. The Definitive RPD typically incorporates a cast metal framework. However, it is recognised that in the Public Dental setting a Definitive RDP may be designed with an acrylic base. The Definitive RPD, generally provides greater longevity and a more stable prosthesis that is less detrimental to the overall oral health.
      Indications:
      - Good oral hygiene
      - Good periodontal health
      - Suitable abutment teeth to support RPD
      - Presence of tori (acrylic denture not possible)
      - Insufficient space in the edentulous area for acrylic denture
      - Occlusal parafunctional habits
   d. **Provision of a Treatment RPD** - typically used as a vehicle to provide a temporary course of treatment and most commonly constructed using acrylic resin.
      Indications:
      - Carrier of tissue treatment material where traumatized tissues are present
      - To restore or increase vertical dimensions
      - To provide splinting following immediate extraction or other surgical corrections in the oral cavity
3. **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 many circumstances, such treatment is 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 of treatment and referral criteria as set out in the referral form for the Prosthodontic Unit.

**Follow-up**

- In all cases where treatment involves the replacement of teeth with a removable or fixed prosthesis, patients should be provided with instructions regarding care of the prosthesis and modification in oral hygiene (as required).
- In the case of RPD, patients should be informed that minor adjustments may be required if the patient experiences problems with fit, function or comfort/tolerance. Removable partial dentures generally require a level maintenance that exceeds that of fixed restorations. A definitive RPD supported by edentulous ridges and abutment teeth will require relining or rebasing over time.
- Patients with a definitive RPD should ideally present for an oral health check-up annually. In the absence of an annual oral health check-up, a patient who has been provided with a definitive RPD should be advised to seek a review according to the current DHSV public oral health waiting list guideline.\(^7\)
- Patients provided with an Interim RPD, a Transitional RPD, or a Treatment RPD will be followed up in line with the treatment plan as required.

**Additional Evidence**

**Oral Functionality**

<table>
<thead>
<tr>
<th>SDA configurations</th>
<th>Mastication ability</th>
<th>Prevalence of complaints</th>
</tr>
</thead>
<tbody>
<tr>
<td>Intact premolar regions &amp; 1 pair of occluding molars</td>
<td>Good</td>
<td>3-5%</td>
</tr>
<tr>
<td>Asymmetric arches &amp; unevenly distributed teeth</td>
<td>Fair</td>
<td>33-54%</td>
</tr>
<tr>
<td>0-2 pairs of occluding premolars</td>
<td>Difficult/Limited</td>
<td>95-98%</td>
</tr>
</tbody>
</table>

**Patient Comfort**\(^5\)

<table>
<thead>
<tr>
<th>Age</th>
<th>Functional Level</th>
<th>Occluding pairs</th>
</tr>
</thead>
<tbody>
<tr>
<td>20-50</td>
<td>Optimal</td>
<td>12</td>
</tr>
<tr>
<td>40-80</td>
<td>Reasonable</td>
<td>10 (SDA)</td>
</tr>
<tr>
<td>70-100</td>
<td>Minimal</td>
<td>8 (extreme SDA)</td>
</tr>
</tbody>
</table>
Clinical presentation of SDA

<table>
<thead>
<tr>
<th>Optimal Function</th>
<th>Reasonable Function</th>
<th>Reasonable Function</th>
</tr>
</thead>
<tbody>
<tr>
<td>Good Masticatory Ability</td>
<td>Satisfactory Masticatory Ability</td>
<td>Fair Masticatory Ability</td>
</tr>
<tr>
<td>Acceptable for age 20-50</td>
<td>Acceptable for age 40-80</td>
<td>Acceptable for age 40-80</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Minimal Function</th>
<th>Minimal Function</th>
<th>Poor Function</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fair Masticatory Ability</td>
<td>Limited Masticatory Ability</td>
<td>Difficult Masticatory Ability</td>
</tr>
<tr>
<td>Acceptable for age 70-100</td>
<td>Acceptable for age 70-100</td>
<td></td>
</tr>
</tbody>
</table>

Definitions

Nil

Revision date

October 2020

Policy owner

Clinical Leadership in Practice Committee

Approved by

Chief Oral Health Advisor

Date approved

October 2017

References and related documents


17. Witter DJ, van Elteren P, Käyser AF. Migration of teeth in shortened dental arches


5. FLOW CHART 1

**Dental Voucher Schemes Process**

**June 2013**

**Offer of care & voucher issue**

- Community Dental Agency:
  - Contacts patient, or is contacted by patient
  - Checks eligibility
  - Offers patient care through an appropriate Voucher Scheme
  - Prints voucher and mails to patient, or patient picks up
  - Attaches appropriate Voucher Scheme Item Schedule to voucher
  - Provides patient with advice on how to choose participating private practices

**Appointment**

- Patient:
  - Contacts private provider of their choice to make an appointment, before the voucher expiry date
  - Presents voucher and Concession Card to private provider
  - Attends appointment for treatment
  - Consents to treatment plan discussed with private provider at first visit
  - Pays any appropriate copayment fees (and out-of-pocket expenses to cover additional denture services negotiated)

**Treatment**

- Private provider:
  - Agrees to participate in Voucher Scheme
  - Accepts patient and voucher, may check eligibility
  - Offers appointment(s)
  - Assesses patient’s oral health status
  - Discusses treatment and copayment fees with patient at first visit
  - Obtains informed consent from patient
  - Provides appropriate itemised treatment under the Voucher Scheme and within capped dollar value
  - Collects appropriate copayment fees from patient, appropriate to the Voucher Scheme

**Completing the voucher**

- On completion of treatment, or when maximum entitlements reached, the:
  - Private provider:
    - Completes the voucher with relevant visits, treatment codes,
    - Collects copayment
    - If Victorian General Dental Scheme voucher (VGDS) - indicates if general dental treatment is complete or further treatment is required, or dentures requires, etc.
    - Signs the voucher
  - Patients:
    - Signs the voucher on a date no earlier than the date of the last visit
      - acknowledging treatment received & appropriate fees paid

**Voucher return & processing**

- Private provider:
  - Returns voucher to agency for payment
  - Returns voucher within 30 days of completion of treatment

- Community Dental Agency:
  - Checks voucher on return to ensure correct item codes and item fees used
  - Checks voucher is signed by both private provider and patient
  - Contacts the private provider if there are any discrepancies
  - Processes the voucher
  - If further treatment is required as indicated on Victorian General Dental Scheme voucher (VGDS) - continue restorative treatment in-house, or offer another VGDS voucher, or if dentures required place on appropriate denture waiting list
  - Pays the private provider within 30 days of receipt of the voucher by the agency
6. FLOW CHART 2

Dental Vouchers Schemes – Complaint Resolution
Patient and Participating Private Provider
June 2014

Patient dissatisfied with service provision by participating private provider

Contacts authorising agency for assistance

Contacts participating private provider

If required, private provider contacts professional association for assistance / advice

Patient and participating private provider discuss issue

Satisfactory dispute resolution

Unable to resolve dispute

Contacts authorising agency for assistance

If required, authorising agency contacts DHSV for assistance / advice

Liaises with patient and participating private provider to resolve issue

Satisfactory dispute resolution

Unable to resolve dispute

Patient may take further with other mediation organisation
7. **FLOW CHART 3**

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

- Dispute between participating private provider and authorising agency
  - Private provider and authorising agency discuss issue
    - Satisfactory dispute resolution
    - Unable to resolve dispute
      - If required, private provider contacts professional association for assistance/advice
      - If required, authorising agency contacts DHSV for assistance/advice
        - Parties continue discussions
          - Satisfactory dispute resolution
          - Unable to resolve dispute
            - Parties may take further with other mediation organization