Primary Care Reimbursement Service

Information and Administrative Arrangements for Clinical Dental Technicians

Health Service Executive
Primary Reimbursement Service

Telephone: 353 1 8647100
Fax: 353 1 8647197
www.hse.ie

TABLE OF CONTENTS

1.0 HSE Primary Care Reimbursement Service

2.0 Schemes Overview

2.1 General Medical Services Scheme

2.1.1 Who is entitled to a Medical Card?

2.1.2 Client Eligibility Confirmation

2.1.3 GP (General Practitioner) Visit Card

2.2 Dental Treatment Services Scheme

2.3 European Economic Area (EEA) Entitlements

2.3.1 European Health Insurance Card (EHIC)

2.3.2 E128 Form

2.4 Health (Amendment) Act 1996

3.0 Administrative Arrangements

3.1 Application to HSE

3.2 Completion of Claim Forms (Form D)

3.3 Claim Submission

3.4 Payment Listings

3.5 Reclaims

3.6 Queries

3.7 Withholding Tax from Payments for Professional Services

3.8 Client Eligibility Confirmation

1.0 HSE Primary Care Reimbursement Service

The Primary Care Reimbursement Service (PCRS) carries out the following functions on behalf of the Health Service Executive in relation to the provision of services by General Practitioners, Pharmacists, Dentists, Clinical Dental Technicians and Optometrists/ Ophthalmologists:

- Calculation of payments
- Making of such payments
- Verification of accuracy and reasonableness of claims
- Compilation of statistics

In respect of the following schemes:

- General Medical Services Scheme (GMS)
- Drugs Payment Scheme (DPS)
- Long Term Illness Scheme (LTI)
- Health (Amendment) Act, 1996 (HAA)
- High Tech Drugs (HTD)
- Methadone Treatment Scheme
- Dental Treatment Services Scheme (DTSS)
- Community Ophthalmic Services Scheme (HBCOSS)

- Primary Childhood Immunisation Scheme

- European Economic Area (EEA)

The Primary Care Reimbursement Service (PCRS) is also responsible for a number of national community based demand led Schemes. These schemes deliver services including Medical Cards, GP Visit Cards and the Drugs Payment Scheme to the entire population.

In 2008, the Government introduced a new medical card scheme for persons aged 70 years and over. The processing of applications under this scheme were centralised to the national office at PCRS in January 2009.

In July 2011, the final phase of centralising client eligibility transferred to PCRS who are now responsible for processing renewals and applications for medical/GP visit cards nationally.

2.0 Schemes Overview – (Dental related)

2.1 General Medical Services Scheme (GMS Scheme)

2.1.1 Who is entitled to a Medical Card?

Entitlement to a medical card is governed by legislation as provided for under Section 45 of the Health Act, 1970:

A person in either of the following categories shall have full eligibility for the services under this part –

(a) Adult persons, who in the opinion of the Health Service Executive, are unable without undue hardship to arrange general practitioner medical and surgical services for themselves and their dependants,

(b) Dependants of the persons referred to in paragraph (a)

There are three main categories of people entitled to a Medical Card:

1. Applicants (and their dependants) whose assessable income comes within the relevant Income Guidelines.
2. Applicants (and their dependants) whose assessable income is in excess of the Income guidelines but where the HSE considers that to refuse a medical card would cause undue hardship.
3. The following applicants are exempt from a means test:-
    a. Persons with EU entitlement.
    b. Persons with retention entitlement under Government Schemes
    c. Persons affected by the drug Thalidomide
    d. Persons affected by Symphysiotomy

The person registers with the Doctor of his/her choice and, once eligibility is confirmed, is entitled to receive certain Doctor, Dentist, Clinical Dental Technicians (CDT's), Optometrists or Ophthalmologists treatments/services and prescribed medicines from Pharmacists as set out under each scheme.

Each eligible person is provided with an individual card, which should be presented when seeking services under the Dental Treatment Services Scheme – each card will have a 'valid to' date embossed on it**.**

Each time G.M.S. cardholders present for treatment under the D.T.S.S. they should present current medical cards and CDT's will be required to satisfy themselves that such persons are the holders of current medical cards by using PCRS online eligibility service or via special messaging service (SMS).

2.1.2 Client Eligibility Confirmation

To assist contractors PCRS has developed a specific tool to verify a client's eligibility prior to providing services under the DTSS. This is a useful step to be taken prior to submitting a complete claim for reimbursement. This online facility is available at www.pcrs.ie under the heading "Dental Eligibility Confirmation".
This service will confirm if a client has a medical card and if that client is eligible for various treatments.

To use the tool, simply select the treatment, the patient's PPS number and then choose the "Check Dental" option. In addition, you can verify the same information in respect of B5 treatments by SMS text using your mobile phone. To use this facility, text the treatment code and PPS number to 087 909 7867, e.g. "A8 1234567P or B5 1234567P" (please note that there is a space between the treatment type and the PPS number).

2.1.3 GP (General Practitioner) Visit Card

A person issued with a discretionary GP Visit Card registers with the doctor of their choice and is entitled to receive free doctor treatment. **They are not entitled to treatment free of charge by a dentist/clinical dental technician/or optometrist or ophthalmologist or prescribed medicines and appliances.**

2.2 Dental Treatment Services Scheme (DTSS)

Under the Dental Treatment Services Scheme, introduced in November 1994, GMS eligible adults (aged sixteen and over) have access to a range of dental treatments and clinical procedures. However in the case of Clinical Dental Technician's an eligible person means a person aged eighteen years or over who is entitled to receive dental prosthetic treatments under the Health Acts.

The Budget 2010 decision limited expenditure under the DTSS. To protect access to emergency dental care for medical card holders and to safeguard

services for Children and Special Needs Groups, the HSE will prioritise the range of treatments available under the DTSS to emergency dental care to eligible patients with a focus on relief of pain and sepsis. Additional care will be considered in exceptional or high risk cases. Where an eligible person seeks emergency dental treatment, the contracting CDT must satisfy her/himself as to the clinical emergency and provide the necessary urgent treatment.

2.3 European Economic Area (EEA) entitlements

2.3.1 European Health Insurance Card (EHIC)

The European Health Insurance Card was introduced in Ireland and in many other EU / EEA member states from **1 June 2004**. It replaced all the paper forms needed to access necessary healthcare under EU regulations within the public system when on a **temporary stay** in another EU / EEA member state or Switzerland. Residents from one of the other states of the European Economic Area, with established eligibility, who require emergency Dental services while on a temporary visit to the State, are entitled to receive such services. **Those persons presenting for treatment with the EHI Card should in the first instance be referred to a Health Service Executive clinic for dental treatment**.

Queries in relation to the European Health Insurance Card procedure or guidelines should be directed to your Health Service Executive, or visit the new website set up for this at www.ehic.ie.

2.3.2 E128 Form

EU Administrative Commission Decision No. 165 of 30th June 1997 provides for the introduction of full health cover for certain workers and their dependents who accompany them abroad, and also for students and their dependents who accompany them abroad for the duration of a course of studies. A form E128 has been introduced on which entitlement to the full range of health care in the

country of posting or study for persons mentioned above is certified – this form must be presented when treatment is required. **Those persons presenting for treatment with Form E128 should in the first instance be referred to a Health Service Executive clinic for emergency dental treatment.**

The Health Service Executive may in certain circumstances make special arrangements for private practitioners to provide treatment to such persons but the resulting claim must be made directly to the Health Service Executive concerned.

You may wish to note that there is no change to the existing arrangements between Ireland and the UK, and residents of either country travelling to the other on a temporary stay are not required to present a European Health Insurance Card or an equivalent paper form. Proof of residency is sufficient. **Those persons presenting for treatment from UK should in the first instance be referred to a Health Service Executive clinic for emergency dental treatment.**

2.4 Health (Amendment) Act, 1996

The Government has provided in the Health (Amendment) Act, 1996 for the making available without charge of certain health services to certain persons who have contracted Hepatitis C, within the State, directly or indirectly from the use of Human Immunoglobulin-Anti-D or the receipt of another blood product or blood transfusion.

Eligible persons will receive a Health (Amendment) Act 1996 Services Card from their Health Service Executive. This card is personal to the holder and is valid for his/her lifetime. The number commences with ‘R’, has five numeric and concludes with ‘A’ e.g. R99999A.

Eligible adults will be required to present the Services Card to a CDT when they wish to avail of services under the Act. Eligible adults requiring B5 treatments must be approved by the Health Service Executive as provided for under the DTSS. Claims for payment of fees in respect of services provided to eligible adults should be submitted to HSE Primary Care Reimbursement Service in the usual manner. The patient's Services Card number should appear in the panel set aside for the medical card number in the appropriate claim form.

3.0 Administrative Arrangements

3.1 Application to HSE

Clinical Dental Technicians who wish to enter into an agreement with the HSE for the provision of Clinical Dental Technician services under the Dental Treatment Services Scheme can email us at CDT.contracts@hse.ie or call us on 01 8647194.

We will send an Application Form and Form of Agreement to interested parties. These documents should be carefully studied before entering into an agreement with the HSE. Those who wish to proceed should return completed forms along with the following supporting documentation:

- Current Professional Indemnity Insurance
- Dental Council Registration Certificate
- Tax Clearance Certificate
- Hepatitis B Status

Once all documentation is verified, successful applicants, will be advised of their DTSS contract number.

3.2 Completion of Claim Forms (Form D)

General

Form D is printed on self-imaging paper. A duplicate copy is provided which has 'Copy' ghosted diagonally across it. Duplicate or copy should not be submitted as a claim form. They should be retained for your own records for a period of six years in accordance with section 147 of Companies Act 1963.

A specific '€' column has been provided to assist you in maintaining your records. This column is solely for Clinical Dental Technicians use and will not cause a claim to reject for payment if left blank. Irrespective of the amount that may be entered, claims will be processed and paid at the appropriate rates.

D Form

In all circumstances details entered must be legible so as to ensure prompt payment. The following step by step process should be adhered to when completing a claim form. For your assistance please refer to Appendix 1:

1. Form Number – The form number is prepopulated on DTSS form
2. Patient's Name, Medical Card/HAA Number, valid to fields -
    a. Patient Name should be entered in the space provided at the top left corner of the form. It is important to satisfy yourself that the patient presenting for treatment is that which is displayed on their medical card.
    b. Patient's medical card/HAA number - The CDT should verify the patient's eligibility for service via online facility which is available at www.pcrs.ie. This service will confirm if a client has a medical/HAA card and if that client is eligible for various treatments. You can alternatively confirm the eligibility by SMS text using your mobile

phone (see 2.1.2). Only claims in respect of treatments provided to eligible GMS patients should be recorded on D forms as only such claims will be approved/paid. Invalid medical card numbers submitted for approval will be returned to you by the Principal Dental Surgeon. Invalid medical card numbers submitted for payment will not be paid.

c. PPS number – please insert patient's personal public service number, if known.

3. Clinical Dental Technician's Name & Panel Number - Please insert clearly your panel number, name and address. The Panel Number must be valid on the commencement of treatment in order to apply for approval/payment.

4. Declaration by Patient

   a. Commencement Date – Please insert the start date of treatment. The medical/HAA cardholder must have a valid card on the commencement date.

   b. Completion Date – **Please ensure this date is populated prior to submitting for payment. Please note this date must not be filled in when seeking approval.**

   c. Patient's Signature – Patient must sign **after treatment has been completed.**

5. Declaration by Clinical Dental Technician

   a. Clinical Dental Technician Signature – CDT must sign on completion of treatment in every case.

   b. Date – Please ensure date is populated prior to submitting for payment. **Completion date must not be filled in when seeking approval.**

6. Clinical Necessity- The CDT must indicate, in this box, that

    a. A soft tissue examination has been completed for all patients and the patient's oral tissues are healthy for fitting of prosthesis.

    b. no abnormality exists which would require referral of the patient to a registered dental or medical practitioner. If the abnormality impacts on the making of the Prosthesis it will be necessary to wait until abnormality resolved. Should such a case present, the CDT will refer the patient appropriately and will also provide them with a list of General Dental Practitioners, in their area, who provide treatment under the DTSS.

    c. the patient has advised they have attended their dentist within the last calendar year, if patient is not edentulous.

e.g.

Clinical Necessity
Soft Tissue Exam Y/N No abnormality detected Y/N Recent dentist visit Y/N Referral to a dentist Y/N

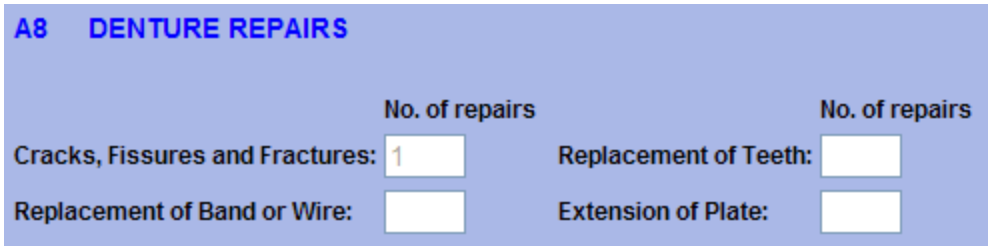
If pre-prepared stamps are used in the clinical necessity box, the form will be returned without approval and reject for payment if submitted directly to PCRS for payment.

As a fundamental part of its control system, the HSE does not accept facsimiles of claims or signatures, nor can it accept anything other than individual contractor's statement regarding clinical necessity by the responsible practicing CDT where appropriate.

7. A1 – Oral Charting – The CDT must record teeth that are present by inserting 'P' on relevant tooth number. If charting is omitted A8 or B5

treatment will not be paid. The number of teeth present will be reviewed, at approval stage for B5 treatment, to ensure the number of teeth present reflect the proposed type of treatment i.e. 12+ teeth etc.

8. A8 - Denture Repairs and Additions involves the repair of cracks, fissures, and fractures; the replacement of teeth; the addition of teeth; the replacement of band or wire and the extensions of any flange or surface in emergency circumstances and where the contracting CDT is satisfied as to the clinical emergency. This treatment type includes an additional box for the number of repairs under each category. The number of repair items should be indicated on the form. The maximum number of fees reimbursed is three. A lab receipt must be available for examination if requested.



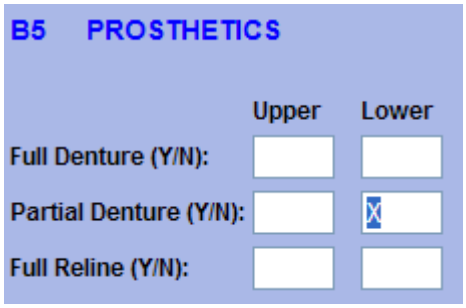
9. <u>B5 Prosthetics -</u> The following Prosthetic treatment will only be allowed in approved emergency circumstances:

    a. Full Dentures (12+ teeth) – a full denture is a removable prosthetic appliance which restores an arch with twelve or more teeth missing. The fee for a full denture shall include the cost of all necessary post insertion visits.

    b. Partial Dentures (1-11 teeth) – is a removable appliance which restores a partially dentate arch. The fee includes the cost of all retentive techniques and devices (clips, clasps, etc.) and all necessary insertion visits.

c. Denture Reline – A reline includes relining and rebasing dentures with a suitable material and, where necessary, replacement of palate. The fee includes all necessary post insertion visits.

Please clearly identify type of B5 item which requires approval prior to submission to Principal Dental Surgeon for approval.



If in emergency circumstances a patient requires a set of denture(s) these circumstances must be detailed in the clinically necessity box. Requests for repeat treatments within five years should include satisfactory clinical information in the clinical necessity box.

One Reline per denture may be approved in a five year period. Repeat relines or requests to reline partials will not be approved; relines are specifically for full dentures.

In the specific case of partial dentures approval will be sanctioned for:

- Dentures replacing anterior teeth (incisors & canines)
- Dentures replacing more than four posterior teeth (premolars & molars), where at least one premolar is being replaced.
- Partial dentures replacing molar teeth only will not normally be approved.

Please submit any ‘D’ form requiring approval to:-

Dr. B. P. Murphy, PDS

HSE Dental Clinic

Old County Road

Crumlin

Dublin 12

The Principal Dental Surgeon will consider the application within 30 days and where treatment is approved he will complete the ‘Official’s Signature’ box and ensure the number of Below the Line treatment items is completed.

Laboratory fees

The B5 fee encompasses both the clinical and laboratory element – separate Laboratory claims are not a feature of the scheme.

3.3 Claim Submission

CDT’s are required to submit their claims tagged in **one** package, once in a month so as to reach the Primary Care Reimbursement Service not later than 20th of the month following the month in which Treatment was completed.

Claim forms should be accompanied by a properly completed Summary of Claims Certificate attached to the top of the claims bundle. PCRS cannot confirm prompt payment of claims if submitted in multiple packages.

Properly completed claims received by the 20th of a month will be included with the payment to be made on the second Thursday of the following month. Where the 20th falls on a Saturday, Sunday, or Bank Holiday the close off date will move to the next available working day. The only exception to 20th of a month falls in December where close off date for submission of DTSS claims is at an earlier date e.g. 10th December and correspondence will issue to each contractor in advance.

Claims should be forwarded to the Primary Care Reimbursement Service in a pre-addressed envelope (supplies are available on request) to: P.O. Box 4563, Finglas, Dublin 11. Please note this is not a free post service.

3.4 Payment Listings

Details of paid claims will be reported on a 'Detailed Payment Listing' sent out shortly after payment is made each month. Errors encountered in the processing of data entered on a form will result in the non-payment of such claims. These will be reported on a Reject/Reclaim Listing, the reason for the rejection will be detailed thereon.

3.5 Reclaims

Claims that are rejected for payment, because of invalid or insufficient data, will report on a reclaim listing. All necessary corrections and amendments should be inserted on the reclaim listing and resubmitted to Primary Care Reimbursement Service for processing. Reclaims may be submitted under separate cover where necessary on a date later than 20th of the month and every effort will be made to ensure that such reclaims are included for payment in the following month. Duplicate claim forms should not be submitted in order to reclaim unpaid items.
A sample of reasons why claims may report on your Reclaim Listing are:

There was a name mismatch on Claim	The name on the claim form did not match that of the medical/HAA card number provided. Please check medical/HAA card details with client and provide correct number.
CDT and patient declarations must be signed and dated	If contractor has failed to sign original claim form CDT should sign reclaim listing or copy to confirm provision of services. If patient failed to sign original claim form, contractor should make every effort to obtain a patient signature on dentist copy.
Card not eligible on date of this Claim/Invalid Card Number	Contractor should check if patient had a valid medical card on commencement date of treatment and resubmit Reclaim Listing with valid medical/HAA card number.

3.6 Queries

When submitting written queries regarding payments made or claims submitted, please quote your Panel Number, Claim Number, Form number and a brief explanation as to the nature of your query. Queries should be submitted to the following address:

Customer Relations Management Unit,
Primary Care Reimbursement Service,
Units 1 – 5 Ground Floor, J5 North Park Offices,
North Park Business Park, North Road,
Finglas, Dublin 11

3.7 Withholding Tax from Payments for Professional Services

Under the terms of the Finance Act, the Primary Care Reimbursement Service is obliged to deduct Withholding Tax, (currently 20%) from all payments for professional services by contractors under all Schemes administered by the Primary Care Reimbursement Service. Each contractor is required under the relevant legislation to furnish the Primary Care Reimbursement Service with his/her income tax reference number on a form provided. The Primary Care Reimbursement Service will issue a completed Form F45-1 each month showing details of the payment and tax deducted to each contractor who has submitted a Tax Reference Number – such information is also shown on monthly Summary Listings. Where no tax reference number has been submitted, the Primary Care Reimbursement Service will be obliged to deduct the tax but will not be authorized to issue form F45-1. It appears that in such circumstances a contractor would be unable to make a claim to the Inspector of Taxes in respect of Withholding Tax paid. Any queries you may have in relation to Withholding Tax should be directed to the Inspector of Taxes for your own region.

3.8 Post Processing Review

The HSE completes post processing review with Medical Card holders, where we hold a record that they have received treatment under the Dental Treatment Services Scheme. If your patients are randomly selected for this review they will receive a form for completion.