The College of
Dental Surgeons
of Saskatchewan

SDHA
SASKATCHEWAN DENTAL
HYGIENISTS' ASSOCIATION

Billing for Hygiene Treatment Time

A Joint Message from the CDSS and the SDHA

The College of Dental Surgeons of Saskatchewan (CDSS) and the Saskatchewan Dental Hygienists' Association (SDHA) are often asked for advice and direction on how to correctly bill for hygiene treatment time. For hygiene procedures that have a per-unit-of-time fee, this message provides clarification of what is included in treatment time, the recommended recording of treatment, and how the treatment should be billed to the patient.

The definition of hygiene treatment time?

Hygiene treatment time ***is not*** limited to just "instrument on tooth time". As noted in the preamble to the preventive section of the CDSS Suggested Fee Guide, treatment time is "all the time the caregiver attends to the patient". It includes time spent with the patient reviewing the chart and asking about the patient's medical history and assessing vital signs, which are necessary to prepare for the treatment. It also includes the time spent performing intra-oral/extra-oral assessments, oral cancer screenings, probing, recording periodontal pocket depth and other hygiene treatment notes in the patient's chart, administering a local anaesthetic (when required), and providing post operative instructions to the patient (when required). This time is billable as scaling and/or root planning. Note that a local anaesthetic performed as part of hygiene treatment is not billable as a separate procedure.

Examples of time spent that is ***not*** included in hygiene treatment time include the breakdown, disinfection and set up of the operatory, idle time while the hygienist is waiting for the doctor to arrive to perform an exam (i.e., when not performing any procedure or procedure related activity), any remaining appointment time after the patient has been discharged and the time for administrative functions such as billing and reappointing the patient. Note that the operatory 'prep' time, like other administrative functions, is considered part of general overhead and the recovery of these costs is built into all procedure fees (although there may be instances when procedure time is rounding up to the nearest unit, or half unit, when this prep time ends up being billed.)

In any appointment, the maximum time billable on a per-unit-of-time basis is the time the patient is seated less the time taken to do any separately billable procedures such as radiographs (if done in the hygiene chair), fluoride, sealants, and the time the doctor takes to perform a recall exam. Note that time spent measuring and/or recording oral/dental findings other than periodontal conditions would *not* be included in hygiene treatment time; this is part of the dentist's exam and this time is billed to the patient in the exam fee, regardless of whether that exam is done at this appointment or at a subsequent appointment.

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Do dental hygienists need to record the start and stop time for all patient appointments?

The dental hygienist should record the time spent providing services that are based upon units of time; specifically the time spent scaling and root planning, polishing and/or desensitizing must be recorded. This time should include all the treatment time as defined above (excluding the time taken to perform procedures that are billed on a per-procedure basis such as fluoride, pit and fissure sealants, radiographs and the dentist's recall exam). Best practice is to record the number of minutes providing each of these services. Recording only as units may be confusing particularly when the office books in 10 minute units because procedure codes are always based on 15 minute units.

It is acceptable to also write the number of units (which should be rounded to the nearest unit of half unit as appropriate) in addition to the minutes spent although this is not a requirement of the regulation. Note that the total time recorded for procedures that are billed as per-unit-of-time plus the actual time taken to perform procedures billed on a per-procedure basis should not exceed the total time the patient is in the chair. Note that it is not appropriate to round up several procedures so that the total time billed exceeds the time the patient is seated by more than just a few minutes.

How are per-unit-of-time procedure codes to be used and how are the fees billed to the patient to be determined?

The College of Dental Surgeons of Saskatchewan publishes *The CDSS Suggested Fee Guide for General Practitioners.* It is intended to serve as a reference for the dentist to enable development of a structure of fees which is fair and reasonable to the patient and to the dentist. The suggested fees are not obligatory and each dentist is expected to determine independently the fees which will be charged for the services performed. The Guide is issued merely for professional information purposes, without any intention or expectation whatsoever that a dentist will adopt the suggested fees.

While the suggested fees are not obligatory, the use of correct procedure codes is, and this means that the dentist must use the code that describes the actual service. In the case of per-unit-of-time procedures such as scaling and root planning, the code used must reflect the amount of time spent providing the service, i.e. treatment time as defined above. ***Time is measured in fifteen minute units.*** If a procedure takes a partial unit of time, the procedure code which corresponds to the half unit of time should be used. Where a half unit of time code does not exist, the code which corresponds to the next higher unit of time may be used and the dentist may adjust his/her usual and customary fee and bill the patient for the actual time.

As mentioned in the preamble to the Preventive section of the CDSS Suggested Fee Guide, if multiple procedures are being performed, the procedure that should be billed (and recorded) is the predominant procedure in any unit (or half unit) of time. Note that if you spend a few minutes on OHI during a unit of scaling, this unit of time should be billed as scaling (scaling is the predominant procedure, OHI would be the predominant procedure if it took more than 7½ minutes and this unit of time should then be billed as OHI, not scaling).

Procedure codes billed and time spent should be individualized to each patient.

A standardized amount billed for all hygiene appointments and to each patient is unacceptable practice and should be avoided.