GUIDELINES FOR FEES, CODING, BILLING, AND THIRD-PARTY CARRIERS

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The College of Dental Surgeons of Saskatchewan provides this document to assist dentists with decisions related to the fees, coding, billing, and third-party carriers. This document is a compilation of references regarding fees, coding, billing, and third-party carriers within other CDSS statements, guidelines, and standards, as well as other best practices.

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(1) CDSS REGULATORY BYLAWS 4(3)(B)

(a) A registrant shall not, nor permit a professional corporation in which the registrant is a director to:
- (xv) falsify a record regarding the examination or treatment of a patient;
- (xvi) sign or issue a certificate, report, or similar document that contains a statement that a registrant knows or ought to know is false, misleading, or otherwise improper;
- (xvii) make a misrepresentation respecting a remedy, treatment, or device;
- (xviii) knowingly submit a false or misleading account or false or misleading charges for services rendered to a patient;
- (xix) charge fees that are excessive, unreasonable, or inaccurate in relation to the services performed;
- (xx) charge for services not performed or not necessary;

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(2) CDSS CODE OF ETHICS

Article B5: Fees and Compensation for Services

A dentist is responsible for establishing fees for professional services performed.

Article B6: Dental Plans and Third-Party Carriers

A dentist who submits a claim form to a third-party reporting incorrect treatment dates, procedure codes, and/or fees charged is engaging in inappropriate billing and unethical practice. It is the patient's right to have alternative treatment options explained regardless of costs or coverage through a third-party provider. This means that a dentist shall explain alternative treatment options, regardless of the cost or insurance coverage. The dentist is obligated to inform a patient of the benefits, risks, disadvantages, and costs of alternative dental treatment options.

A dentist must ensure that claims made to a third-party carrier for patient care are accurate statements of the services rendered and fees charged to the patients. A dentist must not determine or direct a patient's treatment decisions based primarily on the existence or non-existence of a third-party dental plan.

If the patient's third-party carrier plan specifies a co-payment from the patient, the dentist providing the services for the patient must, under the conditions of the plan, engage in usual and customary business practices to collect such co-payments from the patient. A dentist is prohibited from accepting an amount in full payment of an account or charge that is less than the full amount of the account or charge submitted by the dentist to a third-party payer.

(3) CDSS ETHICS OF PATIENT-CENTERED CARE AND THE BUSINESS OF DENTISTRY

4. Dentists must treat colleagues and patients fairly in all financial dealings.

5. The treating dentist should complete an appropriate examination, provide a diagnosis, a treatment plan, an estimate of cost, and obtain informed consent from the patient before proceeding with treatment or overseeing treatment that is appropriately delegated.

   A dentist who assumes responsibility for an existing treatment plan must reassess the patient to ensure that the proposed treatment is appropriate and necessary. If the treatment plan is altered, the dentist must update the patient and obtain informed consent.

11. Dentists must appropriately charge patients and dental plans for goods and/or services provided by a third-party.

12. Dentists must be transparent if the fees are above the fees listed in the suggested fee guide.

(4) INFORMED CONSENT PROCESS STANDARD

8. Not all patients have the capacity to provide consent, so consent should be obtained from someone legally allowed to do so and consent should include the articulation and understanding of the costs involved.

9. There is no current authority in Saskatchewan, Statutory or Regulation, which bases consent on age. If a patient is capable of understanding the appropriate information provided to them, they can provide consent regardless of age. Thorough documentation of the process is prudent. Furthermore, if a parent or other party will be implicated as a ‘payer’ for the services proposed for consent, it would be prudent to obtain permission to approve the payment.

11. Consent forms should include the following information where relevant:
    - (i). Limitations of treatment including prognosis and discussion of costs and treatment that may be necessary if retreatment or revisions are necessary;
    - (j). Estimated costs of proposed treatment;

(5) PRACTICE OF DENTISTRY, CLINIC FACILITIES STANDARD

5 xi. Appropriate use of the Connected dentists billing number for all therapist's, hygienist's and assistant's services.

5 xii. Random and regular auditing of patient records including billing records to ensure scope of authorized practice is observed.

(6) SUGGESTED FEE GUIDE PREAMBLE EXCERPTS

(a) The Suggested Fee Guide is published to serve as a guide. No general practitioner or specialist is required to endorse or to charge the fees itemized in the Suggested Fee Guide.

(b) The intent of the Suggested Fee Guide is to provide reference to dental practitioners which will enable them to develop a structure of fees that is fair and reasonable to patients and themselves.

(c) Insofar as it has been possible, the Suggested Fee Guide reflects those fees that would appear to be appropriate under normal or typical operating conditions, in which the itemized procedure is of normal or typical complexity and performed by a practitioner of average professional skill, judgement, dexterity and responsibility. However, even under circumstances in which these conditions are fulfilled, no practitioner is obliged to charge for services as they are listed in the Suggested Fee Guide.

(d) As these fees are determined on the basis of a single service, it is considered reasonable that dentists may: decrease their fees when multiple services are involved, or when the time factor is significantly reduced below normal; increase their fees when the time factor is significantly greater than normal, or where exceptional effort or skill is required, or where complications are present.

(e) **The College recommends that, to avoid any misunderstanding between patient and dentist, an adequate treatment plan and estimate of costs be presented to the patient prior to commencement of any form of elective treatment. This simple courtesy will eliminate most disputes regarding types of treatment and fees at some later date.**

(f) Coding Instructions
The suggested fee guide uses codes from the Uniform System of Coding and List of Services (USC&LS) which is published annually by the Canadian Dental Association. The USC&LS is a terminological standard that provides descriptions and codes to represent oral health services. Its two main uses are the production of fee guides and the exchange of information with insurance companies. The USC&LS is intended to remove, to the greatest extent possible, any ambiguity in the description of services. This can only be accomplished if the codes are used in a consistent fashion – by all users, at all times.

(g) As dentists, you will mainly use the USC&LS to describe the services provided on claims you prepare for your insured patients.

(h) The descriptors of service provided in the USC&LS are not detailed enough to meet the record keeping requirements of provincial dental regulators. The use of USC&LS codes for record keeping purposes is not recommended.

(i) Inclusions and Exclusions
Codes provided by the USC&LS represent services. When a service is normally comprised of a set of distinct procedures, these procedures are included in the service code and should not be coded separately.

(j) The most important criteria for the identification of which code to use for the representation of a service is factual accuracy. Any misalignment between the service provided and the fully specified descriptor of a code means that the code cannot be used. In cases where more than one code descriptor that accurately matches a service can be identified, the one that provides the best match must be used.

(k) Even when there isn’t a code that accurately represents a service, it is not acceptable to use a code where the full descriptor is not a match to the service. Conversely, the absence of a code that accurately describes a service doesn’t prevent the billing of that service to the patient or the submission of a claim for its reimbursement by a dental plan. Claims for services that cannot be coded through the USC&LS cannot be sent with CDAnet™. However, they can be submitted on paper, ideally on the Standard Dental Claim Form, using the box labeled "FOR DENTIST USE ONLY – FOR ADDITIONAL INFORMATION, DIAGNOSIS, PROCEDURES, OR SPECIAL CONSIDERATION" to provide a text description of the service.

(l) Except for codes in class 06000 Radiographs, which are for specialty use only, all the active service codes from the current edition of the USC&LS are available for the description of services. The code category, scope of practice, or specialty status of the dentist who provides it does not limit the use of a code.

(m) Any combination of codes is allowable providing it accurately describes the services being coded. The requirement is to use the smallest possible number of combined codes that provides an accurate description of a service.

(n) Coding of Restorations
Services that use direct restorative materials or single unit indirect restorations for the improvement of the form, function, and aesthetics of teeth, without consideration for the cause of the need for improvement are coded in section 20000. The use of direct restorative materials or single unit indirect restorations for purposes other than those above cannot be represented by codes in Category 20000. For example, the addition of composite to a tooth to facilitate an orthodontic treatment is part of the description of the orthodontic treatment and must not be represented by codes in class 23000.

(o) The coding for many restorative services is done on a tooth-by-tooth basis and depends on the number of surfaces restored, with one material, at one appointment, not the number of discrete restorations placed on that tooth.

(p) Units of Time
Units of time referenced in the USC&LS are periods of 15 minutes or less. For services where half units of time are coded, a half unit of time is a period of 7 1/2 minutes or less.

(q) For services coded in terms of "units of time", the time spent on the provision of a service begins when the practitioner begins preparing himself/herself and the patient for its delivery and ends either when another service is initiated or when the patient is discharged from the operatory. Treatment time does not include the time spent setting up or breaking down the operatory nor does it include the time spent on administrative tasks such as billing and scheduling the next appointment. Total time units do not equal time on tooth with an instrument as services directly related to the provision of the main service are included.

(r) A unit of time, either half or full as appropriate, is added to the total number of units used as soon as the delivery of the service extends into the next unit of time. For example, a service where a code for half-units of

time is not available that takes between 1 and 15 minutes to deliver should be recorded as one unit of time. One that takes between 16 and 30 minutes as two units of time.

(s) Services for which a code representing a half-unit of time is available should be recorded as the number of full units used plus one half-unit if the overage is more than 7 1/2 minutes. For example, if a service, for which a code representing a half-unit of time is available, took 17 minutes to deliver, it should be coded as one full unit and one half-unit. If the same service took 24 minutes, it would be coded as two full units.

(t) It is important to recognize that "appointment time" is not the same as "treatment time". "Appointment time" may be less than the time represented by the total of the units of time reported for that appointment.

(u) +L, +E and +PS
Services whose descriptor involve the mentions +L, +E or +PS separate the dentist fee from an expense component that is passed through to the patient. The representation of these services requires the use of two codes, one for the service itself and one for the expense that is passed through to the patient.

(7) BEST PRACTICES FOR FEES, CODING, BILLING, AND THIRD-PARTY CARRIERS

The College of Dental Surgeons of Saskatchewan provides these best practices to (A) assist dentists with decisions related to the fees, coding, billing, and third-party carriers and (B) maintain good standing within the profession.

(a) Discounts
Any discount provided to a patient must be made prior to submission to any third-party dental insurance provider.
It is not uncommon for dentists to offer a discount on the services they provide. What is important is the timing of this discount. Any discount needs to be applied before the submission to the third-party insurance provider, and not as a write-off as an outstanding balance after the payment from the third-party insurance provider.

(b) Entry Dates
The date on which a treatment is entered and therefore charged to the patient and any insurance provider, must accurately reflect the date that treatment was rendered.

(c) Coding
Selecting the correct code for the treatment provided. The Preamble in the CDSS Suggested Fee Guide includes the following excerpt:

> The most important criteria for the identification of which code to use for the representation of a service is factual accuracy. Any misalignment between the service provided and the fully specified descriptor of a code means that the code cannot be used. In cases where more than one code descriptor that accurately matches a service can be identified, the one that provides the best match must be used.

Specific criteria requirements for coding are:

i. Date of Coding of Multiple Visit Treatments
For procedures where multiple visits are often needed for the delivery of a service, a dentist can only bill using the appropriate code once the entire procedure as outlined in the CDSS Suggested Fee Guide has been completed.

A fee for the service may still be charged prior to the completion of the entire service but the appropriate code(s) cannot be entered until the entire procedure is completed.

Where the code used will require the completion of a report/interpretation by another provider, the code cannot be entered until the report/interpretation has been completed. An exception to this position may be coding for orthodontic procedures that require the submission of the code prior to the completion of the procedure to satisfy the requirements of the third-party carrier.

ii. Examination Codes

Often with the complete examination codes 01101-01103, the full criteria is not fulfilled as outlined for those codes:

EXAMINATION AND DIAGNOSIS, COMPLETE ORAL to include:

(a) History, medical and dental

(b) Clinical Examination and Diagnosis of Hard and Soft tissues, including the following as necessary: Carious lesions, missing teeth, determination of sulcular depth and location of periodontal pockets, gingival contours, mobility of teeth, interproximal tooth contact relationships, occlusion of teeth, TMJ, pulp vitality tests/analysis, and any other pertinent factors

(c) Radiographs extra, as required.

iii. Extractions

A careful review of the difference between the “Removal of Erupted Teeth, Complicated (712--) codes and the various codes for Removal of Impacted Teeth (72---) is highly recommended to ensure that the service charged for reflects the clinical and radiographic presentation of the tooth prior to extraction.

iv. Units of Time

All registrants should be familiar with the following excerpt from the CDSS Suggested Fee Guide: Units of time. Units of time referenced in the USC&LS are periods of 15 minutes or less. For services where half units of time are coded, a half unit of time is a period of 7 1/2 minutes or less. For services coded in terms of "units of time", the time spent on the provision of a service begins when the practitioner begins preparing himself/herself and the patient for its delivery and ends either when another service is initiated or when the patient is discharged from the operatory.

Treatment time does not include the time spent setting up or breaking down the operatory nor does it include the time spent on administrative tasks such as billing and scheduling the next appointment. Total time units do not equal time on tooth with an instrument as services directly related to the provision of the main service are included. A unit of time, either half or full as appropriate, is added to the total number of units used as soon as the delivery of the service extends into the next unit of time. For example, a service where a code for half-units of time is not available that takes between 1 and 15 minutes to deliver should be recorded as one unit of time. One that takes between 16 and 30 minutes as two units of time. Services for which a code representing a half-unit of time is available should be recorded as the number of full units used plus one half-unit if the overage is more than 7 1/2 minutes. For example, if a service, for which a code representing a half-unit of time is available, took 17 minutes to deliver, it should be coded as one full unit and one half-unit. If the same service took 24 minutes, it would be coded as two full units. It is important to recognize that "appointment time" is not the same as "treatment time". "Appointment time" may be less than the time represented by the total of the units of time reported for that appointment.

(d) Informed Consent

The CDSS Informed Consent Standard, Section 11 indicates what should be included in the documented consent. Included in that list are:

(i) Limitations of treatment including prognosis and discussion of costs and treatment that may be necessary if retreatment or revisions are necessary;

(j) Estimated costs of proposed treatment;

This same message is delivered in the Preamble of the CDSS Suggested Fee Guide:

The College of Dental Surgeons of Saskatchewan recommends that, to avoid any misunderstanding between patient and dentist, an adequate treatment plan and estimate of costs be presented to the patient prior to commencement of any form of elective treatment. This simple courtesy will eliminate most disputes regarding types of treatment and fees at some later date.

Estimates of Fees

i. Dentists should be upfront and transparent about the actual fees that are involved with any treatment plan.
ii. Estimates should be in written format, and not just verbal.
iii. Estimates provided to the patient should be documented in the patient record.
iv. As exact costs cannot always be determined, dentists may provide estimates that include a range of low and high fees.
v. Estimates should include the fees of additional expense of materials (at cost) and laboratory fees (at cost), when applicable, and any additional treatment.
vi. In complex cases, dentists should discuss the fees of possible subsequent treatment.
vii. Dentists may need to schedule a separate appointment to discuss the fees associated with a complex treatment plan.
viii. Dentists should encourage patients to ask questions to fully understand the proposed treatment and its associated fees.
ix. A dentist should only proceed with treatment once informed consent, including fees, is obtained.
x. If a dentist determines that an alteration to the treatment plan is necessary during treatment, while the patient is in the chair, the dentist should explain the additional fees and confirm that the patient, parent, or substitute decision maker agrees before proceeding.
xi. An exception to this may be a dentist treating a patient that has been administered sedation or general anesthesia.