Memorandum of Agreement

HER MAJESTY IN RIGHT OF NEWFOUNDLAND AND LABRADOR, as represented by the Minister of Health and Community Services

And

The Newfoundland and Labrador Dental Association

(collectively referred to as the "Parties")

WHEREAS: The NLDA represents dentists of the province of Newfoundland and Labrador;

AND WHEREAS: The Minister is desirous of providing insured Surgical/Dental services to MCP beneficiaries of Newfoundland and Labrador for the period of April 1, 2018 to March 31, 2022.

THEREFORE, the Parties agree to the conditions and provisions stipulated in the following Memorandum of Agreement.

This Agreement covers the fees for insured Surgical/Dental services provided to MCP beneficiaries of Newfoundland and Labrador for the period of April 1, 2018 to March 31, 2022. Payments for these services are as per the MCP Surgical Dental Schedule, attached hereto.

1.0 Duration

(a) Both parties agree that this Agreement will be effective April 1, 2018 and will expire March 31, 2022. The first year of the Agreement will commence April 1, 2018 and will expire March 31, 2019.

(b) The second year of the Agreement will commence April 1, 2019 and will expire March 31, 2020.

(c) The third year of the Agreement will commence on April 1, 2020 and will expire March 31, 2021.

(d) The fourth year of the Agreement will commence on April 1, 2021 and will expire on March 31, 2022.

7.5 Orthognathic Surgery

For the purpose of this Schedule rigid fixation includes bone plates, bi-cortical screws and K-wires. The fee payable for rigid fixation is for one application per side per arch. **See code 84867 in the Surgical Dental Payment Schedule**

7.6 Temporomandibular Joint

For the purposes of this Schedule, temporomandibular joint procedures are unilateral. If both joints are operated as the same surgery, the fee(s) for service(s) relating to the second joint is payable at 85% of the listed fee(s).

8. FRACTURES

8.1 Open reduction

Open reduction shall mean the reduction of a fracture by an operative procedure to include the exposure of the fracture, or internal skeletal wiring of the fracture, or placement of extra-skeletal pin fixation, such as the Roger Anderson type of apparatus.

8.2 Closed reduction

Closed reduction shall mean the reduction of a fracture by a simple application of arch bars and/or intermaxilliary fixation such as used in a mandibular condylar fracture.

8.3 No reduction

No reduction shall mean the treatment of a fracture by any method other than that designated in 1 or 2 above.

8.4 The stated fee covers full treatment including necessary after care up to 42 days by the Dentist or Specialist of same specialty. This includes the removal of a wire or other device when used for traction or external fixation in the treatment of a fracture.

8.5 Multiple fractures or dislocations

In multiple fractures or dislocations, the fee for the major procedure shall be the full fee and the other fractures or dislocations shall be at eighty-five (85) percent of the listed fees.

8.6 Compound fractures

Compound fractures requiring extensive debridement should be billed IC at 150% of the listed fee for the closed reduction.

8.7 Open reduction of compound facial bone fractures requiring extensive debridement or reconstructive procedures to be assessed at double the operative fee. An IC form is required.

8.8 Where a patient is transferred to another surgeon for after-care of a fracture, the surgeon rendering the initial care shall receive 75% of the listed fee and the surgeon rendering the subsequent care 50% except where otherwise specified.

9. AFTER HOURS

9.1 Call Program (OMFS)

9.1.1 On-Call

(a) An Oral Surgeon will receive $174.00 per 24 hour call period.

(b) On-call Oral Surgeons will be available to respond to urgent and emergent requests for the purpose of examining, treating or providing diagnostic services to discharged or unattached patients:

i. Who present from the community to an emergency department; or
ii. Who are referred by physicians from other facilities; and/or
iii. Who are in-patients admitted by physicians in another specialty.

(c) Approved on-call rotations must follow a defined call schedule which provides coverage 24 hours per day 365 days per year.

(d) Implementation of an on-call rotation requires participation of more than one Oral Surgeon.

9.1.2 Call back

(a) If there is only one OMFS he/she may opt to receive call back but in no case will he/she receive both on-call and call-back compensation

(b) An Oral Surgeon will receive $375.00 per call back.

9.2 Surgical Fees

9.2.1 Oral Surgeons who participate in procedures that are non-elective, unscheduled and which require the services of an Anesthesiologist are eligible for payment of a premium as follows:

(a) If a procedure commences between 6pm and midnight or on Sunday or a Statutory Holiday, then a 30% premium per procedure can be billed.

(b) If a procedure commences between 7am and 6pm on Saturday, then a 30% premium per procedure can be billed.

(c) If a procedure commences between 12am and 7am any day of the week, then a 50% premium per procedure can be billed.

(d) There shall be no pyramiding of the premiums outlined in 10.2.1(a), (b) and (c). For further clarity, an Oral Surgeon can only claim one premium per procedure.

9.3 Examinations after hours

(a) If an examination is rendered after hours (see fee code definition), an after-hours premium may be claimed.

(b) Where an after-hours premium is applicable based on the time the examination is rendered, a starting time indicator for that examination must appear in the patient's record.

(c) Statutory Holidays are as listed in the appropriate MCP Newsletter for that year and do not include additional Civic Holidays (e.g. Regatta Day). Premiums may be claimed for examinations provided on the ACTUAL Statutory Holiday but not on a day held in lieu of the holiday.

10. SEDATION

(a) Restricted to office of an Oral Surgeon,

(b) Can be claimed once per office visit,

(c) Can be claimed only when services being provided are insured under the Surgical Dental Program,

(d) Does not apply to services provided under the Provincial Dental Health Plan,

(e) Provider's remarks not required but a record of services performed must be maintained for audit purposes.

11. SURGICAL ASSISTANT'S SERVICES

11.1 Assistant's fees are payable by MCP only when the complexity of the procedure requires the presence of an assistant.

11.2 In surgical procedures requiring the presence of a Dentist as an assistant, the fee for the assistant shall be at 30% of the fee payable to the Oral Surgeon for the procedures performed.

11.3 Where the presence of a Specialist is required as an assistant because of the difficulty or complexity of a case, the fee payable will be 150% of the listed fee and shall be divided equally between the two providers.

11.4 When multiple or bilateral surgical procedures are done during the same anesthetic, the assistant's fee shall be based on the total fees payable for the procedures performed at which he/she assisted. When bilateral procedures or surgical revisions are carried out at separate times with separate anesthetic, the assistant shall be entitled to receive a full assistant's fee for each procedure.

11.5 In surgical procedures requiring more than one assistant, the second assistant shall compute his/her fees on the same basis as the first assistant.
Note: The time factor applicable to assistants in the Medical-Surgical Payment Schedule does not apply when fee code numbers in the Surgical-Dental Schedule are claimed.

12. MCP REGISTRATION

12.1 All Dentists and Specialists receiving funding from MCP for clinical services provided must be registered with MCP through completion of a Provider Registration Form.

12.2 Changes in practice (e.g. address, licensure status, banking information, method of remuneration, etc.) require notification to MCP prior to the changes being effective for billing purposes.

13. LOCUM COVERAGE

Written documentation of locum practice/services is required for all Dentists and Specialists. Contact MCP for current policy and forms.

Appendix B

EXTRACTION OF ERUPTED TEETH

The extraction of erupted teeth is not an insured benefit of the Surgical Dental Program of MCP except in the following situations:

1. Teeth in the line of an osseous fracture, removed at the time of treatment of the fracture(s).

2. Teeth involved in acute trauma, removed at the time of the initial presentation of the patient for treatment.

3. Teeth specifically associated with the treatment of tumors.

4. Teeth which are the direct or potential source of an infection which may compromise medical treatment for either of:
   (a) diabetes mellitus **(Uncontrolled)**
   (b) bleeding dyscrasia
   (c) steroid therapy
   (d) immunosuppression
   (e) organ transplant
   (f) cardiac surgery (bypass, transplant, valves or septum)
   (g) chemotherapy/radiation therapy
   (h) psychiatric illness when the patient is hospitalized for treatment by a psychiatrist

   Numbers 1-4 above require a form to be signed by a medical or dental practitioner in which a request is made for the extraction of teeth and which clearly identifies the medical condition being treated.

5. Acute dental infection which places the patient in immediate medical distress involving uncontrolled septicemia or airway occlusion.

   This presupposes an emergency situation. Documentation by IC Form or hospital record may be required.

   The final decision of insurability in cases of managed medical conditions will rest with the Oral Maxillofacial Surgeon.

Appendix C

EXTRACTION OF IMPACTED TEETH

The extraction of impacted teeth is not an insured benefit of the Surgical Dental Program of MCP except in cases where such removal of partially erupted, or of completely bone covered, impacted teeth is associated with one or more of the following situations:

1. There is a history of persistent or recurring infection associated with the impacted tooth. Treatment would indicate two or more courses of antibiotics.

2. Extraction is requested by a physician to prevent complications in medically compromised patients who are being treated by the physician for either of:

    (a) Cardiac valvular disease
    (b) Renal disease
    (c) Hematological disorder
    (d) Immunosuppressive disease
    (e) Malignancies
    (f) Insulin dependent diabetes, or
    (g) Any other medical condition requiring in-hospital monitoring.
    (h) Cardiac valvular disease

3. Extraction is surgically indicated to treat a cystic and/or neoplastic process which is evident on radiographic examination

4. Extraction of the mandibular contralateral, partially erupted or completely bone covered, impacted tooth, **is** eligible for payment as described above, and as evidenced by clinical and radiographic data, is completed at the same appointment.

Copy of Hospital Operative Report of procedure is required.

April 1st, 2018

Appendix "B"

Dental Monitoring Committee

Terms of Reference

PURPOSE

- The Committee shall be assigned the responsibility of reviewing and making recommendations to the DOHCS Minister regarding complex dental claims which are referred to the Committee by the DOHCS Dental Consultant

MEMBERSHIP

- The Dental Monitoring Committee shall consist of:
    - –Five voting members, all of whom shall be dentists licensed to practice in Newfoundland and Labrador
    - The DOHCS's Dental Consultant shall be a permanent, non-voting committee member
    - The DOHCS's MCP Manager of Claims Processing shall be a permanent non-voting member
    - The DOHCS may appoint one administrative support position as a permanent non-voting committee member
- The NLDA may recommend individuals as candidates for the position of voting member, and the Minister of the DOHCS shall consider such recommendations.
- Voting members shall be appointed by the Minister for a three year term.
- Whenever possible, to ensure continuity of committee experience, terms for voting members will be staggered.
- No voting member shall serve more than two consecutive terms. A voting member may serve subsequent terms provided there is a three year break in service after his/her two consecutive terms.

COMMITTEE CHAIR

- The Dental Consultant shall be the chairperson
- Meetings will not proceed in the absence of the Chairperson, unless he/she has appointed a DOHCS representative to act in his/her stead.

QUORUM

Three voting members shall constitute a quorum.

MEETING TIMES AND DATES

The committee will meet quarterly.

The dates of the meeting will be made available to the NLDA six months in advance of future DMC meetings.

The NLDA will be informed of any rescheduling of meetings.

Additional meetings may be called at the discretion of the chairperson.

RECORDS OF DECISIONS

A Record of Decisions shall be kept by the Chairperson for all meetings

All discussions shall be held under executive privilege.

A Record of Decisions shall be made available to the DOHCS Minister and NLDA Executive Committee following the meeting of the DMC.

The format of the Record of Decisions will be agreed upon by NLDA Executive Committee and the Dental Consultant.

Remuneration

Voting members will be remunerated in accordance with established committee rates as per government policy

Out of town voting members will be reimbursed for travel expenses as per current government policy

VOTING

All decisions of the committee shall be by majority vote.

(e) The NLDA will inform the Department of Health and Community Services in writing no sooner than 6 months prior to the expiry date of this Agreement of its intention to negotiate a new Agreement.

2.0 Fees

(a) For this Agreement the fee schedule will use the MCP Surgical Dental Schedule of Benefits as a base and apply increases as per the table in 2(b).

(b) Payments for insured services are as per the MCP Surgical Dental Schedule, attached hereto, and will be increased in accordance with the following schedule.

Year 1	Year 2	Year 3	Year 4
0%	0%	0%	0%

(c) Effective April 1, 2018 the following six procedures will **continue to be paid as per attached schedule if performed in the office of the Oral Surgeon.**

- Extractions (erupted and impacted)
- Biopsies (oral soft tissue) exempt from hospital requirement
- Removal of cysts
- Oro antral fistula closure
- Haemorrhage control
- Panorex

In an effort to ensure fiscal responsibility and the ability to provide insured services within the Surgical Dental Program, it is understood by all parties that the Department of Health and Community Services will monitor the volume of work and costs.

(d) **Dental Health Program statistics will be shared with the NLDA. These statistics will include fee codes by capacity as well as other statistics as agreed upon by the NLDA and government. Statistics will be cleaned of any personal /private information.**

IN WITNESS WHEREOF the parties have executed this agreement on the 27th day of **March, 2018**

SIGNED on behalf of Her Majesty the Queen in Right of Newfoundland & Labrador by the Honourable John Haggie, Minister of Health & Community Services, in the presence of the witness hereto subscribing:

Colleen Power
Witness

Hon. John Haggie

SIGNED on behalf of the Newfoundland & Labrador Dental Association by its proper officers in the presence of the witness hereto subscribing:

Witness

Dr. Robert Cochran
President

Witness

Dr. Paul Hurley
Vice President

Witness

Anthony Patey
Executive Director

MCP SURGICAL DENTAL PROGRAM
SCHEDULE A

PREAMBLE

This Payment Schedule identifies the amounts prescribed as payable and rules and conditions of payment under the Physicians and Fee Regulations, adopted under the *Medical Care and Hospital Insurance Act* for insured services rendered by licensed General Dentists (hereafter referred to as Dentists) and Specialists. The fees listed apply to services rendered on or after the "effective date" at the top of each page.

Additions, deletions and changes made to the Payment schedule require approval by the Minister of Heath and Community Services based on recommendations from MCP, in consultation with the Newfoundland and Labrador Dental Association.

Any changes made during the effective life of the Payment Schedule are published in MCP Newsletters. It is the responsibility of claiming Dentists and Specialists to ensure these changes are reflected in their billings.

1. INTRODUCTION

The Payment Schedule is divided into a number of sections:

- General Preamble
- Appendices
- Surgical Procedures

1.1 General Preamble

This section sets out the general definitions and constituent elements common to all insured services, as well as the specific elements for these services.

1.2 Appendices

This section gives details on specific policies referred to within the Preamble. These include:

- Extraction of Erupted Teeth
- Extraction of Impacted Teeth

1.3 Surgical Procedures

Fees for Dentists and Specialists may be listed for each procedure. Dentists bill for procedures using rates listed in the Dentist Column. Specialists bill for procedures using rates listed in the Specialist Column. Where no fee is listed in the Dentist Column, 83.3% of the amount listed in the Specialist Column will apply.

2. INSURED/NON-INSURED SERVICES

2.1 Insured Services

An insured service is defined as one that is:

(a) listed in Section 3(b) of the *Medical Care Insurance Insured Services Regulations under the Medical Care Insurance Act*, 1999; and

(b) Medically necessary. The clinical need of the provision and claim of an insured service may be evaluated by the Dental Monitoring Committee of MCP;

Policies on pre-existing conditions necessary to define "medical necessity" exist for the specific services to qualify as MCP insured services. These are listed as appendices to this Preamble or may be published in MCP Newsletters.

2.2 Non-Insured Services

The following situations/conditions qualify as non-insured services:

(a) Specific services as listed in Section 4 of the *Medical Care Insurance Insured Services Regulations.* Queries as to the insurability of a specific service should be directed to the office of the **Dental Consultant**.

(b) Any dental services provided at the request of a third party, or which are covered by other agencies.

(c) Dental services provided to patients not insured by MCP or any other provincial Health Care Plan.

(d) Services provided as a result of dental research and experimentation.

Payment for dental and professional services which are research-related or experimental are not the financial responsibility of MCP. Only those related to routine, accepted care of a patient's problem and that are not in support of the research related or experimental services are considered to be an insured service.

3. CLAIM SUBMISSION AND DOCUMENTATION REQUIREMENTS

3.1 General Information

3.1.1 All service items billed to MCP are the sole responsibility of the Dentist or Specialist rendering the service with respect to the appropriate documentation and billing.

3.1.2 If a specific fee code for the service rendered is listed in the Payment Schedule, that fee code must be used in claiming for the service, without substitution.

3.1.3 Claims for services rendered in hospitals must include the hospital/facility number of the institution where the service was rendered. **For services rendered in the office of an Oral Maxillofacial Surgeon the institute number 0132 is to be used.**

3.1.4 For claiming purposes, date of the service is the date of the patient contact.

3.1.5 Documentation of services which are to be billed to MCP must be completed before claims for these services are submitted to MCP.

3.1.6 All claims submitted must be verifiable from the Dentist's and Specialist's records with regard to the examination and/or procedure claimed. Where specific elements of record requirement are listed in this Preamble, but do not appear in the patient record of that service, that element of the service is deemed not to have been rendered and the fee component represented by that element is not payable.

3.1.7 Referrals to a Dentist or Specialist that meet the conditions of eligibility for i) extraction of impacted teeth, or ii) extraction of erupted teeth, should be accompanied by a Referral Form which clearly states the medical/dental history that necessitates the extraction.

3.1.8 A Dentist or Specialist shall, upon request by MCP, make available to MCP copies of patient records as may be required to clarify or verify services for which fees have been claimed.

3.1.9 For MCP Audit purposes, it is required that Dentists and Specialists maintain records supporting services billed to MCP for a period of six years. **Audits will be conducted in accordance with the *Medical Care Hospital Insurance Act.* Government agrees to have the audit process available on the Government website under provider information.**

3.2 Procedures

When a procedural fee is claimed, the patient record of that procedure must contain information which is sufficient to verify the type and extent of the procedure according to the fee(s) claimed.

For additional documentation requirements, refer to the specific codes being claimed.

3.3 Independent Consideration (IC)

3.3.1 Specific services in this Schedule are designated as billable on an IC basis only. Dentists and Specialists are required to identify claims for these services as IC and to provide additional applicable information.

3.3.2 Medically necessary services not listed in this Schedule, or for which a set fee is not listed, must be billed IC. For these services an IC claim must

include:

(a) The time involved performing the procedure claimed,
(b) A list of all procedures performed which are represented by the claim,
(c) The actual size of lesions removed or laceration repaired or the area of any defect which was repaired, if applicable,
(d) Comparison in scope and difficulty of the procedure with other procedures listed in the Payment Schedule, and
(e) A copy of the operative report along with the actual operating time for complex surgical procedures.

3.4 Use of Provider Number

3.4.1 Claims must be submitted using the Provider Number of the Dentist or Specialist who actually rendered the service.

3.4.2 Dentists and Specialists are required to request prior approval from MCP for all arrangements where payment is to be directed to a designated payee. The claim must indicate a designated payee in the Payee number section.

3.5 Time Limitations on Claim Submission

3.5.1 All claims must be submitted within **90** days of the date of service. In exceptional circumstances this time period may be extended. A letter giving a full explanation for lateness must be submitted to the Manager of Claims Processing for special consideration.

3.5.2 All queries from MCP must be answered within the times specified on the queries. If no time is specified, a reply must be received within 90 days of the date of query.

3.5.3 All requests for changes to claims and queries regarding claims must be submitted within 90 days after the date of payment for the claims concerned.

4. DEFINITIONS OF TERMS/CONDITIONS

4.1 Specialty Designation

Registration and designation as a Dentist or within a specialty field are as determined by the Newfoundland and Labrador Dental Board for MCP billing purposes.

4.2 Age (unless otherwise specified)

(a) Newborn (neonate) - up to and including 28 days of age,
(b) Infant - 29 days up to but less than 2 years,
(c) Child - 2 years up to and including 15 years,
(d) Adolescent - 16 years up to and including 17 years, and
(e) Adult - 18 years and over.

4.3 Transferal

4.3.1 A transferal, as distinguished from a referral, takes place where the responsibility for the care of an in-patient is completely transferred permanently or temporarily, from one Dentist or Specialist to another (e.g. where the first Dentist or Specialist is leaving temporarily on holidays and is unable to continue to care for the patient). Subject to the requirements of Article 6(a) through to and inclusive of 6(e) of this MOA, a transferal of an in-patient to a Dentist or Specialist should be considered as continuing care and the Dentist or Specialist to whom the patient is transferred is not entitled to claim for a consultation but may be entitled to claim for a new patient examination.

5. DEFINITIONS/REQUIREMENTS OF A NEW PATIENT EXAMINATION

5.1 A new patient examination refers to a situation wherein a patient is referred by another practitioner to an Oral Surgeon for treatment or guidance.

(a) A new patient examination would require a direct physical encounter with the new patient in order to decide upon appropriate treatment **and/or guidance.**

(b) A new patient examination can be claimed under the appropriate fee code only when performed in conjunction with insured services.

(c) Not more than one new patient examination may be claimed by the same Oral Surgeon for the same patient.

(d) If a referral is made, and upon examination treatment is deferred or felt to be unnecessary, then the new patient exam can be billed and a note attached to claim indicating that patient was seen and returned to referring dentist with instructions.

6. DEFINITIONS/REQUIREMENT OF AN EXAMINATION (SUBSEQUENT)

6.1 Such an examination may be claimed by a Dentist or Specialist for the evaluation or management of a **separate oral issue** which is not related to the provision of routine post-operative care for **the primary** surgery. **Payment** will require IC documentation

6.2 A limit of three such examinations will apply per patient admission. Or 42 day period following surgery

7. SURGICIAL PROCEDURES

7.1 Surgical fee codes are "bundled" and not divisible. Unless otherwise stated, the fee listed for a surgical procedure includes the following:

(a) investigation and preparation of the patient at the site of surgery,

(b) the operative procedure,

(c) total post-operative care of the patient within a period **of 42 days** including:

(i) all hospital visits except for insured examinations (subsequent),

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(ii) two office visits following discharge from hospital, if necessary.

The normal post-operative period is deemed to be 42 days for all surgical procedures.

7.2 Unless otherwise stated

(a) When more than one operative procedure is performed by the same surgeon at the same time under the same anesthetic, the fee shall be the full fee for the major procedure: all other procedures shall be paid at the rate of eighty-five (85) percent of the listed fee for each procedure (exception Independent Operative Procedures, 10P's).

(b) When a subsequent operation becomes necessary for the same condition because of a complication during the same hospitalization, the full fee will apply for each procedure.

(c) When a subsequent operation becomes necessary for a new condition developing during the same hospitalization, the full fee will apply for each procedure.

(d) When a surgical procedure must be repeated for the same condition during the same hospitalization or within normal convalescence, the tariff shall be the full fee for the initial procedure and half the usual fee for repeat procedure(s). This will not apply in cases where the subsequent operations are done by another surgeon.

(e) When different operative procedures are done by two different surgeons under the same anesthetic for different conditions, the fee will be 100% of the listed fee for each condition.

(f) Where a Specialist requires the expertise of another Certified Specialist, or a General Surgeon, the fee for the procedures performed shall be 150% of the listed fee and shall be divided equally between the two surgeons.

7.3 Soft Tissue Grafts

For the purpose of this Schedule, cranial bone grafts are deemed not to be from intraoral but rather extra oral sites.

Bone shavings or alloplasts placed simultaneously around dental implants as the sole grafting procedure are not insured services.

7.4 Reconstruction

For the purpose of this Schedule, bone or alloplastic reconstruction do not include surgical resection or tissue harvest

Nasal reconstruction done for cosmetic purposes is not an insured service.