Charging Surgical vs. Non-surgical. That is the Question

There is a fairly clear answer to this question from an insurance perspective, but the discussion reveals some practice philosophies. Log on to the message boards of Dentaltown.com today to participate in this discussion and thousands more.

Townies,

Under what conditions do you go from a simple extraction fee to a surgical extraction fee?

PPO insurance practice.

I take out a lot of wisdom teeth... I can get most uppers 1/16s with a backaction elevator/proximator most of the time. Even decayed at bone level with using a spade proximator. It takes me 10 to 15 minutes to get it out. I feel the better I get with a spade proximator, the fewer surgical extractions I'm doing.

I'm doing better surgery but not compensated because I don't think that I should charge a surgical fee (1. I didn't section a tooth; 2. I didn't flap; 3. I didn't trough bone).

I'm taking out all kinds of stuff with that spade proximator and not troughing bone or laying a flap. Great instrument.

Which would you charge as surgical?
1. Upper wisdom tooth that elevates out (within one minute).
2. Upper wisdom tooth with moderate decay that elevates out and needs a forceps (within 10 minutes).
3. Upper wisdom tooth with severe decay to the gum or below that elevates out (within 15 minutes).
4. Incisors/bicuspids with decayed crowns that you can't grab with a forceps without it crumbling.
5. Tooth that you thought was simple, and then it broke and became surgical or spending time with a spade proximator to get a root out, etc.

Please help me. I enjoy extractions and they're a big part of my practice.
Many thanks! ■ Steve

“djh597”
Posted: 2/26/2009
Post: 2 of 47

1. Simple.
2. Simple.
4. Probably surgical.
5. Probably surgical.

If I pick up my handpiece it equals surgical. ■

More philosophically, but if it was a tooth that you thought would be surgical, but through tedious atraumatic use of the spade proximator, using 3.5 DFV [Designs for Vision] loupes with a 10,000 candle-watt daylight, you are able to get root out simply in about 10 minutes. I know the other four dentists that I have worked with would flap and trough and get it in about 10 minutes as well. They would all charge surgical obviously, but I took extra time and used a modern instrument and caused less post-op pain. I would charge simple and make half the profit.

Stephen M. Kuzmak DDS
“skuzma2dds”
Posted: 2/27/2009
Post: 4 of 47
Ethically it sits well to me to charge simple. That's what matters. However, It eats me away knowing that I spent 10 minutes for profound anesthesia, 10 minutes extraction, five to 10 minutes post-op and going over prescription with a few minutes for the patient to sit and "recover." Thirty minutes for $135 fee that is reduced with PPO participation. I want to produce $350 an hour. If it was the $250 fee it would compensate. I read all over the place here of guys wanting to get to $800-$1,000 hour... I don't want to get that high because I wouldn't be doing these types of extractions.

I used to charge 25 percent surgical extraction fee. Now I’m about seven to 10 percent because I've gotten better and purchased the spade proximator.

As you’ve gotten better with exodontia, do you do less surgical extractions?

Thanks again, I love this job!

Steve

I think it all comes out in the wash. I charge $200 for a routine extraction (very often give group discounts; not for groups of patients, but groups of teeth) and $250 for a surgical. All the other grades of impaction are spaced out up to $300. As I’ve gotten better as surgery and more familiar with anatomy I might need to proceed to a surgical extraction less often. But my experience also lends me to get into surgery much quicker than I used to. I use to be scared of an envelope flap and the handpiece. Now I put the forceps or elevator on the tooth, chant my magic words, sprinkle some magic dust and either proceed with the routine extraction via alveolar expansion, or go straight to the HP. I think it goes both ways, you just need to adjust your price so that you are compensated for your surgical experience.

Stephen,

Here is my protocol and philosophy but there are probably few dentists that will agree with me on DT [Dentaltown] and some that will strongly disagree.

About 99 percent of my third molar extractions are surgical, even if I could simply elevate the tooth out; it is my responsibility to do more when an adjacent tooth is to be left. I routinely reflect a small buccal flap and open the interproximal papillae just as if I were doing a periodontal surgery in the area. I then remove the third and clean the adjacent tooth on the distal with a surgical curette and Gracey curettes if I find subgingival calculus (which I do frequently). My notes will usually say something like "curettage of distal adjacent tooth to osseous crest." I then place a suture to approximate the tissue. Just to be clear, I do remove the interproximal tissue so that I can see the root surface. These areas will then heal and I am sure the root surface is clean. This obviously increases the time it takes to remove a tooth but this is exactly what I would want done if it was my mouth. We have one chance to get that distal surface of the second molar clean and I take it.

The suture is removed in five to seven days and the area checked. I don’t think I actually make more money this way because it does take more time and I do have them back for a suture removal but money is not why I do this.

Actually this is the same protocol I use for most extractions.

You have to understand, I practice general dentistry but I do have a certificate in periodontics. Maybe it’s just the old periodontist in me that refused to leave calculus on root surfaces when I can take a few more minutes to remove it, or at least check the area. You’d be surprised what you see after you take a damp gauze, press it into the socket against the root surface, then pull it out and inspect the tooth with a clean mirror.

Harry J. Jackson DDS
“Harry J. Jackson”
Posted: 2/27/2009
Post: 5 of 47

Dan Boudro, DDS
“dboudro”
Posted: 2/27/2009
Post: 6 of 47

continued on page 26
I make the determination prior to treatment and a written treatment plan is presented to and signed by the patient. I charge anywhere from $120 for the easiest simple to $470 for the most difficult hard. If the simple breaks and becomes a harder simple I do not go back and charge the patient anymore, and if the surgical turns out to be easier than expected I do not refund money either. I charge and collect prior to treatment and I file the insurance according to what I feel was the extraction type. If I collected $220 for a surgical broken off #1 and my skill level allowed me to remove it with a luxator/elevator/spade/etc. I would file the insurance as a D7140. That is what I did. If I collected $120 for a simple and I misjudged because the tooth root was ankylosised and the loose tooth was just the broken crown (has happened to me) and I spent the next 20 minutes cutting out an ankylosis root I would not charge the patient anymore, but I would file the insurance as $120 and code D7210 (surgical) because that is what I did.

It's just semantics but I never, ever say “simple extraction.” There are complex extractions and less complex extractions but never say simple. Sure as you do, that's the one that a root tip breaks off and turns into the day's headache, and then the patient and staff are glaring at you saying, “Moron, you said it was simple.”

I still don't understand how reflecting a papilla, and placing a suture makes any extraction surgical, let alone 99 percent of them. If you want to nickel and dime your patients, and the insurance company just charge for a separate single site SCRP. Don't try to make it sound like it takes you 20 minutes to curette an area and place a suture. Yes it's a very good idea to clean the area when exposed, but that in addition to the extraction, still does not make your procedure a surgical extraction. Every papilla on every extraction should be reflected; it limits crushing tissue damage, but doesn't reach the threshold of surgical extraction.

Now, the suture... justification of the cost of a procedure with a borderline irrelevant treatment is no more noble a position than coming out and saying I commit insurance fraud.

My point behind all this is you shouldn't allow insurance companies to put you in positions where you are making borderline unethical decisions or justifying cost with irrelevant treatment. Provide the service, let the patient know what you are doing, charge an appropriate fee and let the insurance company make the unethical decisions, not us.

Figure out what you need to make for each type of extraction, charge appropriately and stop apologizing to your patients and the insurance companies for the cost of doing business.

[Posted: 2/27/2009]

Dan,

I respect you too, and I respect what you do. But our patients will never understand the complexity of what we do unless we let them know what we are doing and charge appropriately. I hate being nicked and dimed and being told I'm receiving something as a bonus that should be part of the regular package.

continued from page 25

Negotiating a Lease?

Don’t let the landlord take advantage of you.

“I can't imagine anyone doing better work.”

-Dr. Eric Stephan,
Gig Harbor, WA

To level the playing field, simply call toll-free or visit georgevaill.com/dt/

GEORGEVAILL
DENTAL OFFICE LEASE NEGOTIATIONS
800-340-2701

continued on page 28
Give patients your two prices. Tell them why they are different. It’s a perfect time to also discuss the risk and benefits of surgery and obtain informed consent. Then let them know what’s going on during the procedure. I’ve never had a patient complain about me not being able to get a tooth out at the “simple” fee.

This being said, I’ll usually give a patient a discount for multiple extractions. I routinely tell patients $1,000 for four thirds. Even if one is a full impaction. I also increase my price on patients that I know will be difficult (either due to access or attitude). Sometimes I’ll do a “simple surgical” extraction in five minutes and only charge the patient the “simple” price. But I do that to instill goodwill and usually encourage follow up care.

Having low prices and jacking up the procedure code limits your ability to personalize the care. Raise your prices and code what you do. I think your patients will respect you more in the long run.

We price out every extraction as a surgical. We let the patient know that if it comes out routine then it is a lesser charge. Most of the time we get it out routine. Most all emergencies/surgery are added patients on the side so they are easy and fast to do. The only time we charge surgical is when we lay a flap, section a tooth, or section a bridge.

We also keep our prices very low for extractions $90 routine and $150 surgical. We do a ton of extractions and it serves a part of the population that has economic problems. If you are fast at this, and schedule emergencies on the side you can make a lot doing. Surgery is the only thing we keep a low price on purpose.

As I get more experience, I treatment plan more teeth as surgical (unless obviously simple). If I can finesse the tooth out with an elevator and forceps, I charge a simple. Patients appreciate the bill getting cheaper, not the other way around.

Back to the original topic – I see the catch-22 of using advanced surgical skills to remove a tooth but being paid less for your efforts. If you are in a managed care practice, unfortunately you will work your way into making less money but you have to bill for the procedure you perform. Too bad there isn’t an “atraumatic tooth removal in lieu of turning surgical” code. Oh well.

Dan, I love the idea of having a scaler nearby to clean up the adjacent roots. You’re right, great access for that.
With many extractions, I do a small envelope flap with no releasing incisions. It’s more like making a spot where I can put the tip of the Minnesota retractor against bone and to aid in visibility. I then can see and use the spade proximator to get the tooth loosened and expand the PDL space for a larger elevator.

Curette and compress the gingiva buccal and lingual with moist gauze and moderate pressure for one minute. 3.0. Chromic gut horizontal mattress if needed.

Is this a surgical extraction?

Many times these flaps are small, still in attached gingiva, and I don’t release them. Is just flapping the papilla to increase visibility and maybe take the flap to the buccal of the tooth to be extracted a real flap? I guess to me it is. It’s the smallest amount I can flap to achieve visibility.

This would be for a broken down tooth other than a lower molar (which will become a surgical if it doesn’t get moving with three to five minutes of elevating).

Thanks Again. ■ Steve

Harry,

I don’t think you understand my practice. I quote all fees prior treatment and all patients pay 100 percent prior to treatment. I never ask for more and I never give back the $50 difference if it turns easier than I initially thought.

I wish everyone else would do the same when I am the consumer. I would love to go to the Chevy dealership and be told it will cost $500 and when I go back to pick up the truck they say they also had to do XYZ but they are not charging me. It doesn’t happen.

I love up-front pricing. If I thought it was too much (or my patients think it is too much) I or them can go elsewhere.

The fee doesn’t matter and the code doesn’t matter if we both agree on the fee prior to treatment and the fee is collected prior to treatment. No misunderstandings. ■

Harry,

Interesting, what about a small sulcular flap and luxators?

The luxators sometimes do fragment tiny spicules of bone during use.

I do a lot of endo treated roots in solid bone, and I use a small sulcular “flap” to expose the PDL and work it with the luxators. In my old days as a newbie, I would have made a big flap and troughed the bone around the root. So less trauma, plus more skill, plus more experience equals less fee? ■

As an oral surgeon, I often feel short changed by having to code for a “simple” extraction (I also hate that term) when only my skill and expertise prevented it from being a surgical extraction in someone else’s hands. You are truly penalized by having more experience and skill in that regard.

As far as downgrading the level of extraction afterward, it becomes very tricky with third molars and insurance. For example, if a patient has medical insurance which typically only covers the removal of partial and full bony impactions and does not have dental insurance, and I treatment plan a third molar as a partial bony and it ends up being a surgical, the patient often ends up paying more because now the procedure is not covered under their medical plan and they pay completely out of pocket. In some cases it goes from a $20 co-pay to a $295 charge.
My policy in general is to treatment plan/code pre-op for what I believe might be required to remove a tooth, including a third molar. I’ve had third molars that appear full bony on panorex only to elevate out in 30 seconds (often upper thirds). I’ve also had upper and lower second molars that have given me fits and could only code for a surgical. The bottom line is that the dental coding design is truly flawed. If you think about, what do you do differently to remove a partial bony versus a full bony impaction? Nothing. Flap, trough, section, elevate, suture. That is probably why most oral surgeons bill mainly for two types of extractions – surgical and full bony.

Just my two cents. And in the end, whatever you do to remove the tooth most atraumatically should be the goal, because we’re treating patients, not insurance companies.

[Posted: 2/27/2009]

One last thing. When I began practicing, I remember being told by my first boss that the dental codes assume that a practitioner of average skill is performing the work. So one could argue that the final code/charge should be the one that would correlate to the treatment that would be needed in an average dentist’s hands. You all can decide whether or not you’re “average” but I don’t think I am since it’s practically all I do.

Read the rest of the conversation and add your comments on www.towniecentral.com. Type in “Charging Surgical” in the search box and click, “Search.”