DENTAL GUIDE

C-616 - REV JUN 2020

GENERAL GUIDELINES FOR PROVIDING DENTAL SERVICES

1. All dental services, other than the examination, and emergency treatment, must be authorized before treatment is commenced. The WCB Dental Report must be completed after the first examination, along with a cost breakdown of the proposed treatment. The WCB Dental Report and cost breakdown must be submitted to WCB within two (2) business days of the initial examinations. See page 3 for information on form completion. Although pre-authorization is required in all cases, it is particularly critical in the event of proposed treatment for TMJ dysfunction and implants.

2. The WCB responsibility for dental care is limited to **the restoration of dental function to the pre-accident state.** The addition of refinements to obtain a better cosmetic result is not the WCB's responsibility. Dentists should take into consideration the oral health of the worker prior to finalizing a treatment plan.

3. **Workers cannot be billed directly, under the Workers' Compensation Act (WCA) (Section 86). No part of the cost of any treatment provided to or in respect of a worker related to the compensable injury is payable by the worker.**

4. WCB will only pay for dental services provided to workers who are entitled to benefits under the WCA.

5. The investment in extensive and costly dental restorations should not exceed what the average worker would reasonably be expected to provide for himself. All TMJ treatment and dental implants must be pre-authorized by a WCB Dental Consultant.

6. Dental implants will be considered on an individual case-by-case basis, following review by the WCB Dental Consultant. The following may be considered in each case:

- Implant warranty offered by the treating dentist,
- Oral and general medical health of the worker,
- Smoker or non-smoker,
- Age of the worker,
- Whether the success of other dental treatment is dependent upon the implant, and/or
- Alternative treatment options.

7. Replacement of implants will be limited to once every ten (10) years if ongoing responsibility is accepted.

8. Where the worker's dental condition is extremely compromised, the cost of total extraction and replacement with dentures may be authorized where it appears to be a better alternative than repairing the specific work-related injury. Replacement will be limited to once every five (5) years if ongoing responsibility is accepted.

9. Pre-accident oral hygiene status will have some bearing on the authorization of dental procedures and must be reported to the WCB. Dental scaling and polishing is not ordinarily covered, unless pre-authorized.

10. The cooperation of all members of the Alberta Dental Association & College (ADA&C) in following these guidelines is appreciated and will assist in avoiding delays in payment and potential conflict with the WCB. Dentists must bear in mind that they and all health care providers are bound by the WCA.

GENERAL INSTRUCTIONS FOR REPORT COMPLETION
DENTAL REPORT (C-055/C-887)

This guide provides clarification of information required for the Dental Report. A copy of the form can be found on the WCB website.

DENTAL REPORT COMPLETION

The dental report form should be completed at the time of the examination and must be sent to WCB within two (2) business days of the examination.	
Please submit the form and any supporting documents by email to **dental@wcb.ab.ca**.	
Type or Print	Legibility is important as all forms are electronically scanned.
Black Ink	Use **black ink only** to ensure a quality image is used for scanning into electronic files.
Electronic Form	On the WCB website (www.wcb.ab.ca) under the *'Health care Providers*' section, click *'Find forms and supporting documents* ' and scroll down to '*Dentists'* or click the link below. https://www.wcb.ab.ca/assets/pdfs/providers/C055_C887.pdf

Additional or sensitive information may be provided by attaching a separate sheet to the report.

X-rays, in general, should not be sent with the Dental Report. The WCB Dental Consultant may request x-rays dependent upon the nature of the injury or the complexity of the proposed treatment plan, prior to authorization of treatment.

1. Is the patient working?
- Indicate whether or not the compensable injury affects the worker's ability to work.
- Missing time from work for appointments does not apply to this question.

2. Who provided first dental treatment?
- Indicate the name of dentist or facility where the first treatment was provided.
- Indicate the date of the first treatment.

3. The worker attended my office on:
- Indicate the first date that the worker attended your practice for examination or emergency treatment. This would be the same as **2.** above, if you provided the first treatment.

4. History of Injury:
- Briefly describe the worker's explanation of the accident and the mechanism of the injury.
- Include the location, and the materials, tools or equipment involved in the accident in your description.

5. Describe dental injury resulting from the accident (include damage to any prosthesis).
- Describe damage to dentition or any prosthesis.
- Include any fractures, contusions or lacerations.
- Provide any other comments relevant to the case and the overall pre-accident oral hygiene.

6. Describe emergency treatment carried out.

- If emergency treatment is required during the visit, indicate the nature of that treatment.
- **Attach a standard ADA&C claim form (copy on page 8) for purposes of payment for emergency treatment and the examination.**
- **Ensure you include the WCB claim number.**

7. Describe further treatment required as a result of injury.

- Outline the treatment required to restore or repair the damage caused by the injury. The proposed treatment should not exceed what the average worker would reasonably be expected to provide for himself.

Remember to:

- **Attach a standard dental claim form for pre-authorization purposes.**
- **Ensure you include the WCB claim number.**

8. Evidence of relevant pre-existing conditions.

- Document any pre-existing oral hygiene conditions that may have a bearing on the success of the proposed dental treatment.

9. Any complicating factors affecting recovery.

- Document other conditions or circumstances that may delay recovery, or have a bearing on the success of the dental treatment or recovery.
- This information will help us to determine the extent of injury attributed to the workplace and if there is a need for additional resources.

10. Were x-rays taken?

- Indicate by whom and the date taken.
- This enables WCB to request the results or the x-rays, if required.

****It is not necessary to routinely send x-rays to WCB with your pre-authorization requests. If the WCB requires the x-rays the WCB Dental Consultant will request them.**

11. Referral to Specialist.

- Indicate whether the worker will be referred to a specialist.
- Provide the name of the specialist and specialty type.
- Where more than one specialist may be involved, a separate sheet should be attached to identify all specialist names, specialty type, addresses and telephone numbers.

MEDICAL/LEGAL REPORTS

Unless specifically requested by the WCB, Medical/Legal Reports are generally not required.

In the event that the WCB requests a Medical/Legal Report, fees shall be paid in accordance with the current WCB Fee Guide.

REPORTING FEES

The WCB, in cooperation with the ADA&C, has agreed to pay the following report fees:

	General Practitioner	Specialist
First Report	$38.70	$55.42
Progress Report	$29.86	$29.86

This agreement is based on the understanding reports will be:

- Legible
- Complete
- Of professional quality

Incomplete or illegible report forms will be returned unpaid. Reports may be emailed to dental@wcb.ab.ca for review.

GENERAL INSTRUCTIONS FOR BILLING
STANDARD DENTAL CLAIM FORM

A Standard Dental Claim Form should be submitted to WCB in the following cases:

1) Following the worker's initial examinations

2) Upon completion of any emergency treatment the worker requires

3) As a means of pre-authorization for further compensable dental treatment as a result of the accident. If possible, include an estimate of any laboratory charges

4) Once all dental treatment is completed

BILLING FORM COMPLETION

- Use a Standard Dental Claim Form (copy on page 8 of this guide).
- Provide your WCB billing number in place of your "UNIQUE" number.
- Please include the WCB claim number above the patient's name and address.
- Please indicate on the claim form if it is submitted for the purposes of:
    - Pre-authorization;
    - Completed emergency treatment; or
    - Informing that all compensable treatment has been completed.

CANADIAN DENTAL ASSOCIATION

Canadian Life and Health Insurance Association Inc.

STANDARD DENTAL CLAIM FORM

PART 1 DENTIST

UNIQUE NO. | SPEC. | PATIENTS OFFICE ACCOUNT NO.

I HEREBY ASSIGN MY BENEFITS PAYABLE FROM THIS CLAIM TO THE NAMED DENTIST AND AUTHORIZE PAYMENT TO HIM/HER

PATIENT

DENTIST

PHONE NO.

SIGNATURE OF SUBSCRIBER

FOR DENTIST USE ONLY - FOR ADDITIONAL INFORMATION, DIAGNOSIS, PROCEDURES,OR SPECIAL CONSIDERATIONS.

I UNDERSTAND THAT THE FEES LISTED IN THIS CLAIM MAY NOT BE COVERED BY OR MAY EXCEED MY PLAN BENEFITS. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE TO MY DENTIST FOR THE ENTIRE TREATMENT. I ACKNOWLEDGE THAT THE TOTAL FEE OF $ IS ACCURATE AND HAS BEEN CHARGED TO ME FOR SERVICES RENDERED.
I AUTHORIZE RELEASE OF THE INFORMATION CONTAINED IN THIS CLAIM FORM TO MY INSURING COMPANY / PLAN ADMINISTRATOR. I ALSO AUTHORIZE THE COMMUNICATION OF INFORMATION RELATED TO THE COVERAGE OF SERVICES DESCRIBED IN THIS FORM TO THE NAMED DENTIST.

SIGNATURE OF PATIENT (PARENT/GUARDIAN)

OFFICE VERIFICATION

DATE OF SERVICE DAY MO. YR.	PRO-CEDURE CODE	INTL TOOTH CODE	TOOTH SURFACES	DENTIST'S FEE	LABORATORY CHARGE	TOTAL CHARGES

FOR CARRIER USE

ALLOWED AMOUNT	INC	%	PATIENT'S SHARE

CHEQUE NO. | DATE

DEDUCTIBLE	PATIENT PAYS	PLAN PAYS

THIS IS AN ACCURATE STATEMENT OF SERVICES PERFORMED AND THE TOTAL FEE DUE AND PAYABLE, E & OE.

TOTAL FEE SUBMITTED

CLAIM NO.

INSTRUCTIONS FOR CLAIM SUBMISSION

BEING A STANDARD FORM, THIS FORM CANNOT INCLUDE SPECIFIC INSTRUCTIONS ON WHERE IT SHOULD BE SENT, DEPENDING ON WHO IS THE CARRIER FOR YOUR PLAN. YOU CAN OBTAIN DETAILS FROM EITHER YOUR PLAN BOOKLET, YOUR CERTIFICATE OR FROM YOUR EMPLOYER.
IF YOU PLAN REQUIRES SUBMISSION DIRECTLY TO THE CARRIER, PLEASE SEND THIS FORM WITH ONLY PARTS 1, 2 AND 3 COMPLETED TO THE CARRIER'S APPROPRIATE CLAIMS OFFICE.
*IF YOUR PLAN REQUIRES SUBMISSION TO YOUR EMPLOYER, PLEASE DIRECT THIS FORM TO YOUR PERSONNEL OFFICE/PLAN ADMINISTRATOR WHO WILL COMPLETE PART 4 AND FORWARD THE FORM TO THE CARRIER.

PART 2 - EMPLOYEE/PLAN MEMBER/SUBSCRIBER

1. GROUP POLICY/PLAN NO. _____ DIVISION/SECTION NO. _____

EMPLOYER _____

NAME OF INSURING AGENCY OR PLAN _____

2. YOUR NAME (PLEASE PRINT) _____

YOUR CERT. NO. OR S.I.N. OR I.D. NO. _____

YOUR DATE OF BIRTH _____
DAY MONTH YEAR

PART 3 - PATIENT INFORMATION

1. PATIENT: RELATIONSHIP TO EMPLOYEE/ PLAN MEMBER/SUBSCRIBER _____

DATE OF BIRTH _____ IF CHILD INDICATE: ❑ STUDENT ❑ HANDICAPPED
DAY MONTH YEAR

IF STUDENT, INDICATE SCHOOL _____

PATIENT I.D. NO. _____

2. ARE ANY DENTAL BENEFITS OR SERVICES PROVIDED UNDER ANY OTHER GROUP INSURACE OR DENTAL PLAN, W.C.B. OR GOV'T PLAN? ❑ NO ❑ YES

POLICY NO. _____ SPOUSE DATE OF BIRTH _____

NAME OF OTHER INSURING AGENCY OR PLAN _____

3. IS ANY TREATMENT REQUIRED AS THE RESULT OF AN ACCIDENT? IF YES, GIVE DATE AND DETAILS SEPERATELY. ❑ NO ❑ YES

4. IF DENTURE, CROWN OR BRIDGE, IS THIS INITIAL PLACEMENT? GIVE DATE OF PRIOR PLACEMENT AND REASON FOR REPLACEMENT. ❑ NO ❑ YES

5. IS ANY TREATMENT REQUIRED FOR ORTHODONTIC PURPOSES? ❑ NO ❑ YES

6. I AUTHORIZE THE RELEASE OF ANY INFORMATION OR RECORDS REQUESTED IN RESPECT OF THIS CLAIM TO THE INSURER / PLAN ADMINISTRATOR AND CERTIFY THAT THE INFORMATION GIVEN IS TRUE, CORRECT AND COMPLETE TO THE BEST OF MY KNOWLEDGE.

DATE _____
DAY MONTH YEAR

SIGNATURE OF EMPLOYEE/PLAN MEMBER/SUBSCRIBER

PART 4. - POLICY HOLDER/EMPLOYER (FOR COMPLETION ONLY IF APPLICABLE. SEE ABOVE*)

	DAY	MONTH	YEAR
1. DATE COVERAGE COMMENCED			
2. DATE DEPENDENT COVERED			
3. DATE TERMINATED			

4. CONTRACT HOLDER

DATE					
DAY		MONTH		YEAR	

AUTHORIZED SIGNATURE

(POSITION OR TITLE)

ALL INFORMATION RECORDED ON THIS FORM IS CONFIDENTIAL

ADDITIONAL INFORMATION

ORDERING INFORMATION

Please visit our website to order copies of our forms and this guide for your clinic.
https://www.wcb.ab.ca/resources/for-health-care-and-service-providers/hcp_form_orders.asp

**In order to maintain an adequate province-wide supply and to reduce costs, we ask that you order no more than a three-month supply.*

To ensure faster service when sending information to the WCB, indicate the worker's claim number. Always retain copies of all documents for your files.

QUESTIONS/CONTACTS

• Fees/ Payment	780-498-3999; ask for Medical Aid Department
• Claim number • Other claim information	Customer Contact Centre Edmonton: 780-498-3999 Province wide toll free: 1-866-922-9221
• To discuss clinical aspects of the case • For assistance in completing reports	WCB Dental Consultant 780-498-4040 dental@wcb.ab.ca Toll free: 1-800-661-5419 Province wide toll free: 1-866-922-9221
Mailing Address Workers' Compensation Board P.O. Box 2415 Edmonton, AB T5J 2S5	Fax Numbers General: 780-427-5863 or 1-800-661-1993 Form order requests: 780-498-7882