Billing Corner

ALBERTA MEDICAL ASSOCIATION

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Billing Corner is also available on the Alberta Medical Association website
albertadoctors.org/billing-corner

March 31, 2020 Changes ONLY

April 2020

Please read this document and then share with your billing staff

Please ensure that your billing software has been updated to reflect the changes that are described within this document. The Billing Corner is a summary document.

Alberta Health Care Insurance Plan
Schedule of Medical Benefits
Effective March 31

***Disclaimer**: While care has been taken to provide accurate information, the Alberta Medical Association does not warrant or guarantee the accuracy of the information contained herein. Please refer to the Schedule of Medical Benefits for complete details. If you provide services specific to more than one section, the AMA recommends that you refer to all those that are applicable to the services that you provide.*

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Adjust Complex Patient Modifiers – Rescinded on March 17, 2020 (MED 209)

Please Note: The proposed changes to the time requirements and payment rates for complex patient modifiers were rescinded by Alberta Health on March 17, 2020, and **will not be going forward** on March 31, 2020, **NO CHANGES TO THE FOLLOWING:**

- CMXC modifier – for comprehensive visit and consultation services
- CMXV modifiers –for other specialist visit services
- CMGP modifier – time requirements or payment for General Practitioner visit services

Complex modifiers are NOT applicable to virtual care codes.

De-list Comprehensive Care Plans 03.04J (MED 210)

Health Service Code 03.04J – Development of a Comprehensive Annual Care Plan – is de-listed from the Schedule of Medical Benefits. Claims for 03.04J submitted on March 31, 2020 or later will not be paid.

Comprehensive care planning is still considered an insured service and if provided can be claimed as a part of 03.04A when all of the criteria for 03.04A have been met.

The following changes in bold show the changes to the Governing Rules:

4.2.3 Comprehensive Visit: An in-depth evaluation of a patient. This service includes the recording of a complete history and performing a complete physical examination appropriate to the physician's specialty, an appropriate record and advice to the patient. It may include the ordering of appropriate diagnostic tests and procedures as well as discussion with the patient.

Advice to the patient must include discussion of a care plan related to the patient's condition(s). Patient care advice, including the discussed care plan, must be documented in the patient's record. The care plan does not have to be formally signed by the patient.

AMA Billing Tips;
The AMA has requested that Alberta Health clarify whether or not a care plan MUST be completed in order to bill 03.04A, to date, a response has NOT been provided. Previous information from AH stated that it was NOT a requirement however, that was prior to the addition of the text above to the GR's.

De-insure Drivers Medical 03.05H (MED 211)

Driver's Medical Examination for Patients 74.5 Years of Age or Older – is de-insured from the Schedule of Medical Benefits.

Physicians must advise patients 74.5 years of age or older of the cost for the exam before starting the exam. Please consult the AMA's *Guideline to Billing Uninsured Services* available on the AMA website (login required).

AMA Billing Tips;
The Drivers Medical cannot be claimed as 03.04A or any other SOMB code. Patients are responsible for the fee for the service and must be made aware of the fee in advance of providing the service. Physicians may charge a fee that is reflective of the service, time, intensity and complexity while keeping in mind the patients' ability to pay.

De-insure Imaging when Referred from Uninsured Practitioners (MED212)

Patients who are referred for imaging services by a chiropractor, physiotherapist, or audiologist are not payable under the Alberta Health Care Insurance Plan, fees for these services are the responsibility of the patient.

- Chiropractors, Physiotherapists, and Audiologists will have to inform their patients of the costs for these services.

AMA Billing Tips;
It is expected that ordering providers will inform patients that there will be a charge for the imaging when the service is direct to diagnostic. Physicians must still inform patients of the fees for the images requested in advance of providing the services.

Diagnostic Imaging Appropriateness (MED 213)

Health Service Codes X301, X303, X311, X315, X316, X317, X318, and X319 will be amended to preclude specific combinations of services. Physicians are advised to adhere to the following billing restrictions:

- X301 - May not be claimed with X338
- X303 - Max of one call
- X311 - May not be claimed with X312, X314 or X315
- X315 - May not be claimed with X311 or X324
- X316 - May not be claimed with X312 or X324
- X317 - May not be claimed with X324
- X318 - May not be claimed with X314
- X319 - May not be claimed with X314

Daily Volume Caps (MED 220)

The following rule was introduced:

19 DAILY PATIENT VOLUME PAYMENT RULES

19.1 Daily patient volume payment rules will apply to visit services with a "V" category code (excluding HSC 13.82A) that are provided in an office, home, or a non-registered facility.

The codes activated during a pandemic by the Chief Medical Officer of Health will be exempt from the daily patient volume payment rules.

Excluding Grande Prairie and Fort McMurray, the daily patient volume payment rules will not apply to services provided in communities that are eligible for variable fee payments under the Rural Remote Northern Program.

The total of all billings for eligible category "V" codes that are accepted for payment under the Alberta Health Care Insurance Plan will be calculated for each practitioner for each calendar day. When the daily total exceeds 50, the practitioner's payment on the category "V" codes that exceed 50 will be discounted by 50 percent. When the daily total exceeds 65, the practitioner's payment on the category "V" codes that exceed 65 will be discounted by 100 percent. Services will be assessed and payment/discounts will be applied to services in the order in which they are accepted for payment by the Alberta Health Care Insurance Plan.

AMA Billing Tips

Alberta Health added Home and non-registered facility to the rule even though it was not mentioned in MED 220. This means that if a physician provides services in their office and then proceeds to provide home care or visits to a non registered facility, the services provided in those locations will *also* be applied to the daily cap. The cap will not apply to services provided in rural communities, hospitals, and emergency rooms. Rates will be reduced as follows:

#of visits/day	Discount Rate
0 to 50	0%
51 to 65	50%
66 and greater	100%

The cap ONLY applies in the following areas:

Edmonton	Sherwood Park	St. Albert	Devon	Stony Plain
Leduc	Fort McMurray	Grand Prairie	Airdrie	Red Deer
Calgary	Medicine Hat	Lethbridge		

Examples:

1) Physician in Edmonton provides services in office location #1 in the morning, then proceeds to provide services in office location #2. “V” category services for both locations will be included in the total
2) Physician in Brooks provides 52 services in a single day including LTC and office patients. No reductions, Brooks is a rural community, the rule does not apply to rural AB.

A list of the “V” category codes that may contribute to the overall cap is included on the next page

V category codes 2020			
03.01B	03.03NB	03.07A	08.44C
03.01BA	03.03P	03.07B	08.44D
03.01BB	03.03Q	03.07C	08.45
03.01C	03.03R	03.08A	08.45A
03.01J	03.04A	03.08B	09.01F
03.01LG	03.04B	03.08C	09.02A
03.01LH	03.04I	03.08F	09.02D
03.01LI	03.04K	03.08H	13.55A
03.01LJ	03.04M	03.08I	13.59D
03.01LK	03.04N	03.08J	13.99AC
03.01LL	03.04O	03.08K	13.99AZ
03.01LM	03.04P	03.08L	13.99J
03.01LN	03.04Q	03.08M	13.99JA
03.01LO	03.04R	03.09A	13.99K
03.01LT	03.05I	03.09B	13.99KA
03.01LU	03.05JA	03.11A	13.99KB
03.01LV	03.05JB	07.57B	13.99O
03.01MT	03.05JC	08.11A	13.99OA
03.01N	03.05JD	08.11B	13.99UM
03.01NG	03.05JE	08.11C	13.99V
03.01NH	03.05JF	08.12A	98.12S
03.01NI	03.05JG	08.19A	
03.01NJ	03.05JH	08.19AA	
03.01NK	03.05JJ	08.19B	
03.01NL	03.05JK	08.19BB	
03.01NM	03.05JM	08.19C	
03.01O	03.05JN	08.19CC	
03.01R	03.05JP	08.19D	
03.01S	03.05JQ	08.19F	
03.01T	03.05JR	08.19G	
03.02A	03.05K	08.19GA	
03.03A	03.05LA	08.19GB	
03.03B	03.05LB	08.19H	
03.03C	03.05T	08.19J	
03.03F	03.05U	08.19K	
03.03FA	03.05V	08.19L	
03.03ME	03.05W	08.19M	
03.03MF	03.05X	08.19N	
03.03N	03.05Y	08.44A	
03.03NA	03.05YM	08.44B	

Reduction of Overhead in Publically Funded Facilities - The "Z" Codes (MED 215)

Physicians will no longer be able to submit claims for specific service when they are provided inside a publicly funded facility such as:

- Active Treatment Centre
- Ambulatory Care Centre
- Auxiliary Hospital
- Health Canada Nursing Station
- Community Mental Health Clinic
- Nursing Home
- Regional Contracted Practitioner Office (a facility that has a contract with AHS to provide specific services)
- Subacute Auxiliary Hospital
- Urgent Care Center
- Advanced Ambulatory Care Centre

Claims for the following will no longer be paid when provided in a publicly funded facility:

03.03A	03.03B	03.03F	03.04A	03.05I	03.07A
03.08A	03.08B	03.08I	03.08J	08.19A	08.19G
08.19GA	08.45				

Physicians will use the following codes instead of the above when they are providing service in any publicly funded facility:

03.03AZ Limited assessment of a patient's condition requiring a history related to the presenting problems, an examination of the relevant body systems, appropriate records, and advice to the patient - out of office.
NOTE: 1. Benefit includes the ordering of appropriate diagnostic tests and procedures as well as discussion with the patient.
2. May not be claimed in addition to HSC 03.05JB at the same encounter

03.03BZ Prenatal visit - out of office.

03.03FZ Repeat office visit or scheduled outpatient visit in a regional facility, referred cases only - out of office.

03.04AZ Comprehensive assessment of a patient's condition requiring a complete history, a complete physical examination appropriate to the physician's specialty, an appropriate record and advice to the patient - out of office.
NOTE: 1. This may be used for an annual medical examination within the limitations of GR 4.6.1.
2.Complete physical examination shall include examination of each organ system of the body, except in psychiatry, dermatology and the surgical specialties. "Complete physical examination"

shall encompass all those organ systems which customarily and usually are the standard complete examination prevailing within the practice of the respective specialty. What is customary and usual may be judged by peer review.
3. Benefit includes the ordering of appropriate diagnostic tests and procedures as well as discussion with the patient.

03.05IZ Direct care, reassessment, education and/or general counselling of a patient requiring palliative care, per 15 minutes or portion thereof – out of office.

03.07AZ Minor consultation - out of office
NOTE: 1. May not be claimed in addition to a surgical assist(SA,SAQS,SSOS) for the same patient by the same physician.

03.08AZ Comprehensive consultation - out of office
NOTE: 1. May not be claimed in addition to a surgical assist (SA, SAQS,SSOS) for the same patient by the same physician.
2. A comprehensive consultation may not be claimed for a transfer of care.

03.08BZ Obstetrical consultation - out of office

03.08IZ Prolonged cardiology, clinical immunology, endocrinology/metabolism, gastroenterology, hematology, infectious diseases, internal medicine, nephrology, physiatry, medical oncology, neurology, respiratory medicine or rheumatology consultation or visit, full 15 minutes or major portion thereof for the first call when only one call is claimed - out of office.
NOTE: May only be claimed in addition to HSCs 03.04A, 03.04AZ, 03.04C, 03.07B, 03.08A, and 03.08AZ when these services exceed 30 minutes.

03.08JZ Prolonged consultation or hospital admission by pediatrics (including subspecialties) and clinical immunology and allergy for patients 18 years of age and under, or by medical genetics (no age restriction), full 15 minutes or portion thereof for the first call when only one call is claimed - out of office.
NOTE: May only be claimed:
- in addition to HSC 03.08A, 03.08AZ and 03.04C after 30 minutes;
- in addition to HSC 03.07A, 03.07AZ, and 03.07B after 20 minutes.

08.19AZ Formal major psychiatric consultation, first full 30 minutes or major portion thereof for the first call when only one call is claimed - out of office.
NOTE: 1. Each subsequent 15 minutes, or major portion thereof, may be claimed at the rate specified on the Price List after the first full 30 minutes has elapsed.
2. HSCs 08.19GA, 08.19GB or 08.19GZ may not be claimed at the same encounter. The total time spent providing the consultation must be claimed using the applicable consultation code.

08.19GZ Direct contact with an individual patient for psychiatric treatment (including medical psychotherapy and medication prescription), psychiatric reassessment, patient education and/or psychiatric counselling, per 15 minutes or major portion thereof - out of office.

NOTE: 1. May be claimed:

-if the intent of the session is the therapy of one individual patient, whether or not more than one person is involved in the session.

-when a physician assessment has established (during the same or previous visit) that the patient is suffering from a psychiatric disorder.

2. For treatment of non-psychiatric disorders, the appropriate office visit health service code should be claimed.

3.May not be claimed at the same encounter as HSCs 08.11A, 08.11C, 08.19A, 08.19AA, 08.19B, 08.19BB, 08.19C, 08.19CC or 08.19AZ.

08.45Z Assessment or therapy of a family, requiring comprehensive psychiatric or family systems evaluation, first full 45 minutes or major portion thereof for the first call when only one call is claimed_- out of office.

NOTE: 1. May only be claimed:

- when the purpose of the visit is to provide psychiatric assessment or therapy to deal with systemic issues in the family unit;
- by general practice physicians, generalists in Mental Health, pediatricians (including subspecialties) and psychiatrists.

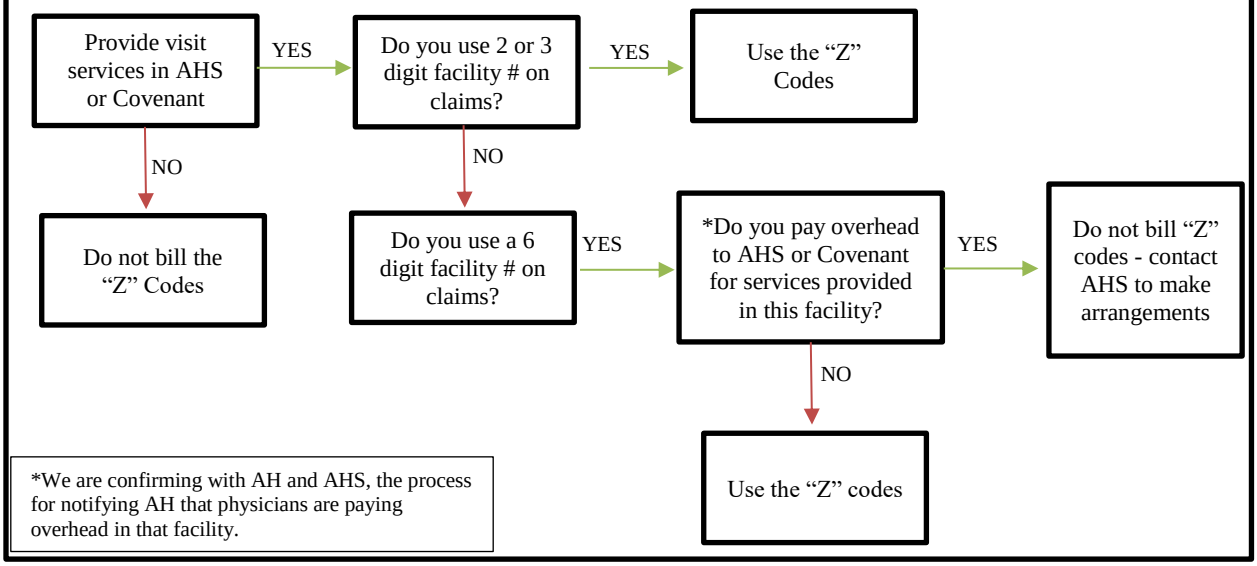
2. Each subsequent 15 minutes, or major portion thereof, may be claimed at the rate specified on the Price List after the first full 45 minutes has elapsed.

*The 08.19G and 08.19GA will be rolled up into the 08.19GZ code.

AMA Billing Tips

Physicians that currently have an overhead payment arrangement with AHS *and* must use the "Z" codes as a result of the facility, should contact their Zone Medical Directors to make arrangements to avoid paying the overhead twice.

How to know if you MUST bill the "Z" codes?



Removal of Clinical Stipends

AHS has indicated they **will not stop the clinical stipends before August 2020** unless physicians have been notified otherwise. More information to follow.

Claims Submission to 90 Days (GEN 123)

The time limit for practitioners to submit claims to Alberta Health for services provided in Alberta changes from 180 days to **90 days**.

Any outstanding claims submitted after 90 days (and within 180 days of the service date) for services performed prior to March 31, 2020, will require manual adjudication. These claims will require text indicating the service was performed prior to the March 31 submission time limit change.

Requests to consider extenuating circumstances in relation to outdated claims are reviewed on a case-by-case basis. Examples of extenuating circumstances are disasters where records have been destroyed (fire/flood), fraud, theft of computer or paper records, and claims refused by the Workers' Compensation Board.

AMA Billing Tips:
The last day Alberta Health processed claims for dates of service prior to March 31 was actually March 26. This means that claims for dates of service prior to March 31 that were submitted after March 26, were rejected as out of date. When a physician has just a few claims to submit, they can be submitted with text and will be manually reviewed. For larger volumes of claims, please contact AH directly at Health.HCIPAProviderClaims@gov.ab.ca and include health.hlink@gov.ab.ca in the email as well.

Standardize payments for non-invasive diagnostic services in AHS facilities

The AMA does not have any additional details about this proposal at this time.

Stop Accepting Good Faith Claims (GEN 122)

Claims made under the Good Faith Policy will no longer be paid. Physicians will have to verify coverage of the patient prior to submitting a claim. If proof of eligibility is not provided, physicians may consider collecting payment from the patient and submitting a pay-to-patient claim. You may charge the patient the listed rate in the SOMB and submit a pay to patient claim to Alberta Health using the patient demographic information, including their PHN, provided. If the information provided by the patient is accurate and the patient has coverage at the time of the service or has it backdated to the date of service, the patient will receive a cheque in the mail (to the address Alberta Health has for the patient) for the amount that was paid. See the Physician's Resource Guide for more information.

In an AHS facility, physicians are obligated to see patients without the requirement for compensation. In a private clinic, physicians are not obligated to see patients who cannot pay or provide proof of coverage.

To help reduce the number of claims refused due to problems with a patient's eligibility for benefits, always verify that your patient has AHCIP coverage.

- Physicians and office staff can verify a patient's eligibility using the person directory on Alberta Netcare. For more information on Alberta Netcare, see www.albertanetcare.ca
- Alberta Health provides a 24-hour interactive telephone inquiry service to check a patient's eligibility for coverage and validity of their PHN. To use the service phone 780-422-6257 in Edmonton, or from outside Edmonton call toll-free 1-888-422-6257.

Continuing Medical Education Program (CME) (MED 219)

The following changes to CME will be made:

- Alberta Health funding for CME will end.
- Physicians will no longer be reimbursed for costs that are currently covered by the CME program through Alberta Health funds.
- If you have not already done so, and have outstanding CME credits, you may still submit your claims for reimbursement up to March 31, 2020

Medical Liability Reimbursement Program (MLR) (MED 218)

The following changes to the MLR program will be made:

- Funding will be based on a fixed funding amount paid to the Alberta Medical Association (AMA).
- The AMA may choose to revise the amount paid for each physician's deductible.

Rural Remote Northern Program (RRNP) (MED 217)

There are no changes until March 31, 2021.

Effective March 31, 2021, the following changes to RRNP will be made:

- Flat Fee (FF) payments will be eliminated.
- The Variable Fee Premium (VFP) payment component will be maintained and a new eligible community list and new percentage for each eligible community may be assessed and changed,
- Through a consultation process with the AMA, the eligible community list will be revised.

Business Cost Program (BCP) (MED 216)

There are no changes until March 31, 2021.

Effective March 31, 2021, the following changes to the BCP will be made:

- BCP payments will be made at the rate of one BCP base payment per eligible claim.
- BCP payments for subsequent calls and modifiers associated with claims will be discontinued.
- All other program parameters will remain the same.