Billing Corner

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Billing Corner is also available on the Alberta Medical Association website
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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; there are changes to rates that are not stated in the Billing Corner. Please refer to the Schedule of Medical Benefits for complete details.

***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.*

Alberta Health Care Insurance Plan
Schedule of Medical Benefits
Changes for November 1, 2018

Please note: Wording in **bold** indicates changes.

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CHANGES IMPACTING ALL PHYSICIANS

03.01LJ Physician**, nurse practitioner, midwife** or podiatric surgeon to physician telephone or telehealth videoconference or secure videoconference consultation, consultant, weekdays 0700 to 1700 hours

03.01LK Physician**, nurse practitioner, midwife** or podiatric surgeon to physician telephone or telehealth videoconference or secure videoconference consultation, consultant, weekdays 1700 to 2200 hours, weekends and statutory holidays 0700 to 2200 hours

03.01LL Physician**, nurse practitioner, midwife** or podiatric surgeon to physician telephone or telehealth videoconference or secure videoconference consultation, consultant, any day 2200 to 0700 hours
NOTE:

1. HSCs 03.01LJ, 03.01LK, 03.01LL may only be claimed when initiated by the referring physician**, nurse practitioner, midwife** or podiatric surgeon.
2. The consultant may not claim a major consultation or procedure for the same patient for the same condition within 24 hours unless the patient was transferred from an outside facility and advice was given on management of that patient prior to transfer.
3. May only be claimed when the consultant has provided an opinion and recommendations for patient treatment as well as management after reviewing pertinent family/patient history and history of the presenting complaint as well as discussion of the patient's condition and management after reviewing laboratory and other data where indicated. It is expected that the purpose of the call will be to seek the advice of a physician more experienced in treating the particular problem in question, and that the referring physician**, nurse practitioner, midwife** or podiatric surgeon intends to continue to care for the patient.
4. May not be claimed for situations where the purpose of the call is to:
    - arrange for an expedited consultation or procedure within 24 hours except when the conditions in note 2 are met
    - arrange for laboratory or diagnostic investigations
    - discuss or inform the referring physician or podiatric surgeon of results of diagnostic investigations.
5. A maximum of two (any combination of HSC 03.01LJ, 03.01LK, 03.01LL) claims may be claimed per patient, per physician, per day.
6. Documentation must be recorded by both the referring physician**, nurse practitioner, midwife** or the podiatric surgeon and the consultant in their respective records.
7. Telehealth videoconferences may only be claimed when all participants are participating in the videoconference from regional telehealth facilities.
8. Claims for secure videoconference may only be claimed when the service is provided using a secure videoconference system that is in compliance with the CPSA guidelines on secure electronic communication and when the physician/clinic has submitted a Privacy Impact Assessment for this service accepted by the Office of the Privacy Commissioner of Alberta.
9. **Advice to nurse practitioners may only be claimed if the nurse practitioner is in autonomous practice or working at a nursing station where no physician is present.**
10. **Advice to midwives may be claimed if the midwife is in independent practice or working at a midwifery center.**

AMA Billing Tip: *HSCs 03.01LJ, 03.01LK, 03.01LL are intended for situations when the consulting physician is unfamiliar with the patient and in order to provide advice, the consulting physician must complete a history or assessment of the patient. If the consulting physician has an existing relationship with the patient, they must bill either HSC 03.01NG, 03.01NH, 03.01NI when providing advice to the appropriate referring practitioner.*

03.01NG Patient care advice to paramedic - pre hospital patch, assisted living/designated assisted living and lodge staff, active treatment facility worker for hospital in-patient, long term care worker for patients in a long term care facility, nurse practitioner, hospice worker, home care worker**,** **midwife** or public health nurse weekdays 0700 to 1700 hours, provided via telephone or other telecommunication methods, in relation to the care and treatment of a patien**t**

03.01NH Patient care advice to paramedic - pre hospital patch, assisted living/designated assisted living and lodge staff, active treatment facility worker for hospital in-patient, long term care worker for patients in a long term care facility, nurse practitioner, hospice worker, home care worker**,** **midwife** or public health nurse weekdays 1700 to 2200 hours, weekends and statutory holidays, 0700 to 2200 hours, provided via telephone or other telecommunication methods, in relation to the care and treatment of a patient

03.01NI Patient care advice to paramedic - pre hospital patch, assisted living/designated assisted living and lodge staff, active treatment facility worker for hospital in-patient, long term care worker for patients in a long term care facility, nurse practitioner, hospice worker, home care worker**,** **midwife** or public health nurse any day 2200 to 0700 hours, provided via telephone or other telecommunication methods, in relation to the care and treatment of a patient

NOTE:

1. Active treatment facility worker may include registered: nurse, licensed practical nurse**,** **midwife,** occupational therapist, physiotherapist, speech language pathologist, social worker, pharmacist, psychologist, recreational therapist or respiratory therapist.
2. Long term care worker/hospice worker may include registered: nurse, licensed practical nurse, occupational therapist, physiotherapist, speech language pathologist, social worker, pharmacist, psychologist or recreational therapist.
3. Advice to nurse practitioners may only be claimed if the nurse practitioner is in ~~independent~~ **autonomous** practice or working at a nursing station where no physician is present. Advice to a public health nurse may only be claimed if the public health nurse is employed by AHS and working in an AHS health unit.
4. **Advice to midwives may be claimed if the midwife is in independent practice or working at a midwifery center.**
5. In the case of long term care or active treatment facility worker, claims may only be submitted when the physician is outside the facility where the patient is located.
6. May be claimed for advice given to **midwife,** hospice worker, home care worker or public health nurse in person as well as advice by telephone or other telecommunication methods.
7. HSCs 03.01NG, 03.01NH and 03.01NI are to be claimed using the Personal Health Number of the patient.
8. May only be claimed when the call is initiated by the long term care worker, assisted living/designated assisted living or lodge staff member, active treatment facility worker, home care worker, nurse practitioner, hospice worker**, midwife,** public health nurse or paramedic.
9. In the case of a long term care or hospice patient the call may be initiated by the physician if it is in response to receipt of diagnostic or other information that would affect the patient's treatment plan.
10. May be claimed in addition to visits or other services provided on the same day, by the same physician.
11. A maximum of two (any combination of HSC 03.01NG, 03.01NH, 03.01NI) claims may be made per patient, per physician, per day.
12. Documentation of the communication must be recorded in their respective records.

03.01O Physician **or Nurse Practitioner** to Physician secure E-Consultation, consultant
NOTE:

1. May only be claimed when both the referring and consulting physician **or referring nurse practitioner and the consulting physician** exchange communication using secure electronic communication that is in compliance with the CPSA guidelines on secure electronic communication and when the physician**/ nurse practitioner/**clinic has submitted a Privacy Impact Assessment for this service acceptable to the Office of the Privacy Commissioner of Alberta.
2. This service is only eligible for payment if the consultant physician has provided an opinion/advice and/or recommendations for patient treatment and/or management within thirty (30) days from the date of the e-consultation request.
3. May only be claimed when initiated by the referring physician **or nurse practitioner**.
4. The consultant may not claim a major consultation, physician to physician phone call, or procedure for the same patient for the same condition within 24 hours of receiving the request for an e-consultation unless the patient was transferred from an outside facility and advice was given on management of that patient prior to transfer.
5. May only be claimed when the consultant has provided an opinion and recommendations for patient treatment as well as management after reviewing pertinent family/patient history, history of the presenting complaint as well as laboratory and other data where indicated. It is expected that the purpose of the communication will be to seek the advice of a physician more experienced in treating the particular problem in question, and that the referring physician **or nurse practitioner** intends to continue to care for the patient.
6. May not be claimed for situations where the purpose of the communication is to:
   a. arrange for an expedited consultation or procedure within 24 hours except when the conditions in note 4 are met
   b. arrange for laboratory or diagnostic investigations
   c. discuss or inform the referring physician of results of diagnostic investigations.
7. Documentation of the request and advice given must be recorded by the consultant in their patient records.
8. This service may not be claimed for transfer of care alone.
9. **Advice to nurse practitioners may only be claimed if the nurse practitioner is in autonomous practice or working in a nursing station where no physician is present.**

03.01S Physician to patient secure electronic communication
NOTE:

1. A maximum of ~~seven~~ **fourteen** 03.01S per calendar week per physician may be claimed.

03.01T Physician to patient secure videoconference
NOTE:

1. A maximum of ~~seven~~ **fourteen** 03.01T per calendar week per physician may be claimed.

03.04Q Post surgical cancer surveillance examination
A **referral is required for this service—cannot be self-referred**

03.05JB Formal, scheduled family conference relating to a specific patient, per 15 minutes or major portion thereof
NOTE:
1. May not be claimed at the same encounter as ~~HSC 03.03A.~~ **a visit.**
2. May be claimed to a maximum of 12 calls or ~~three~~ **3** hours per year (April 1 to March 31), per patient, per physician.

03.05JR Physician telephone call directly to patient, to discuss patient management/diagnostic test results
NOTE:
1. A maximum of ~~7~~ **14** telephone calls per physician, per calendar week may be claimed.

03.7 BA Medical Assistance in Dying – Determination Phase, full 15 minutes or major portion thereof for the first call when only one call is claimed
NOTE:
1. **May only be claimed for patient management for Medical Assistance in Dying.**
2. **Services related to the Determination Phase include:**
   a. **Patient assessment for Medical Assistance in Dying;**
   b. **Obtaining and reviewing medical records;**
   c. **Reviewing but not waiting for lab and other diagnostic information, and**
   d. **Completion of appropriate documents and forms.**
3. **All services must be provided in accordance with the CPSA standards for Medical Assistance in Dying.**
4. **May not be claimed in addition to a visit, consultation or assessment.**
5. **May not be claimed for travel time.**
6. **The total time spent during the Determination Phase may be calculated on a cumulative basis over the course of several hours or several days.**
7. **The patient's record must include a detailed summary of all services provided including a summary of time spent per day per activity.**

03.7 BB Medical Assistance in Dying – Action Phase, full 15 minutes or major portion thereof for the first call when only one call is claimed
NOTE:
1. **May only be claimed for patient management for Medical Assistance in Dying.**
2. **Services related to the Action Phase include:**
   a. **Patient visit and assessment,**
   b. **Pharmacy visit,**
   c. **Patient care advice to pharmacist, providing physician and nurse practitioner,**
   d. **Review and administration of medication,**
   e. **Coordination of procedure, and**
   f. **Completion of appropriate documents and forms.**
3. **All services must be provided in accordance with the CPSA standards for Medical Assistance in Dying.**
4. **May not be claimed in addition to a visit, consultation or assessment.**
5. **May not be claimed for travel time.**
6. **The total time spent during the Action Phase may be calculated on a cumulative basis over the course of several hours or several days.**
7. **The patient's record must include a detailed summary of all services provided including a summary of time spent per day per activity.**

03.7 BC Medical Assistance in Dying – Care After Death Phase, full 15 minutes or portion thereof for the first call when only one call is claimed

NOTE:

1. **May only be claimed for patient management for Medical Assistance in Dying.**
2. **Services related to the Care After Death Phase include:**
   a. **Reporting of event;**
   b. **Post event arrangements,**
   c. **Completion of death certificate, and**
   d. **Completion of appropriate documents and forms.**
3. **All services must be provided in accordance with the CPSA standards for Medical Assistance in Dying.**
4. **May not be claimed for travel time.**
5. **The total time spent during the Care After Death Phase may be calculated on a cumulative basis over the course of several hours or several days.**
6. **The patient's record must include a detailed summary of all services provided including a summary of time spent per day per activity.**

AMA Billing Tip: *A Bulletin from Alberta Health providing more details on MAID will be published in the near future.*

SECTION OF ANESTHESIA

Amended anesthetic time modifier from ANE/ANEST to 2ANE/2ANES for the following HSCs:

16.43D	47.15B	47.92C	91.15A
16.43E	47.15C	47.93A	91.15B
20.73	47.25B	47.93B	93.69A
44.01	47.25C	48.0 A	
44.3 A	47.25D	49.7 A	
44.4 C	47.25E	49.62B	
44.5 B	47.39A	49.85	
44.5 C	47.54A	50.08A	
46.1 A	47.55A	50.08AA	
46.1 B	47.55B	50.09A	
46.3 B	47.55C	50.34B	
46.3 C	47.72A	50.34C	
46.09B	47.72B	50.34K	
47.02C	47.72C	50.34LA	
47.12A	47.81	50.75B	
47.12B	47.82	51.1 A	
47.13A	47.83B	51.21A	
47.13B	47.84A	51.21B	
47.14A	47.91A	65.8 A	
47.14B	47.92A	65.8 B	
47.15A	47.92B	90.40B	

01.12 **Delete. Will be replaced by HSC 01.12B and 01.12 will become a heading.**

01.12B **HSC 01.12B replaces HSC 01.12 which has been deleted in order to make the appropriate headings**

01.12 Other nonoperative esophagoscopy

01.12A Functional endoscopic esophageal study

01.12B Other nonoperative esophagoscopy, rigid

01.24BA Flexible proctosigmoidoscopy for screening of patients considered to be of high risk for colon cancer due to a family history of Familial Adenomatous Polyposis (FAP)

NOTE:

1. HSCs 57.13A, 57.21A, 57.21B, **57.21C**, and 58.99D may be claimed in addition.
2. Benefit includes biopsies.
3. Benefit includes the removal of diminutive polyps that are 5mm or less in size.
4. May be claimed once every year beginning at the age of 10.

Add HSC 57.21C

01.24BB Flexible proctosigmoidoscopy for screening of patients who are considered to be of average risk for colon cancer

NOTE:

1. HSCs 57.13A, 57.21A, 57.21B, **57.21C,** and 58.99D may be claimed in addition.
2. Benefit includes biopsies.
3. Benefit includes the removal of diminutive polyps that are 5mm or less in size.
4. Average risk is defined as an individual who is asymptomatic and aged 50 to 74 years.
5. May be claimed once every 5 years.

Add HSC 57.21C

SECTION OF CARDIOLOGY

03.08I **Addition of skill CARD, CLIM, and MDON descriptions in the list of eligible providers**
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.

SECTION OF CRITICAL CARE MEDICINE

03.05A Intensive care unit visit per 15 minutes

NOTE:

1. Time spent with a patient **must** be claimed on a cumulative basis per day.
2. When a consultation is claimed in association with 03.05A during the same encounter, the consultation is considered to occupy the first 30 minutes of time spent with the patient.
3. Time spent performing procedures should be excluded from the cumulative time spent with the patient per day.
4. When a procedure and 03.05A are provided during the same encounter, only the greater benefit may be claimed.
5. **Conditions for unscheduled services apply as per GR 15.7**

SECTION OF EMERGENCY MEDICINE

GR 6.12.1 If a physician attempts a closed reduction of a fracture unsuccessfully and finds it necessary to transfer the care of the patient to another physician, the referring physician may claim up to **100%** of the benefit listed for such fractures.
(attempted reductions require just as much if not more effort than successful fracture reductions)

17.71B Femoral nerve block – injection with or without ultrasound
NOTE:

1. **May not be claimed for services related to chronic pain management or treatment.**
2. **May not be claimed in addition to any other anesthetic services by the same physician.**
3. **May be claimed in addition to a visit or consultation by the same physician.**
4. **May not be billed with a visit if another physician has provided and claimed a visit on the same date of service in the same location.**

SECTION OF GASTROENTEROLOGY

01.12 **Delete. Will be replaced by HSC 01.12B and 01.12 will become a heading.**

01.12B **HSC 01.12B replaces HSC 01.12 which has been deleted in order to make the appropriate headings**

01.12 Other nonoperative esophagoscopy

01.12A Functional endoscopic esophageal study

01.12B Other nonoperative esophagoscopy, rigid

01.24BA Flexible proctosigmoidoscopy for screening of patients considered to be of high risk for colon cancer due to a family history of Familial Adenomatous Polyposis (FAP)

NOTE:

1. HSCs 57.13A, 57.21A, 57.21B, **57.21C**, and 58.99D may be claimed in addition.
2. Benefit includes biopsies.
3. Benefit includes the removal of diminutive polyps that are 5mm or less in size.
4. May be claimed once every year beginning at the age of 10.

Add HSC 57.21C

01.24BB Flexible proctosigmoidoscopy for screening of patients who are considered to be of average risk for colon cancer

NOTE:

1. HSCs 57.13A, 57.21A, 57.21B, **57.21C,** and 58.99D may be claimed in addition.
2. Benefit includes biopsies.
3. Benefit includes the removal of diminutive polyps that are 5mm or less in size.
4. Average risk is defined as an individual who is asymptomatic and aged 50 to 74 years.
5. May be claimed once every 5 years.

Add HSC 57.21C

SECTION OF GENERAL PRACTICE

03.04J Development, documentation and administration of a comprehensive annual care plan for a patient with complex needs

NOTE:

1. A maximum of 15 comprehensive annual care plans per physician per calendar week may be claimed.
2. May only be claimed by the most responsible primary care general practitioner **who has an established relationship with the patient and where the physician intends to provide ongoing care and management of the patient.**
3. May only be claimed once per patient per year and includes ongoing communication as required as well as re-evaluation and revision of the plan within a year.
4. May be claimed in addition to HSCs 03.03A, 03.03N or 03.04A.
5. Time spent on the preparation of the complex care plan may not be included in the time requirement for a complex modifier.
6. "Complex needs" means a patient with multiple complex health needs including chronic disease(s) and other complications. The patient must have at least two or more diagnoses from group A or one diagnosis from group A and one or more from group B in order to be eligible.

Group A
- Hypertensive Disease
- Diabetes Mellitus
- Asthma
- Heart Failure
- Ischemic Heart Disease
- Chronic Renal Failure
- Chronic Obstructive Pulmonary Disease

Group B
- Mental Health Issues
- Obesity (Adult = BMI 40 or greater Child = 97 percentile)
- Addictions
- Tobacco

7. "Care plan" means a single document that meets the following criteria:
    a. Must be communicated through direct contact with the patient and/or the patient's agent.
    b. Must include clearly defined goals which are mutually agreed upon between the patient and/or the patient's agent and the physician.
    c. Must include a detailed review of the patient chart, current therapies, problem list and past medical history.
    d. Must include any relevant information that may affect the patient's health or treatment options, such as demographics (education, income, language) or lifestyle behaviors (addictions, exercise, sleep habits, etc.)
    e. Must incorporate the patient's values and personal health goals in the care plan, with respect to his or her complex needs.
    f. Must outline expected outcomes as a result of this plan, including end-of-life issues when clinically appropriate.
    g. Must identify other health care professionals that would be involved in the care of the patient and their expected roles.
    h. Must include confirmation that the care plan has been communicated verbally and in writing to the patient and/or the patient's agent.
    i. Must be signed by **both** the physician and the patient or patient's agent. **The comprehensive annual care plan is only billable if the care plan form on record is signed by both the physician and the patient or patient's agent.**
    j. **The signed copy of the care plan form must** be retained in the patient's medical record.

03.05JR Physician telephone call directly to patient, to discuss patient management/diagnostic test results

NOTE:

1. A maximum of ~~7~~ **14** telephone calls per physician, per calendar week may be claimed.

13.99JA **Amend Note 7 and the Price List to read as follows:**

Management of complex labour, per 15 minutes

NOTE: 7. A maximum of **twelve** 15 minute units may be claimed per patient per pregnancy.

CALL M15			V
1-**12**		For Each Call Pay Base At	100%
SURC EV	Y	Increase By	48.70
SURC NTAM	Y	Increase By	116.83
SURC NTPM	Y	Increase By	16.83
SURC WK	Y	Increase By	48.70

91.01M Closed reduction of fracture, radius amd ulna displaced.

Remove the UNDP (Undisplaced) modifier from Price List

AMA Billing Tip: *HSC 91.01K should be claimed for an undisplaced fracture.*

SECTION OF GENERAL SURGERY

GR 6.9.7 The section on multiple procedures does not apply where the lesser or secondary procedure is:

a. a fracture that is otherwise provided for in this Schedule,
b. a dislocation,
c. a procedure considered to be part of an inclusive benefit, or
d. a secondary procedure that is paid in full as an additional item or as an interpretation of a diagnostic test as a listed benefit in the Schedule,
e. a procedure listed in the following table which may be claimed at 100% when performed as a second or subsequent procedure by any physician, regardless of whether the procedures are performed by one or more physicians and regardless of whether additional incisions are required to perform the procedure. This does not apply to anesthetic services; refer to GR 12.4.9.
Remove HSC 65.9 A

f. a procedure listed in the following table that may be claimed at 100% when performed as a second or subsequent procedure through a different incision by any physician, regardless of whether the procedures are performed by one or more physicians. This does not apply to anesthetic services; refer to GR 12.4.

g. Procedures in different groups in the following table may be claimed at 100% each when performed at the same operative encounter. For example, procedures listed in group B may be claimed at 100% when performed at the same operative encounter as procedures listed in group A. Two procedures from the same group will continue to be paid at 100% and 75% for second and subsequent procedures. This does not apply to anesthetic services; refer to GR 12.4.
Remove HSCs 56.51A and 56.93

Group A
Group B
Group C
Add HSCs 56.93F and 65.9 E
Group D

01.12 **Delete. Will be replaced by HSC 01.12B and 01.12 will become a heading.**

01.12B **HSC 01.12B replaces HSC 01.12 which has been deleted in order to make the appropriate headings**

01.12 Other nonoperative esophagoscopy
01.12A Functional endoscopic esophageal study
01.12B Other nonoperative esophagoscopy, rigid

01.24BA Flexible proctosigmoidoscopy for screening of patients considered to be of high risk for colon cancer due to a family history of Familial Adenomatous Polyposis (FAP)
NOTE:
1. HSCs 57.13A, 57.21A, 57.21B, **57.21C**, and 58.99D may be claimed in addition.
2. Benefit includes biopsies.
3. Benefit includes the removal of diminutive polyps that are 5mm or less in size.
4. May be claimed once every year beginning at the age of 10.

Add HSC 57.21C

01.24BB Flexible proctosigmoidoscopy for screening of patients who are considered to be of average risk for colon cancer
NOTE:
1. HSCs 57.13A, 57.21A, 57.21B, **57.21C,** and 58.99D may be claimed in addition.
2. Benefit includes biopsies.
3. Benefit includes the removal of diminutive polyps that are 5mm or less in size.
4. Average risk is defined as an individual who is asymptomatic and aged 50 to 74 years.
5. May be claimed once every 5 years.

Add HSC 57.21C

13.99GA **Amend Note 6 to read as follows:**
Trauma assessment, multiple trauma, severely injured patient
NOTE: 6. Following the **seventh** day of trauma care, the appropriate level of hospital care should be claimed using HSC 03.03D.

52.2 Regional lymph node excision
That for TB etc
NOTE:
May not be claimed in addition to HSC**s 55.8 B, 55.9 AA and** 63.69A.
Add HSCs 55.8 B and 55.9 AA

52.49E Radical excision of other lymph nodes
Delete

53.53A **Spleen -** ~~R~~**r**upture with repair
NOTE: May not be claimed for incidental repair.

54.21A Biopsy of esophagus via rigid esophagoscopy
Delete

54.6 Esophagomyotomy
NOTE:
May not be claimed with 54.76A, 65.7B, ~~65.7C~~, 65.8B or 65.8C.
Remove HSC 65.7C from note

55.8 B Radical sub-total
NOTE:
1. May be claimed in addition to HSC 66.83.
2. **May not be claimed in addition to HSCs 52.2, 56.2, 57.7, and 66.3 A.**

55.8 C Radical sub-total with splenectomy
Delete

55.8 D Radical sub-total with splenectomy and partial pancreatectomy
Delete

55.9 AA Total gastrectomy for malignancy
NOTE:
May not be claimed with HSCs **52.2,** 52.43A, 55.9 A, **56.2,** ~~and~~ 57.7, **and 66.3 A.**

55.9 B With elective splenectomy
Delete

55.9 C With elective splenectomy and partial pancreatectomy
Delete

56.2 Gastroenterostomy (without gastrectomy)
NOTE:
May not be claimed with HSCs **55.8 B, 55.9 AA,** 64.3, 64.43A, 64.49A or 64.7.

56.4 A Gastrectomy revision with or without resection
NOTE:
May not be claimed in addition to HSC 66.4 A.

56.51A Closure of perforated gastric ulcer
Delete; included in HSC 56.39A

56.93 Gastric partitioning
That for obesity
Delete; to be replaced by HSC 56.93F

56.93 Gastric partitioning for obesity
56.93F Placement of gastric band including port placement

56.93D Removal of gastric band
NOTE:
May not be claimed in addition to HSC**s 56.93E, 66.4 A, and** 66.83.

56.93E Port revision or replacement
NOTE:
May not be claimed in addition to HSC 56.93D

57.7 Small to small intestinal anastomosis
NOTE:
1. May be claimed for ileostomy closure and/or stricturoplasty.
2. May not be claimed in addition to HSCs **55.8 B, 55.9 AA,** 57.42A or 63.69A.

57.42A Small bowel resection
NOTE:
1. May only be claimed with HSC 57.59A when two anastomoses are performed.
2. May only be claimed with HSC 60.52B when two discontinuous areas are resected and two anastomoses are performed.
3. May not be claimed in addition to HSC**s 57.7 or** 63.12B.

65.01A Repair of inguinal hernia - with or without incarceration, obstruction or strangulation
Delete

65.7 C Anti-reflux procedure
That for recurrent esophagitis, following a previous repair
Delete – replaced by new HSC 65.9 E

65.8 C Anti-reflux procedure
That for recurrent esophagitis, following a previous repair
Delete

65.9 A Strangulated hernia with resection
Delete

65.9 E Repair of diaphragmatic hernia, abdominal or thoracic approach, anti-reflux procedure
That for recurrent esophagitis, following a previous repair
Replaces HSCs 65.7 C and 65.8 C

65.11A Repair of inguinal hernia – with or without incarceration, obstruction or strangulation, includes the use of mesh if used
Replaces HSC 65.01A

66.3 A Omentectomy, for abdominal malignancy, additional benefit
NOTE:
May be claimed in addition to the primary procedure performed**, except for HSCs 55.8 B and 55.9 AA.**

66.83 Laparoscopy
Diagnostic, with or without biopsy
NOTE:
1. May not be claimed in addition to other procedures if the laparoscopy is an integral part of the procedure with the exception of HSCs 62.12B, 81.09, 82.63 or 83.2 B, which may be claimed at 100%.
2. May be claimed in addition to HSCs 55.8 A, 55.8 B, 55.8 C, 55.8 D, 55.9 A, 55.99A, 55.9 B, 55.9 C, 64.43A, 64.49A.
3. **May not be claimed in addition to HSC 56.93D.**

67.01C Renal exploration to include drainage of renal or peri-renal abscess
Delete

SECTION OF INTERNAL MEDICINE

01.12 **Delete. Will be replaced by HSC 01.12B and 01.12 will become a heading.**

01.12B **HSC 01.12B replaces HSC 01.12 which has been deleted in order to make the appropriate headings**

01.12 Other nonoperative esophagoscopy

01.12A Functional endoscopic esophageal study

01.12B Other nonoperative esophagoscopy, rigid

01.24BA Flexible proctosigmoidoscopy for screening of patients considered to be of high risk for colon cancer due to a family history of Familial Adenomatous Polyposis (FAP)

NOTE:

1. HSCs 57.13A, 57.21A, 57.21B, **57.21C**, and 58.99D may be claimed in addition.
2. Benefit includes biopsies.
3. Benefit includes the removal of diminutive polyps that are 5mm or less in size.
4. May be claimed once every year beginning at the age of 10.

Add HSC 57.21C

01.24BB Flexible proctosigmoidoscopy for screening of patients who are considered to be of average risk for colon cancer

NOTE:

1. HSCs 57.13A, 57.21A, 57.21B, **57.21C,** and 58.99D may be claimed in addition.
2. Benefit includes biopsies.
3. Benefit includes the removal of diminutive polyps that are 5mm or less in size.
4. Average risk is defined as an individual who is asymptomatic and aged 50 to 74 years.
5. May be claimed once every 5 years.

Add HSC 57.21C

03.01NL Patient care advice to active treatment facility worker in relation to a patient receiving outpatient IV medication day treatment, any day 2200 to 0700 hours

NOTE:

1. Active treatment facility worker may include registered: nurse, licensed practical nurse, occupational therapist, physiotherapist, speech language pathologist, social worker, pharmacist, psychologist, recreational therapist or respiratory therapist.
2. May only be claimed by **hematology,** infectious disease specialists, internal medicine and rheumatologists.
3. May only be claimed when the physician is outside the facility from where the patient is located.
4. May be claimed for advice given to the worker by telephone or other telecommunication means.
5. To be claimed using the Personal Health Number of the patient.
6. May only be claimed when the call is initiated by the health care worker.
7. A maximum of two (any combination of HSCs 03.01NJ, 03.01NK, 03.01NL) claims may be made per patient, per physician, per day.
8. Documentation of the communication must be recorded in their respective records.

03.03FA **Addition of MDON and NEUR to list of skill codes that are eligible to claim for the service**

Prolonged repeat office or scheduled outpatient visit in a regional facility, referred cases only, full 15 minutes or portion thereof for the first call when only one call is claimed
NOTE:

1. May only be claimed in addition to HSC 03.03F when the 03.03F exceeds 30 minutes.
2. May only be claimed by pediatrics (including subspecialties) and clinical immunology and allergy for patients 18 years of age and under, or by cardiology, endocrinology/metabolism, gastroenterology, infectious diseases, internal medicine, hematology, medical genetics, **medical oncology, neurology,** physiatry, respiratory medicine, rheumatology, urology and vascular surgery (no age restriction).

03.39 Other nonoperative measurements and examinations

03.39A 24-hour ambulatory blood pressure monitoring (ABPM), interpretation
NOTE: May only be claimed by internal medicine specialists.

03.39B 24-hour ambulatory blood pressure monitoring (ABPM), technical
NOTE: May only be claimed by internal medicine specialists.

03.08I **Addition of skill CARD, CLIM, and MDON descriptions in the list of eligible providers**

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.

SECTION OF NEUROLOGY

03.03FA **Addition of MDON and NEUR to list of skill codes that are eligible to claim for the service**

Prolonged repeat office or scheduled outpatient visit in a regional facility, referred cases only, full 15 minutes or portion thereof for the first call when only one call is claimed
NOTE:

1. May only be claimed in addition to HSC 03.03F when the 03.03F exceeds 30 minutes.
2. May only be claimed by pediatrics (including subspecialties) and clinical immunology and allergy for patients 18 years of age and under, or by cardiology, endocrinology/metabolism, gastroenterology, infectious diseases, internal medicine, hematology, medical genetics, **medical oncology, neurology,** physiatry, respiratory medicine, rheumatology, urology and vascular surgery (no age restriction).

SECTION OF OBSTETRICS AND GYNECOLOGY

03.08M Extended uro-gynecology**, pediatric gynecological,** gyne-oncology, reproductive endocrinology or perinatology consultation, per 15 minutes or major portion thereof

13.99JA Management of complex labour, per 15 minutes
NOTE:

1. Time may be determined on a cumulative basis.
2. May be claimed for complex or non-progressive labour where the physician is actively managing a higher risk labour (defined as prolonged labour exceeding 12 hours during the first stage of labour or 1 hour during the second stage of labour, non-progressive labour, non-reassuring fetal/maternal status, multiple gestation, pregnancy induced hypertension, HELLP, insulin dependent diabetes, antepartum hemorrhage, prelabour ruptured membranes, non-reassuring fetal heart tracing, multiple pregnancy and preterm labour, seizure disorder, unstable patient).
3. May only be claimed when the physician is on-site and immediately available or when called to monitor or reassess the patient with complex or non-progressing labour.
4. Only HSC 13.99JA or the services relating to labour provided may be claimed, but not both. Concurrent billing for overlapping time for separate patient encounters/services may not be claimed.
5. May be claimed in addition to HSCs 86.9 B, 86.9 D or 87.98A.
6. May not be claimed in addition to HSCs 87.98B or 87.98C.
7. A maximum of ~~eight~~ **twelve**15 minute units may be claimed per patient per pregnancy.

SECTION OF OPHTHALMOLOGY

GR 6.5 NON-INVASIVE DIAGNOSTIC PROCEDURES IN HOSPITAL, AACC OR UCC
Add HSCs 03.39A, 03.39B, 03.44A, 09.02E, 09.13G, 09.13H

03.08H Formal major neuro-ophthalmology consultation, **including complex consultations of orbit or oncology.**

13.57A Iontophoresis ~~or ionization~~**, ionization or gluing** of corneal ulcer

21.71 Dacryocystorhinostomy (DCR)
Addition of BMIPRO modifier

L10	**UNDER 10 YEARS** **The patient has not reached their 10th birthday.**

Add L10 to the following HSC codes:

22.13A	22.4 A	26.2 B	26.71	28.72B
22.13B	25.55A	26.25B	27.72A	29.02A

AMA Billing Tip: *L10 is an implicit modifier meaning the payment rate will be adjusted automatically for patients that have not reached their 10th birthday.*

It is not necessary to add the L10 modifier to the claim to have the rate adjusted.

22.13C **Non cosmetic** ~~E~~excision of benign tumor of eyelid not requiring pathology analysis**, for functional reasons including obstruction of visual axis, tearing, inflammation, or lid malposition**
NOTE: For services requiring pathology analysis see HSC 22.13A.
(Amending the wording to better define the criteria for insurability under the Alberta Health Care Insurance Plan. Those not meeting the criteria are considered uninsured.)

22.32A Major full thickness repair of lid involving eyelid margin entropion, ectropion, trauma or tumor)
Addition of BMIPRO modifier

23.99A Strabismus repair, one muscle
Adjust CALL NBRSER 2-6 to pay 75% from the current 56%

27.72A Phacoemulsification cataract extraction, anterior approach, with or without insertion of intraocular lens
Addition of BMIPRO modifier

28.72B Posterior total vitrectomy with 2 or 3 port infusion and cutting device
Addition of BMIPRO modifier

29.02A ~~Remove orbital tumor posterior to globe~~ **Complicated orbital reconstruction or tumor excision -** first 90 minutes

SECTION OF OTOLARYNGOLOGY

17.08G Division of nerves to sternomastoid in neck
Delete

20.55C Transphenoidal or transethmoidal hypophysectomy, Otolaryngological component
Delete

32.5 A Fenestration of lateral semi-circular canal
Delete

32.71A Decompression and shunt of endolymphatic sac
Delete

32.79A Excision of glomus tumors, Shambough operation
Delete

32.79E Labyrinth destruction, Cawthorne operation
Delete

43.0 A ~~Injection of Teflon~~ **Laryngeal injection of material excluding Botulinum A Toxin**

SECTION OF PEDIATRICS

03.03DG Complex pediatric hospital visit per full 15 minutes
NOTES:
1. May only be claimed for visits where the patient is complex and requires a minimum of ~~20~~ **15** minutes on patient care management.

03.05G ~~Care of healthy~~ **Initial assessment of** newborn ~~in hospital (first day)~~

03.05GA Care of healthy newborn in hospital (subsequent days)
NOTE:
May only be claimed when no other visit service has been provided on that day, regardless of physician.
Addition of PED skill code

03.08M Extended uro-gynecology**, pediatric gynecological,** gyne-oncology, reproductive endocrinology or perinatology consultation, per 15 minutes or major portion thereof

AMA Billing Tip: *The L13 modifier is an implicit modifier meaning the modifier does not need to be added to the claim to adjust payment.*

L13 is automatically applied when the patient has not reached their 13th birthday.

50.94D Introduction of central venous catheter, with or without ultrasound guidance
NOTE:
May not be claimed in addition to HSC 49.95A.
Addition of L13 modifier

50.94E Introduction of catheter into peripheral vein, requiring ultrasound guidance
NOTE:
May not be claimed for routine venous access or initiation of intravenous.
Addition of L13 modifier

50.94F Introduction of venous catheter for hyperalimentation, percutaneous or by cutdown
Delete – refer to HSC 50.94D and 50.94E

SECTION OF PLASTIC SURGERY

89.0 B **Reconstruction of sternum using plates and screws**
NOTE:
May not be claimed for closure of sternum for routine cardiac procedures.

96.02A Amputation and disarticulation of thumb**, distal to MP joint**
Amending the wording to distinguish this service from HSC 96.02B.

97.43 Unilateral augmentation mammoplasty by implant or graft **prosthesis**

97.95 Insertion of tissue expander **for breast reconstruction**
NOTE: Bilateral procedures may be claimed using 2 calls.

97.96 Removal of breast tissue expander~~(s)~~ **for breast reconstruction**
NOTE:
1. When removal is the only procedure performed and not part of another procedure.
2. **Bilateral procedures may be claimed using 2 calls.**

98.49G Functional split thickness skin graft over 64 **and to 100** total square cms
Amending the wording to distinguish this service from HSC 98.49N

SECTION OF RADIOLOGY

X128 **Add Note 4 to read as follows:**
Bone mineral content determination dual photon absorptiometry with or without vertebral fracture assessment (VFA)
NOTE: **4. Nurse Practitioners and physicians that are part of Cancer Control Alberta may refer for patients under 50 years of age who are at high risk of bone density loss. Text is required on both the referral and the claim to indicate the patient's risk.**

X321 Ultrasound, obstetrical, second or third trimester, **high risk –** for example, significant maternal disease (i.e. diabetes), fetal anomaly, fetal markers, Intrauterine Growth Retardation (IUGR), oligohydramnios, growth discordance in twins, suspected fetal anemia, genetics, fetal therapy