Billing Corner

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

April 2024

***Please read this document and then share it with your billing staff*.**

Please ensure that your billing software has been updated to reflect the changes described in this document. The Billing Corner is a summary document; there are changes to rates 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 sections that apply to your services.*

Alberta Health Care Insurance Plan
Schedule of Medical Benefits
Changes for April 1, 2024

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

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AMA NOTES:

- These changes are retroactive to April 1, 2024.
- Claims for services that have already been submitted and have had a rate adjustment will be reassessed and paid at the April 1, 2024 rate for dates of services April 1, 2024 onward. Physicians do not need to resubmit their valid claims to receive the adjusted rates.
- Claims for services that are new additions (e.g., 18,29EA) or changes to existing fee codes (e.g., 03.03AO) may be submitted to AH for dates of April 1, 2024 and onward.

GOVERNING RULE CHANGES

6.5 – **Addition of 09.13I and 09.13J**:

NON-INVASIVE DIAGNOSTIC PROCEDURES IN HOSPITAL, AACC OR UCC

Benefits for non-invasive diagnostic procedures including HSCs in Section E (Laboratory and Pathology) and X (Diagnostic Radiology) performed for a hospital inpatient, registered outpatient or AACC or UCC patient are not payable under the Schedule. Payment for these services is the responsibility of the hospital/Regional Health Authority. This applies to both the technical and professional components. Such procedures include but are not limited to the following list.

9.1.2 Three technical services and three interpretive services from the following examinations may be claimed in addition to HSCs 03.04A, 03.04AZ, 03.08A, 03.08AZ, 03.08H and 09.04:

- 09.01B Gonioscopy
- 09.01C Orthoptic analysis, interpretation
- 09.01E Orthoptic analysis, technical (may include Hess screen)
- 09.02B Anterior chamber depth measurement
- 09.02E Amblyopia evaluation for patients nine years of age or younger
- 09.05A Full threshold perimetric examination, technical
- 09.05B Full threshold perimetric examination, interpretation
- 09.06A Color vision test, interpretation and technical
- 09.11A Bilateral specular microscopy for corneal graft patients only - technical
- 09.11B Bilateral specular microscopy for corneal graft patients only - interpretation
- 09.11C Potential acuity measurement (PAM)
- 09.12A Intravenous fluorescein angiography (IVFA), interpretation
- 09.12B Intravenous fluorescein angiography (IVFA), technical
- 09.13E Optical coherence tomography (OCT), interpretation
- 09.13F Optical coherence tomography (OCT), technical
- **09.13I Yearly bilateral biometry for myopic progression in children under 18 years of age, technical**
- **09.13J Yearly bilateral biometry for myopic progression in children under 18 years of age, interpretation**
- 09.26A Diurnal tension curve
- 09.26D Bilateral corneal pachymetry
- 21.31A Diagnostic irrigation of nasolacrimal duct, office procedure, per eye
- 24.89B Diagnostic conjunctival scraping
- 25.81A Diagnostic corneal scraping

9.1.3 Three technical services and three interpretive services from the following examinations may be claimed in addition to HSCs 03.02A, 03.03A, 03.03AZ, 03.07A, 03.07AZ, and 03.07B:

03.12A Intraocular pressure measurement
09.01A Biomicroscopy (slit lamp examination)
09.01B Gonioscopy
09.01C Orthoptic analysis, interpretation
09.01E Orthoptic analysis, technical (may include Hess screen)
09.02B Anterior chamber depth measurement
09.02E Amblyopia evaluation for patients nine years of age or younger
09.05A Full threshold perimetric examination, technical
09.05B Full threshold perimetric examination, interpretation
09.06A Color vision test, interpretation and technical
09.11A Bilateral specular microscopy for corneal graft patients only – technical
09.11B Bilateral specular microscopy for corneal graft patients only – interpretation
09.11C Potential acuity measurement (PAM)
09.12A Intravenous fluorescein angiography (IVFA), interpretation
09.12B Intravenous fluorescein angiography (IVFA), technical
09.13E Optical coherence tomography (OCT), interpretation
09.13F Optical coherence tomography (OCT), technical
09.13I Yearly bilateral biometry for myopic progression in children under 18 years of age, technical
09.13J Yearly bilateral biometry for myopic progression in children under 18 years of age, interpretation
09.26A Diurnal tension curve
09.26D Bilateral corneal pachymetry
21.31A Diagnostic irrigation of nasolacrimal duct, office procedure, per eye
24.89B Diagnostic conjunctival scraping
25.81A Diagnostic corneal scraping

10.2.3 A child 17 years of age and under requires extensive dental rehabilitation **that** could not otherwise be **provided** due to the length of time for the treatment.

Extensive dental rehabilitation is defined as a service that has been scheduled for at least 60 minutes. Extensive dental rehabilitation does not include extraction of wisdom teeth or any routine dental treatment.

Routine dental treatment or care (defined as restorative, prosthetic, periodontal, implant procedures or for routine dental extractions), is not a benefit, regardless of the location or type of facility where they are performed. See GR 5.1 of the Schedule of Oral and Maxillofacial Surgery Benefits for a full list of excluded services.

11.1.1 Claims for services under the pathology and radiology sections will not be payable unless the physician has **successfully completed the examinations offered by a recognized certification program. A completed Physician Skill Validation form signed by the applying physician and Medical Director of the facility validating the evaluation of the physician's professional competence, qualifications, licensure and qualifications must be submitted to Alberta Health for formal registration.**

11.2 ELECTROCARDIOGRAPHY/TAPE ECG/CARDIOVASCULAR STRESS TESTING

A claim for HSCs 03.41A, 03.41B, 03.41C, 03.44A, 03.52B, 03.52D, 03.55B and 03.56B may be submitted by physicians who have **successfully completed the examinations offered by a recognized certification program,** to provide these services. For purposes of claims for HSC 03.52D, **a completed Physician Skill Validation form signed by the applying physician and Medical Director of the facility validating the evaluation of the physician's professional competence, qualifications, and licensure must be submitted to Alberta Health.**

AMA NOTES: The Physician Skill Validation Form (AHC13188) can be downloaded by clicking this link:
https://www.alberta.ca/health-professional-business-forms#jumplinks-0

11.2.1 PULMONARY FUNCTION PROCEDURES

Physicians performing procedures identified as Level I **(HSCs 03.37A, 03.37B, 03.38D, 03.38E and 03.38R)** do not require a **completed Physician Skill Validation form.-**Physicians performing procedures identified as requiring either Level II, III or IV **skill validation** may only be claimed by physicians with the appropriate level of **certification as confirmed by the completed Physician Skill Validation form signed by the applying physician and Medical Director of the facility validating the evaluation of the physician's professional competence, qualifications, and licensure.**

In addition to Level I procedures, physicians with Level II approval may claim:
03.38A, 03.38B, 03.38C, 03.38F, 03.38G

In addition to Level I and Level II procedures, physicians with Level III approval may claim:
03.38H, 03.38K, 03.38M, 03.38N, 03.38P, 03.38Q, 03.38S, 03.38T, 03.38X

11.2.3 EVOKED POTENTIAL

A claim for HSCs 03.19C, 09.21B, 09.23B and 09.46A may be submitted by physicians who have **successfully completed the examinations offered by a recognized certification program and who have submitted a Physician Skill Validation form signed by the applying physician and Medical Director of the facility validating the evaluation of the physician's professional competence, qualifications, and licensure to Alberta Health for formal registration.**

14.1 – **Addition of 18.29FA**:
A major tray service benefit may be claimed for the following procedures only when they are performed in a location other than a nursing home, general or auxiliary hospital, AACC, UCC or a facility which has a contract with a regional health authority to provide any of these insured services.

14.2 – **Addition of 18.29EA**:

MINOR TRAY SERVICE

A minor tray service benefit may be claimed for the following procedures only when they are performed in a location other than a nursing home, general or auxiliary hospital, AACC, UCC or a facility which has a contract with a regional health authority to provide any of these insured services.

SUBD SUBD SUBDIVISION – (Explicit) – This modifier type is used with visit health service codes to indicate during which time period the service recipient/service provider encounter took place. These modifiers are applicable during the evening on weekdays, during the day and evening on weekends and statutory holidays, and during the night on any day. A fee is added to the base rate as indicated by the modifier.

For home visits and hospice visits, the SUBD modifier should be claimed based on the time at which the encounter commences and the physician responds on an unscheduled basis within a 24 hour period from the time of the call. **The time of the initial call as well as time of service must be documented in patient's record.**

CHANGES APPLICABLE TO ALL PHYSICIANS

03.01S – **Addition of the word "calendar" in Note 6:**

Physician to patient secure electronic communication

6. May only be claimed once per **calendar** week per patient per physician.

03.01T – **Addition of the word "calendar" in Note 4:**

Physician to patient secure videoconference

4. May only be claimed once per **calendar** week per patient per physician.

03.05JP – **Addition of Note 7:**

Family conference via telephone relating to acute care facility in-patient or registered emergency or out-patient, or auxiliary Hospital, nursing home patient, hospice patient, AACC or UCC patient.

7. May only be claimed when the physician provides the service.

SECTION OF ANESTHESIA

36.99AA Anesthetic fee for **extensive** dental **rehabilitation treatment**
NOTE: 1. May only be claimed when the conditions described in GRs 10.2 and 10.3 are met.
2. May only be claimed for dental rehabilitation for children 17 years and under when the scheduled length of the rehabilitation treatment is at least 60 minutes.
3. The extraction of wisdom teeth or any routine dental treatment alone is not considered to be extensive dental rehabilitation.

36.99AA	147.48	**ROLE2ANES 2ANU 2ANU**	**Y**	**Replace Base**	**22.25**
		1		**For Each Call Pay Base At**	**100%**
		2-150		**For Each Call Increase By**	**22.25**

SECTION OF DIAGNOSTIC RADIOLOGY

18.29E Paravertebral block

NOTES: 1. When claimed for a diagnostic branch block of a spinal facet joint, one call may be claimed for each individual joint blocked. For example, L4/5 and L5/S1 on the right is two calls. L4/5 and L5/S1 bilaterally is four joints; therefore four calls.
2. Up to three calls may be claimed per side when nerves for that number of joints are blocked, for a maximum of six calls.
3. The first joint (cervical, thoracic, or lumbar) for Diagnostic medical branch block(s) requires two needle placements, each additional contiguous joint requires one additional needle placement.
4. Branch blocks of a spinal facet joint may only be claimed for diagnostic procedures, not for therapeutic use.
5. May not be used in place of HSCs 16.89B, 16.89C, or 16.89D for facet joint injections when the limits for HSC 16.89 have otherwise been reached.
6. Fluoroscopy HSC (X107A) may only be submitted for the first call.

18.29E **CALL NBRSER**

1	**For Each Call Pay Base At**	**100%**
2-6	**For Each Call Pay Base At**	**50%**

18.29EA Sacroiliac block

NOTES: 1. May only be claimed for a diagnostic branch block of a sacroiliac joint, one call may be claimed for each individual joint blocked.
2. Two calls may be claimed for bilateral sacroiliac joints. Refer to Price List.
3. When claimed in addition to HSC 18.29E on the same date of service, only one benefit for HSC X107A may be claimed.

18.29EA	**107.03**	**TRAY**	**MINT**		**Increase By**	**13.11**	**M+**
		NBTR	**NBTR**	**Y**			
		CALL	**NBRSER**				
			1		**For Each Call Pay Base At**	**100%**	
			2-2		**For Each Call Pay Base At**	**50%**	
		SURC	**EV**	**Y**	**Increase By**	**48.70**	
		SURC	**NTAM**	**Y**	**Increase By**	**116.83**	
		SURC	**NTPM**	**Y**	**Increase By**	**116.83**	
		SURC	**WK**	**Y**	**Increase By**	**48.70**	
		LVP	**LVP75**	**Y**	**Reduce Base To**	**75%**	

18.29F Radiofrequency ablation of the facet joint medial branch nerves, using fluoroscopic guidance

NOTES: 1. One call applies for each individual spinal facet joint treated. For example, L4/5 and L5/S1 on the right is two calls. L4/5 and L5/S1 bilaterally is four joints, therefore four calls.

2. Up to three calls may be claimed per side when nerves for that number of joints are ablated, for a maximum of six calls bilaterally.

3. HSC 18.29E or 18.29EA may not be claimed on the same day.

4. When claimed in addition to HSC 18.29FA on the same date of service, only one benefit for HSC X107A may be claimed.

18.29F	469.85	CALL NBRSER		
		1	For Each Call Pay Base At	100%
		2-**6**	For Each Call Pay Base At	50%

18.29FA Radiofrequency ablation of the sacroiliac joint medial branch nerves, using fluoroscopic guidance

NOTES:1. Two calls may be claimed for bilateral sacroiliac joints. Refer to Price List.

2. When claimed in addition to HSC 18.29F on the same date of service, only one benefit for HSC X107A may be claimed.

3. HSC 18.29E or 18.29EA may not be claimed on the same day.

18.29FA	**600.00**	**TRAY MAJT**	**Increase By**	**38.88**	**1**
		CALL NBRSER			
		1	**For Each Call Pay Base At**	**100%**	
		2-2	**For Each Call Pay Base At**	**50%**	

50.79A Vascular occlusion by catheter, to include intraoperative angiograms, **per vessel**.

NOTE: 1. A single call applies regardless of the number of lesions treated within a single vessel.

2. Multiple calls may only be claimed when multiple vessels are treated.

50.79A	412.67	**CALL NBRSER**		
		1	**For Each Call Pay Base At**	**100%**
		2-2	**For Each Call Pay Base At**	**75%**

50.99E Peripheral embolectomy or endarterectomy, additional benefit

NOTE: 1. May only be claimed in association with other vascular surgery through the same arteriotomy.

2. A single call applies regardless of the number of embolectomies or endarterectomies provided in the same vessel.

3. Multiple calls may only be claimed when multiple vessels are treated.

50.99E	205.71	**CALL NBRSER**		
		1	**For Each Call Pay Base At**	**100%**
		2-3	**For Each Call Pay Base At**	**75%**

51.59B Percutaneous transluminal angioplasty, excluding coronary vessels
NOTE: 1. May not be claimed in addition to HSCs 50.91D or 50.91E.
2. A single call applies regardless of the number of angioplasties provided in the same vessel.
3. Multiple calls may only be claimed when multiple vessels are treated.

51.59B	548.68	CALL NBRSER		
		1	For Each Call Pay Base At	100%
		2-2	**For Each Call Pay Base at**	**75%**
		3-4	**For Each Call Pay Base at**	**50%**

X 27C Screening mammography (age 40 to 4**4** years inclusive)
NOTE: Refer to notes following X27**G** for further information.

X 27D Screening mammography (age **45** to 74 years inclusive)
NOTE: Refer to notes following X27**G** for further information.

X 27E Screening mammography (age 75 years and over)
NOTE: **Refer to notes under X 27G for further information.**
~~1. Benefits for X27C, X27D and X27E include patient education. A visit benefit may not be claimed in conjunction with these services by the radiologist performing the screening mammogram or by a different radiologist in conjunction with the same radiological examination.~~
~~2. Only one Screen Test or fee-for-service benefit may be claimed every calendar year.~~
~~3. X27C and X27E must be referred initially. Subsequent yearly referrals are not required. X27D does not require a referral.~~
~~4. X27C, X27D or X27E may not be claimed subsequent to X27 within the same calendar year.~~
~~5. Supplementary views, refer to X27F.~~
~~6. X27C, X27D and X27E require submission of data to the Alberta Breast Cancer Screening Program through either the Alberta Society of Radiologists or the Alberta Health Services' Screening Programs.~~
~~7. X27C, X27D or X27E may not be claimed in addition to HSCs X105 or X105A.~~

X 27G Screening mammography for patients with the following conditions: implants, augmentation, mammoplasty, and when determined appropriate for screening by a radiologist and/or primary care physician, with the following conditions: post intervention (e.g. biopsy, excision, etc.)
NOTE:
1. Benefits for HSCs X27C, X27D and X27E include patient education. A visit benefit may not be claimed in conjunction with these services by the radiologist performing the screening mammogram or by a different radiologist in conjunction with the same radiological examination.
2. Only one Screen Test or fee-for-service benefit may be claimed every calendar year.
3. HSCs X27C and X27E must be referred initially. Subsequent referrals are not required. HSC X27D does not require a referral.
4. HSCs X27C, X27D or X27E may not be claimed subsequent to HSC X27 within the same calendar year.
5. Supplementary views, refer to HSC X27F.
6. HSCs X27C, X27D, X27E, X27F (related to mammography work up), X27G, and TOMO modifier require submission of data to the Alberta Breast Cancer Screening Program through either the Alberta Society of Radiologists or the Alberta Health Services' Screening Programs.
7. HSCs X27C, X27D, X27E, and X27G may not be claimed in addition to HSCs X105 or X105A.
8. Required data submitted to the Alberta Breast Cancer Screening Program or results communication cannot be claimed as 03.01S, 03.01T or 03.05JR.

X308 Ultrasound, breast, including axilla
NOTE:
1. Two calls may only be claimed for bilateral ultrasound.
2. May not be claimed with HSC X309.
3. Ultrasounds completed due to dense breast tissue require submission of data to the Alberta Breast Cancer Screening Program through either the Alberta Society of Radiologists or the Alberta Health Services' Screening Programs.

SECTION OF EMERGENCY MEDICINE

98.22B – Addition of age modifier

AGE L10 Increase Base to 130%

L10 applies to patients who have not reached their 10th birthday.

The age modifier is an implicit modifier meaning that the modifier will be added, and the adjusted rate will pay automatically based on the patient's age at the time of the service.

SECTION OF FAMILY MEDICINE

03.03NB – **SUBD modifier removed**

Home visit to patients residing in Assisted Living, Designated Assisted Living (DAL), group homes, seniors lodges or personal care home, second/subsequent patients

NOTE: 1. A maximum of one visit per day, per facility, per patient may be claimed.

2. If a special call for attendance is made for a second visit on the same date of service, a second 03.03NB may be submitted with supporting information.

3. If the facility provides a room for the physician to see the patient, an appropriate visit (03.02A, 03.03A or 03.04A) should be billed instead.

4. At a minimum, a physician must complete a 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.

03.04K – **Age requirement reduced from 75 to 65:**

Comprehensive geriatric assessment, first full 90 minutes

NOTE: 1. If the assessment is less than 90 minutes, then HSC 03.04A, 03.04AZ, 03.08A or 03.08AZ should be claimed.

2. May only be claimed in an AHS regional facility or AHS/Contracted partner run geriatric program(s) or Community clinic where a PCN multi-disciplinary team is contributing to the assessment.

3. May only be claimed for patients aged **65** years or older.

4. May only be claimed by general practitioners, internal medicine specialists or geriatric medicine specialists.

5. May only be claimed once per patient per year.

6. Each subsequent 15 minutes, or major portion thereof, may be claimed at the rate specified on the Price List, to a maximum of 7 calls.

7. Assessment must include the following components:

a) Medical includes but is not limited to a complete physical examination, a problem list, co morbidity conditions and disease severity, a medication review and nutritional status.
b) Functional includes but is not limited to a review of basic activities of daily living, instrumental activities of daily living, activity/exercise status, gait, balance and assessment of senior falls.
c) Cognitive/psychological includes but is not limited to review of mental status, administration of the Mini Mental State Examination (MMSE) and mood/depression testing through Geriatric Depression Scale (GDS)**or other relevant appropriate mental health examinations.**
d) Social includes but is not limited to a review of informal support needs and assets, care resource eligibility and a financial assessment.
e) Environmental includes but is not limited to a review of current living situation, home safety and transportation.

8. Evidence that all components in note 7 were completed must be documented in the patient's records. This includes physician notes and copies of the MMSE and GDS **or other relevant appropriate mental health examinations**.

03.05I Direct care, reassessment, education and/or general counselling of a patient requiring palliative care, per 15 minutes or portion thereof - in office **or a patient's home**
NOTE:
For palliative care services provided in the patient's home, the subdivision (SUBD) modifier may only be claimed when a special call has been made on behalf of the patient and the physician responds within a 24 hour period from the time of the call. The time of the initial call as well as the time of the service must be documented in patient's record.

03.05I	53.97	CALL	M15			V
			1-96		For Each Call Pay Base At	100%
		SUBD	**OFEV**	**Y**	**Increase Base By**	**44.61**
		SUBD	**OFEVWK**	**Y**	**Increase Base By**	**52.30**
		SUBD	**OFNTAM**	**Y**	**Increase Base By**	**119.89**
		SUBD	**OFNTPM**	**Y**	**Increase Base By**	**119.89**
		TELE	TELES	Y	Increase Base To	120%

08.44A – **Addition of Note 4**:
Group psychotherapy, where all members of the group are receiving therapy in the session, full 15 minutes or major portion thereof for the first call when only one call is claimed.
4. May be claimed by a general practitioner (GP) or a generalist in mental health (GNMH) when providing services in the capacity of the second or subsequent physician for psychotherapy of complex groups (HSC 08.44D).

87.0 A Termination of pregnancy between 13 and 20 weeks for medical or genetic reasons using potent prostaglandins **or for termination of ectopic pregnancy using methotrexate** by any route.
NOTE:
1. Includes the insertion of a laminaria tent if required.
2. A D & C **or surgical treatment** if required within 14 days should be claimed under HSC 81.09 or **78.52C.**

87.98E **Delivery detention time, may be claimed per full 15 minutes after the first full 30 minutes has elapsed**
NOTE: 1. May only be claimed when a physician is specifically requested by the physician intending to perform a delivery and no other service may be claimed for that attendance.
2. May be claimed following the first 30 minutes after the physician has arrived for the attendance at delivery.
~~2~~**3**. **Services following delivery may be claimed in addition, e.g., care of healthy newborn (HSC 03.05G), neonatal resuscitation (HSC 13.99F), resuscitation (HSC 13.99E), etc.**
4. This service is **only** billable when physician attendance on behalf of the baby is required.
5. If the mother is transferred to another hospital prior to the delivery, the physician may claim for the time spent providing the service to a maximum of 3 calls (60 minutes) of HSC 87.98E with text.

87.98E	88.99	**CALL**	**M30M15**		
		1		**For Each Call Pay Base At**	**100%**
		2-3		**For Each Call Increase By**	**44.50**

98.22B – **Addition of age modifier:**

AGE L10	**Increase Base to**	**130%**

L10 applies to patients who have not reached their 10th birthday.

The age modifier is an implicit modifier meaning that the modifier will be added, and the adjusted rate will pay automatically based on the patient's age at the time of the service.

98.71D Vandenbos procedure
NOTE: A single call applies per digit treated.

98.71D	**108.41**	**TRAY MAJT**		**Increase By**	**38.78**	**1**
		NBTR NBTR	**Y**			
		LVP LVP75	**Y**	**Reduce Base To**	**75%**	

SECTION OF GENERAL SURGERY

66.4 A – **Addition of Note 4:**

Lysis of adhesions

NOTE 1. May only be claimed when a full 15 minutes has been spent on adhesions. Each subsequent 15 minutes or major portion thereof may be claimed at the rate specified on the Price List.

2. May not be claimed in addition to procedures billed with REDO modifier(s).

3. May not be claimed in addition to HSCs 58.42A, 58.44A, 58.81A, 58.81B, 65.61A, **71.02** and 81.29C.

4. Benefit includes time spent on lysis of adhesions in the retroperitoneum.

SECTION OF NEPHROLOGY

03.03AO – **Addition of skill codes:**

Transfer of care of hospital in-patient

NOTE: May only be claimed by endocrinology/metabolism, general internal medicine, gastroenterology, infectious disease, general surgery, cardiology, hematology, clinical immunology, medical oncology, **nephrology, pediatrics, pediatric subspecialities** and respiratory medicine.

03.03AO	95.38	**SKLL NEPH**	**Replace Base**	**210.92**
		SKLL NPM	**Replace Base**	**205.35**
		SKLL PDGE	**Replace Base**	**205.35**
		SKLL PDNR	**Replace Base**	**205.35**
		SKLL PED	**Replace Base**	**205.35**
		SKLL PEDC	**Replace Base**	**205.35**
		SKLL PEDN	**Replace Base**	**205.35**

SECTION OF NEUROLOGY

13.59L Botulinum toxin injection for treatment of sialorrhea
NOTE: May only be claimed by Otolaryngology/Neurology specialists.

SECTION OF OBSTETRICS & GYNECOLOGY

81.99AA **Removal of fallopian tubes at the same time as hysterectomy for risk reduction for ovarian cancer, additional benefit**
NOTE: The benefit is for the removal of one or both fallopian tubes at the time of the hysterectomy.

81.99AA	**100.00**	**BMI**	**BMIPRO**	**Y**	**Increase By**	**25%**	**14**
		LVP	**ADD**	**Y**	**Replace Base By**	**100%**	

83.9 A Operations on the adnexa, any method
NOTE:
1. May be claimed with HSCs 71.7 A, 82.7 A and 81.99A.
2. May not be claimed in association with a hysterectomy for the removal of fallopian tubes alone. **Removal of fallopian tubes for ovarian cancer risk reduction, at the same time as a hysterectomy, should be claimed using HSC 81.99AA.**
3) May not be claimed for sterilization.
4)When performed as a second or subsequent procedure through the same incision, the procedural rate should be claimed at 50% using modifier LVP50. Anesthetic claims using ANE for second and subsequent procedures should use the LVP75 modifier.

87.0 A Termination of pregnancy between 13 and 20 weeks for medical or genetic reasons using potent prostaglandins **or for termination of ectopic pregnancy using methotrexate** by any route.
NOTE:
1. Includes the insertion of a laminaria tent if required.
2. A D & C **or surgical treatment** if required within 14 days should be claimed under HSC 81.09 or **78.52C.**

87.98E **Delivery detention time, may be claimed per full 15 minutes after the first full 30 minutes has elapsed**
NOTE: 1. May only be claimed when a physician is specifically requested by the physician intending to perform a delivery and no other service may be claimed for that attendance.
2. May be claimed following the first 30 minutes after the physician has arrived for the attendance at delivery.
~~2~~**3**. **Services following delivery may be claimed in addition, e.g., care of healthy newborn (HSC 03.05G), neonatal resuscitation (HSC 13.99F), resuscitation (HSC 13.99E), etc.**
4. This service is **only** billable when physician attendance on behalf of the baby is required.
5. If the mother is transferred to another hospital prior to the delivery, the physician may claim for the time spent providing the service to a maximum of 3 calls (60 minutes) of HSC 87.98E with text.

87.98E	88.99	**CALL M30M15**			**V**
		1	**For Each Call Pay Base At**	**100%**	
		2-3	**For Each Call Increase By**	**44.50**	

SECTION OF OPHTHALMOLOGY

9.1.2 Three technical services and three interpretive services from the following examinations may be claimed in addition to HSCs 03.04A, 03.04AZ, 03.08A, 03.08AZ, 03.08H and 09.04:

09.01B Gonioscopy
09.01C Orthoptic analysis, interpretation
09.01E Orthoptic analysis, technical (may include Hess screen)
09.02B Anterior chamber depth measurement
09.02E Amblyopia evaluation for patients nine years of age or younger
09.05A Full threshold perimetric examination, technical
09.05B Full threshold perimetric examination, interpretation
09.06A Color vision test, interpretation and technical
09.11A Bilateral specular microscopy for corneal graft patients only - technical
09.11B Bilateral specular microscopy for corneal graft patients only - interpretation
09.11C Potential acuity measurement (PAM)
09.12A Intravenous fluorescein angiography (IVFA), interpretation
09.12B Intravenous fluorescein angiography (IVFA), technical
09.13E Optical coherence tomography (OCT), interpretation
09.13F Optical coherence tomography (OCT), technical
09.13I Yearly bilateral biometry for myopic progression in children under 18 years of age, technical
09.13J Yearly bilateral biometry for myopic progression in children under 18 years of age, interpretation
09.26A Diurnal tension curve
09.26 Bilateral corneal pachymetry
21.31A Diagnostic irrigation of nasolacrimal duct, office procedure, per eye
24.89B Diagnostic conjunctival scraping
25.81A Diagnostic corneal scraping

9.1.3 Three technical services and three interpretive services from the following examinations may be claimed in addition to HSCs 03.02A, 03.03A, 03.03AZ, 03.07A, 03.07AZ, and 03.07B:

03.12A Intraocular pressure measurement
09.01A Biomicroscopy (slit lamp examination)
09.01B Gonioscopy
09.01C Orthoptic analysis, interpretation
09.01E Orthoptic analysis, technical (may include Hess screen)
09.02B Anterior chamber depth measurement
09.02E Amblyopia evaluation for patients nine years of age or younger
09.05A Full threshold perimetric examination, technical
09.05B Full threshold perimetric examination, interpretation
09.06A Color vision test, interpretation and technical
09.11A Bilateral specular microscopy for corneal graft patients only - technical
09.11B Bilateral specular microscopy for corneal graft patients only - interpretation
09.11C Potential acuity measurement (PAM)
09.12A Intravenous fluorescein angiography (IVFA), interpretation
09.12B Intravenous fluorescein angiography (IVFA), technical
09.13E Optical coherence tomography (OCT), interpretation
09.13F Optical coherence tomography (OCT), technical
09.13I Yearly bilateral biometry for myopic progression in children under 18 years of age, technical
09.13J Yearly bilateral biometry for myopic progression in children under 18 years of age, interpretation
09.26A Diurnal tension curve
09.26D Bilateral corneal pachymetry
21.31A Diagnostic irrigation of nasolacrimal duct, office procedure, per eye
24.89B Diagnostic conjunctival scraping
25.81A Diagnostic corneal scraping

09.12A Intravenous fluorescein angiography (IVFA), interpretation
NOTE: 1. May not be claimed with HSC 13.59C.
2. Benefit includes both eyes.

09.13I Yearly bilateral biometry for myopic progression in children under 18 years of age, technical.
NOTES: 1. May only be claimed for patients with a refractive error of -3D or worse. The refractive error must be recorded in the patients' chart.
2. Benefit rate includes both eyes.

09.13I 25.00 T

09.13J Yearly bilateral biometry for myopic progression in children under 18 years of age, interpretation.
NOTES: Refer to notes on HSC 09.13I for further information.

09.13J 10.00 T

22.4 A – **Increase calls from 2 to 4:**

CALL NBRSER		
1	For Each Call Pay Base At	100%
2-**4**	For Each Call Pay Base At	75%

27.3 C Yttrium Aluminium Garnet (YAG) laser capsulotomy
NOTE: Two calls may be claimed for bilateral services.

27.3 C

CALL NBRSER		
1	**For Each Call Pay Base At**	**100%**
2	**For Each Call Pay Base At**	**75%**

SECTION OF ORTHOPEDICS

16.09N Intervertebral fusion, thoracic & lumbar spine only (anterior lumbar intervertebral fusion (ALIF), posterior lumbar intervertebral fusion (PLIF), translateral lumbar intervertebral fusion (TLIF)**, or lateral lumbar interbody fusion)**

SECTION OF PEDIATRICS

03.03AO – **Addition of skill codes:**

Transfer of care of hospital in-patient

NOTE: May only be claimed by endocrinology/metabolism, general internal medicine, gastroenterology, infectious disease, general surgery, cardiology, hematology, clinical immunology, medical oncology, **nephrology, pediatrics, pediatric subspecialities** and respiratory medicine.

03.03AO	95.38	**SKLL NEPH**	**Replace Base**	**210.92**
		SKLL NPM	**Replace Base**	**205.35**
		SKLL PDGE	**Replace Base**	**205.35**
		SKLL PDNR	**Replace Base**	**205.35**
		SKLL PED	**Replace Base**	**205.35**
		SKLL PEDC	**Replace Base**	**205.35**
		SKLL PEDN	**Replace Base**	**205.35**

87.98E **Delivery detention time, may be claimed per full 15 minutes after the first full 30 minutes has elapsed**

NOTE: 1. May only be claimed when a physician is specifically requested by the physician intending to perform a delivery and no other service may be claimed for that attendance.

2. May be claimed following the first 30 minutes after the physician has arrived for the attendance at delivery.

~~2~~**3**. **Services following delivery may be claimed in addition, e.g., care of healthy newborn (HSC 03.05G), neonatal resuscitation (HSC 13.99F), resuscitation (HSC 13.99E), etc.**

4. This service is **only** billable when physician attendance on behalf of the baby is required.

5. If the mother is transferred to another hospital prior to the delivery, the physician may claim for the time spent providing the service to a maximum of 3 calls (60 minutes) of HSC 87.98E with text.

87.98E	88.99	**CALL M30M15**		
		1	**For Each Call Pay Base At**	**100%**
		2-3	**For Each Call Increase By**	**44.50**

98.22B – **Addition of age modifier:**

AGE L10	**Increase Base to**	**130%**

L10 applies to patients who have not reached their 10th birthday.

The age modifier is an implicit modifier meaning that the modifier will be added, and the adjusted rate will pay automatically based on the patient's age at the time of the service.

SECTION OF PHYSICAL MEDICINE AND REHAB

18.29E Paravertebral block

NOTES: 1. When claimed for a diagnostic branch block of a spinal facet joint, one call may be claimed for each individual joint blocked. For example, L4/5 and L5/S1 on the right is two calls. L4/5 and L5/S1 bilaterally is four joints; therefore four calls.
2. Up to three calls may be claimed per side when nerves for that number of joints are blocked, for a maximum of six calls.
3. The first joint (cervical, thoracic, or lumbar) for Diagnostic medical branch block(s) requires two needle placements, each additional contiguous joint requires one additional needle placement.
4. Branch blocks of a spinal facet joint may only be claimed for diagnostic procedures, not for therapeutic use.
5. May not be used in place of HSCs 16.89B, 16.89C, or 16.89D for facet joint injections when the limits for HSC 16.89 have otherwise been reached.
6. Fluoroscopy HSC (X107A) may only be submitted for the first call.

18.29E	**CALL NBRSER**		
	1	**For Each Call Pay Base At**	**100%**
	2-6	**For Each Call Pay Base At**	**50%**

18.29EA Sacroiliac block

NOTES: 1. May only be claimed for a diagnostic branch block of a sacroiliac joint, one call may be claimed for each individual joint blocked.
2. Two calls may be claimed for bilateral sacroiliac joints. Refer to Price List.
3. When claimed in addition to HSC 18.29E on the same date of service, only one benefit for HSC X107A may be claimed.

18.29EA	**107.03**	**TRAY MINT**		**Increase By**	**13.11**	**M+**
		NBTR NBTR	**Y**			
		CALL NBRSER				
		1		**For Each Call Pay Base At**	**100%**	
		2-2		**For Each Call Pay Base At**	**50%**	
		SURC EV	**Y**	**Increase By**	**48.70**	
		SURC NTAM	**Y**	**Increase By**	**116.83**	
		SURC NTPM	**Y**	**Increase By**	**116.83**	
		SURC WK	**Y**	**Increase By**	**48.70**	
		LVP LVP75	**Y**	**Reduce Base To**	**75%**	

18.29F Radiofrequency ablation of the facet joint medial branch nerves, using fluoroscopic guidance

NOTES: 1. One call applies for each individual spinal facet joint treated. For example, L4/5 and L5/S1 on the right is two calls. L4/5 and L5/S1 bilaterally is four joints, therefore four calls.
2. Up to three calls may be claimed per side when nerves for that number of joints are ablated, for a maximum of six calls bilaterally.
3. HSC 18.29E or 18.29EA may not be claimed on the same day.
4. When claimed in addition to HSC 18.29FA on the same date of service, only one benefit for HSC X107A may be claimed.

18.29F	469.85	CALL NBRSER		
		1	For Each Call Pay Base At	100%
		2-**6**	For Each Call Pay Base At	50%

18.29FA Radiofrequency ablation of the sacroiliac joint medial branch nerves, using fluoroscopic guidance

NOTES:1. Two calls may be claimed for bilateral sacroiliac joints. Refer to Price List.
2. When claimed in addition to HSC 18.29F on the same date of service, only one benefit for HSC X107A may be claimed.
3. HSC 18.29E or 18.29EA may not be claimed on the same day.

18.29FA	**600.00**	**TRAY MAJT**	**Increase By**	**38.88**	**1**
		CALL NBRSER			
		1	**For Each Call Pay Base At**	**100%**	
		2-2	**For Each Call Pay Base At**	**50%**	

SECTION OF PSYCHIATRY

08.11A - **Change from 45 to 30 minutes:**

Requiring complete mental status examination and investigation, First full **30** minutes or major portion thereof for the first call when only one call is claimed

08.11A	43.53	CALL M**30**M15		
		1	For Each Call Pay Base At	100%
		2-1**1**	For Each Call Increase By	40.82

08.11B – **Addition of Notes 3 and 4:**

Evidence from a psychiatrist at a Review Panel on behalf of a Specific patient, as required under section 37(3) of the Mental Health Act, per 15 minutes or portion thereof

3. Time spent completing and reviewing relevant forms and documents may be claimed using this code. Time spent may occur on a separate date of service as the hearing, and must be recorded on a session by session basis in the patient record. A maximum of 30 minutes of preparation time may be claimed.

4. Benefit does not include travel time.

08.11C – **Change time from 45 to 30 minutes:**

For complex patient, requiring complete mental status examination and investigation, first full **30** minutes or major portion thereof for the first call when only one call is claimed

08.11C	187.90	CALL	**M30M15**		V
			1	For Each Call Pay Base At	100%
			2-**11**	For Each Call Increase By	46.97

08.12A Certification under the Mental Health Act

NOTE:

1. For the completion of forms under the Mental Health Act.

2. May not be claimed for completion of forms that are covered by other health service codes.

SECTION OF VASCULAR SURGERY

50.79A Vascular occlusion by catheter, to include intraoperative angiograms, **per vessel**
NOTE: 1. A single call applies regardless of the number of lesions treated within a single vessel.
2. Multiple calls may only be claimed when multiple vessels are treated.

50.79A	412.67	**CALL NBRSER**		
		1	**For Each Call Pay Base At**	**100%**
		2-2	**For Each Call Pay Base At**	**75%**

50.99E Peripheral embolectomy or endarterectomy, additional benefit
NOTE: 1. May only be claimed in association with other vascular surgery through the same arteriotomy.
2. A single call applies regardless of the number of embolectomies or endarterectomies provided in the same vessel.
3. Multiple calls may only be claimed when multiple vessels are treated.

50.99E	205.71	**CALL NBRSER**		
		1	**For Each Call Pay Base At**	**100%**
		2-3	**For Each Call Pay Base At**	**75%**

51.59B Percutaneous transluminal angioplasty, excluding coronary vessels
NOTE: 1. May not be claimed in addition to HSCs 50.91D or 50.91E.
2. A single call applies regardless of the number of angioplasties provided in the same vessel.
3. Multiple calls may only be claimed when multiple vessels are treated.

51.59B	548.68	CALL NBRSER		
		1	For Each Call Pay Base At	100%
		2-2	**For Each Call Pay Base at**	**75%**
		3-4	**For Each Call Pay Base at**	**50%**